IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

State of KANSAS, *et al.*, Plaintiff-Appellants, v. XAVIER BECERRA, *et al.*, Defendant-Appellees.	Case No. 25-1097 On appeal from the United States District Court for the Northern District of Iowa Case No. 1:24-cv-00110

MOTION FOR INJUNCTION PENDING APPEAL

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JURISDICTION

The district court has federal question jurisdiction under 28 U.S.C. § 1331. Because Plaintiffs were denied injunctive relief, this Court has jurisdiction over an interlocutory appeal under 28 U.S.C. § 1292(a).

INTRODUCTION

The Biden-Harris Administration forced upon nursing homes a Rule[1] that put its policy preferences above the reality of nationwide staffing shortages and sky-high compliance costs. Because this desire to "help" nursing home residents costs at least $43 billion in compliance, it will inevitably and predictably shutter homes, leaving many patients with nowhere else to go.

Plaintiffs—a diverse group of States and organizations with nursing homes as members—understood the Rule's impact. So, they sued to stop it.

The district court recognized the Rule would irreparably harm Plaintiffs, but tried to sever that harm from what it perceived as the

[1] Specifically, Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting. 89 Fed. Reg. 40,876 (May 10, 2024).

aspects of the Rule Plaintiffs had challenged. That was wrong. Because the Rule irreparably harms Plaintiffs, who challenged the *entire* Rule, this Court should enjoin the Rule pending appeal.

BACKGROUND

On May 10, 2024, Defendants issued their Rule. *See* 89 Fed. Reg. 40,876. The Rule imposed a staffing mandate that tripled Congress's standard for RN care (the 24/7 RN requirement), imposed an inflexible hours-per-resident-day (HPRD) staffing mandate without considering local needs or conditions, and supported those staffing mandates with a new enhanced facility assessment (EFA).[2] *See* 89 Fed. Reg. at 40,876. It also imposed onerous, yet vague, new "institutional payment transparency reporting" requirements on state Medicaid agencies. *See* 89 Fed. Reg. 40,995

Plaintiffs—20 states and 18 organizations representing long-term care facilities (LTCs)—challenged the Rule on October 8, 2024. R. Doc. 1; Appx. 1.[3] On October 22, Plaintiffs moved for a preliminary injunction. R. Doc. 30. After hearing oral argument, on January 16,

[2] To avoid redundancy, these requirements are discussed in more detail in the applicable Argument subsections.
[3] "Appx. _" is the Appendix accompanying this Motion.

2025, the district court denied the motion, principally because it concluded that although the alleged harms existed and were irreparable, they were too speculative for injunctive relief. R. Doc. 95; Appx. 351.

On January 17, Plaintiffs moved for a stay pending appeal in the district court, R. Doc. 102, which was denied on January 21, R. Doc. 103.

ARGUMENT

Plaintiffs are entitled to an injunction pending appeal. In considering Plaintiffs' request, this Court "engage[s] in the same inquiry as when it reviews the grant or denial of a preliminary injunction." *Walker v. Lockhart*, 678 F.2d 68, 70 (8th Cir. 1982). So, the Court must consider "(1) the threat of irreparable harm to the movant; (2) the state of the balance between this harm and the injury that granting the injunction will inflict on other . . . litigant[s]; (3) the probability that movant will succeed on the merits; and (4) the public interest." *Dataphase Sys., Inc. v. CL Sys., Inc.*, 640 F.2d 109, 113 (8th Cir. 1981).

As the district court found, Plaintiffs have shown the Rule causes irreparable harm. And because the other factors also support Plaintiffs, this Court should enjoin it nationwide.

I. The Rule irreparably harms Plaintiffs

a. The EFA is integral to the Rule

The Rule has—and will continue to—irreparably harm Plaintiffs. The district court considered irreparable harm as a threshold matter. R. Doc. 95 at 8; Appx. 358. And it correctly determined the Rule's EFA requirement irreparably harms Plaintiffs. R. Doc. 95 at 16; App. 366. The court nevertheless erroneously applied a selective and piecemeal analysis of the harm.

Effective since August 8, 2024, the EFA requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. *See* 89 Fed. Reg. at 40,908; *id.* at 40,905-06. Facilities must "review and update" the EFA at least annually, without clear guidance on when updates are "necessary"—thus, leading to potential civil penalties. *Id.* at 40,999. LTC facilities must also create "contingency planning," despite already having emergency plans in place. *Id.* at 41,000.

Overall, the EFA imposes significant administrative burdens and vague requirements that can penalize LTC facilities despite good-faith compliance efforts. CMS estimates each EFA costs around $4,955 per facility, which is low. Plaintiff Dooley Center, for example, required approximately 16 hours of staff time to complete the EFA, which comes out to approximately $579.36 per month to stay in compliance. R. Doc. 30-25 at 5; Appx. 265. And Plaintiff Wesley Towers required 89 hours, which cost thousands of dollars of staff time and diverted attention from other work. R. Doc. 30-24 at 3; Appx. 258. Underscoring the arbitrary nature of the Rule's staffing mandates, Dooley Center's and Wesley Towers' enhanced facility assessments demonstrated there is no need for 24/7 RN coverage. *See* R. Doc. 30-25 at 2-4; Appx. 263-65; R. Doc. 30-24 at 4; Appx. 259.

The Rule's EFA requirement irreparably harms Plaintiffs. But instead of analyzing Plaintiffs' likelihood of success on the merits for the Rule *as a whole*, the district court considered likelihood of success only with respect to the EFA requirement. The court also did not determine the EFA requirement were severable, declining to perform any severability analysis. R. Doc. 95 at 21 n.11; Appx. 371. Absent a

severability determination, the Rule should be considered as a whole for considering injunctive relief.[4] The district court erred by not doing so; the Rule should have been enjoined because an inseverable part will irreparably harm Plaintiffs.

The district court did not cite any case to support splitting up the Rule, which goes against this Court's precedent. In *Missouri v. Biden*, 112 F.4th 531 (8th Cir. 2024), this Court enjoined the entire loan forgiveness rule, despite a district court finding that only the ultimate forgiveness provision imposed irreparable harm.

The district court asserted the *Missouri* injunction was issued "only because the Government created a hybrid rule that made the district court's injunction useless." R. Doc. 95 at 17; Appx. 367. But that is incorrect. If the hybrid rule caused irreparable harm by enabling continuing loan forgiveness despite the district court injunction, this Court could have enjoined the loan forgiveness provision of the hybrid rule. Instead, it enjoined the *entire rule* because the *entire rule* facilitated irreparable harm.

[4] Plaintiffs have consistently maintained they are challenging the entire Rule. *See* R. Doc. 95 at 10 n.5; Appx. 360.

Here, the EFA is a not a separate, unconnected provision of the Rule but is instead an inseparable support for the minimum staffing requirements. The Rule repeatedly acknowledges the EFA's role.[5] The EFA move LTCs toward compliance with those requirements. Proposed section 483.71(b)(4), for example, requires LTCs to "use their facility assessment to develop and maintain a staffing plan to maximize recruitment and retention of nursing staff." 89 Fed. Reg. at 40,906.

The EFA is an essential to the Rule's minimum staffing standard.[6] The district court erroneously considered it separately.

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[5] *See, e.g.,* 89 Fed. Reg. at 40,881 ("[N]ational minimum staffing standards in LTC facilities and the adoption of a 24/7 RN and [EFA] requirements, will help to advance equitable, safe, and quality care sufficient to meet the nursing needs for all residents and greater consistency across facilities."); *id.* at 40,883 ("The [EFA requirements] . . . guard against any attempts by LTC facilities to treat the minimum staffing standards included here as a ceiling, rather than a floor."); *id.* at 40,906 ("We proposed at new § 483.71(b)(4) that LTC facilities would have to use their facility assessment to develop and maintain a staffing plan to maximize recruitment and retention of nursing staff."); *id.* ("The facility assessment is an important complement to the minimum staffing requirements."); *id.* at 40,909 ("The facility assessment is the foundation for LTC facilities to assess their resident population and determine the direct care staffing and other resources, to provide the required care to their residents.").

[6] *See* 89 Fed. Reg. at 49,909 ("The facility assessment must be conducted and developed with the intent of using it to inform decision making, especially about staffing decisions.").

b. The staffing mandates irreparably harm Plaintiffs

Beyond the EFA—which merits injunctive relief—the Rule's minimum staffing requirements will also irreparably harm Plaintiffs. The district court properly held that compliance costs may constitute irreparable harm because Plaintiffs cannot recover monetary damages due to sovereign immunity. R. Doc. 95 at 12; Appx. 362. Accordingly, an injunction is necessary.

The district court correctly recognized the 24/7 RN requirement and HPRD requirements "will impose tremendous costs on LTC facilities" but it decided such costs were "too speculative" for relief. *Id.* That was wrong.

Plaintiffs submitted substantial evidence that they *currently* incur costs from the 24/7 RN and HPRD requirements. Multiple Plaintiffs filed declarations conveying the changes many of their member LTCs were already undertaking to comply with the Rule. For example, LeadingAge Virginia discussed how many of their nursing homes already were "attempting to hire additional RNs rather than LPNs" because of the 24/7 RN and HPRD requirements, and were "increasing hiring efforts" more broadly in preparation for the Rule going into

effect. R. Doc. 30-22 at 9; Appx. 244. Similarly, LeadingAge Iowa affirmed their member facilities "are attempting to hire RNs over LPNs whenever possible" and engaging in expensive and aggressive recruitment strategies due to the Rule. R. Doc. at 30-10 at 8; Appx. 120.

The district court did not dispute these current costs, instead noting that Plaintiffs did not submit "cost breakdowns" for these efforts. A detailed cost breakdown was not required, and the district court erred in holding Plaintiffs to this heightened evidentiary standard.

State Plaintiffs operate nursing homes that are subject to the Rule and will incur these same costs and burdens. For example, Arkansas has a state-operated 310-bed psychiatric nursing home, the Arkansas Health Center. *See* Ark. Code Ann. § 25-10-401. These nursing homes, *i.e.*, the States, will suffer the same harms as the other LTCs suffer, with massively increased staffing costs, an inability to hire necessary staff such that they are forced to reduce services or even close, and increased staff time and costs devoted to EFAs.

State Plaintiffs' harms are even more extensive due to their additional regulatory role. In Indiana, for example, the Indiana Health Coverage Program and Indiana PathWays for Aging provide coverage

for long-term care services provided to eligible members with an applicable level-of-care determination. CMS estimates that complying with the 24/7 RN Requirement will cost over $10.9 million annually in Indiana. 89 Fed. Reg. at 40962, tbl. 18. Statewide, CMS estimates that complying with this Rule will cost Indiana LTC facilities $151.2 million. *Id.* at 40984, tbl. 28. Much of this cost will be passed on to health plans offered by the State.

Plaintiffs established irreparable harm.[7]

II. Defendants will not suffer any harm

An injunction will alleviate Plaintiffs' burden without harming Defendants.

First, Defendants alleged that briefly delaying their rulemaking would "frustrate Congress's objectives" by blocking a statutorily-authorized regulation. *See* R. Doc. 72 at 52. But if Plaintiffs are likely to succeed on the merits (they are), Defendants cannot be harmed by being

[7] Additionally, State Plaintiffs will be required to engage in "institutional payment transparency reporting," 89 Fed. Reg. at 40,995, so they have had and will continue to devote staff resources to acquiring and organizing the information for those reports, *see, e.g.*, R. Doc. 30-4 at 79; Appx. 79. And they will incur additional costs posting these reports online. The Rule acknowledges these costs to the States of $183,851 in the first year. 89 Fed. Reg. at 40,991.

unable to enact an unlawful regulation. *Cf. Missouri v. Biden*, 576 F. Supp. 3d 622, 635 (E.D. Mo. 2021).

Second, an injunction pending appeal would not delay the Rule's purported benefits because it is front-loaded, so Plaintiffs' harms occur long before any alleged benefits. Compliance costs have begun, which the district court agreed "will recur on an ongoing basis." R. Doc. 95 at 16; Appx. 366. Along with the EFA, Plaintiffs incur costs as they prepare to comply with the staffing mandates. Because the staffing mandates are not effective until 2026 at the earliest, the benefits, if any, are also years away.

The balance of harms greatly favors Plaintiffs.

III. Plaintiffs are likely to succeed on the merits

The Rule is contrary to statute, violates the Major Questions Doctrine, exceeds Defendants' statutory authority, and is arbitrary and capricious.

The district court acknowledged Plaintiffs "raised substantial issues and concerns about [the] Final Rule's 24/7 RN requirement and HPRD requirements." R. Doc. 95 at 21; Appx. 371. But it erroneously did not meaningfully evaluate Plaintiffs' likelihood of success.

This Court has repeatedly held that likelihood of success is the "most significant" factor for a preliminary injunction. *See, e.g.*, *Missouri*, 112 F.4th at 536. Had the district court properly considered this factor and the equities, it would have issued an injunction. *See Fennell v. Butler*, 570 F.2d 263, 264 (8th Cir. 1974) ("If the balance [of the equities] tips decidedly towards the plaintiffs *and the plaintiffs have raised questions serious enough to require litigation*, ordinarily the injunction should issue." (emphasis added)).

1. The Rule is unlawful

The Rule violates existing law. Congress already established the minimum RN staffing necessary to participate in Medicaid or Medicare: LTC facilities "must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* § 1395i-3(b)(4)(C)(i). The Rule replaces Congress's 8/7 RN requirement with a 24/7 mandate: that LTC facilities "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40,997.

For the Rule to be remotely lawful, any staffing mandates for nursing care must be less than 24 hours. Congress only requires 24-

hour nursing staff "which are sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i)(I); *accord id.* § 1395i-3(b)(4)(C)(I). But the Rule mandates 24/7 RN staffing. 89 Fed. Reg. at 40,997. It effectively writes out the phrase "which are sufficient to meet the nursing needs of its residents" out by requiring every facility regardless of the nursing needs of its residents to have 24-hour nursing case unless they get a waiver.

The statutory plain language demonstrates there would be at least some instances where 24-hour nurse staffing would not be required without seeking a waiver. If not, the "which are sufficient to meet the nursing needs of its residents" language would have no purpose. The Rule turns all of this on its head by demanding via executive fiat that all nursing homes have 24-hour nurse staffing unless they receive a waiver. "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). Defendants got caught playing sorcerer and have no defense. On that basis alone, the court can find the Rule is unlawful.

This is the textbook case where an agency—believing it knows best—tries to rewrite Congress's policy choices. Defendants cannot do

this, so the Rule is unlawful.

2. The Rule violates the Major Questions Doctrine

When agency action involves a matter of "vast economic and political significance," the agency must find clear congressional authority approving of such action. *Alab. Ass'n of Realtors v. Dep't of Health and Hum. Servs.*, 594 U.S. 758, 764 (2021) (finding no clear congressional authority for the CDC to issue a nationwide eviction moratorium); *see also West Virginia v. EPA*, 597 U.S. 697, 723 (2022) (recognizing clear authorization is necessary). Accordingly, courts should "'typically greet' assertions of 'extravagant statutory power over the national economy' with 'skepticism.'" *West Virginia*, 597 U.S. at 723 (quoting *Util. Air Regul. Group v. EPA*, 573 U.S. 302, 324 (2014)).

The Rule poses a major question. Indeed, Defendants propose to revamp the entire nursing home industry through at least $43 billion dollars in compliance costs, meaning the Rule has vast economic significance. *See Ala. Ass'n of Realtors*, 594 U.S. at 764 (finding $50 billion cost triggered Doctrine); *see also Missouri*, 112 F.4th at 537 (applying Doctrine after recognizing that costs around $50 billion trigger it). The actual cost is likely higher. The Rule also impacts nearly

all LTCs in almost every state, threatening to drive a large percent out of business. Because of the Rule's significant cost, the Doctrine applies. *See Missouri*, 112 F.4th at 537

The Doctrine also considers the States: "When an agency claims the power to regulate vast swaths of American life, it not only risks intruding on Congress's power, it also risks intruding on powers reserved to the States." *Ala. Ass'n of Realtors*, 594 U.S. at 744. (Gorsuch, J., concurring).

Defendants "intruded" on powers traditionally reserved to the States through the mandatory staffing requirements. Because Congress required only 8/7 staffing and allowed flexibility for LTCs based on the needs of their facilities, the States have moved to add further requirements based on the needs of their residents and communities.

When a court finds a major question, it must look for "clear authorization," not some "vague statutory grant." *West Virginia*, 597 U.S. at 732. Defendants have no more than a vague statutory grant upon which to hang their hat, and even that requires ignoring statutory staffing requirements. The Rule violates the Major Questions Doctrine.

3. The Rule exceeds Defendants' statutory authority

Defendants not only lack clear statutory authorization, they lack any *plausible* authorization. CMS is a "creature[] of statute," and "possess[es] only the authority that Congress has provided." *Nat'l Fed'n of Indep. Bus.,* 595 U.S. at 117. It "literally has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986); *see also* 42 U.S.C. § 1302(a) (Secretary may not "publish rules and regulations" that are "inconsistent with" the law).

Defendants invoked their "miscellaneous" and "other" authority to *triple* the minimum staffing hours Congress has already implemented and authorize extra-statutory staffing ratios. Even if CMS had some authority to set staffing requirements, it could not use that limited authority to contradict Congress. The Rule is a crude, improper attempt by CMS to play sorcerer. *See Alexander*, 532 U.S. at 291

a. 24/7 RN requirement

Defendants have no authority to triple the minimum amount of RN staffing required. Congress already decided the issue: 8 hours a day, 7 days a week. 42 U.S.C. § 1396r(b)(4)(C)(i); *accord id.*

§1395i-3(b)(4)(C)(i).

CMS can only promulgate rules "pursuant to authority Congress has delegated to [it]." *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). But Defendants did not rely on specific delegations of authority; they relied on "various provisions" elsewhere in sections 1395i-3 and 1396r that contain "separate authority" for minimum staffing levels, s*ee* 89 Fed. Reg. at 40879, 40890-91:

1) an LTC meet "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary," 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B);
2) an LTC "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care," 42 U.S.C. § 1396r(b)(2), *accord* 42 U.S.C. § 1395i-3(b)(2); and
3) an LTC "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident," 42 U.S.C. §

1396r(b)(1)(A); *accord* 42 U.S.C. § 1395i-3(b)(1)(A).

Defendants claim authority to rewrite the *specific* minimum staffing statutes through a *general* authority found in other, catch-all provisions. But it is an elementary canon of statutory interpretation 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." *See, e.g.*, *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)). The best reading of the statutory authority upon which CMS relied is that it is related to administrative details concerning the health and safety of LTC patients that the rest of the Medicare and Medicaid statute does not already cover. It does not authorize a 24/7 RN mandate that replaces the 8/7 RN mandate.

b. The HPRD requirements

The Rule's HPRD requirements similarly exceed statutory authority. Congress carefully considered whether to enact *quantitative* staff-to-patient ratios for LTC facilities, and it chose not to do so. Congress chose a *qualitative* standard in the underlying statutes, leaving quantitative staff-to-patient ratios to the states: LTC facilities

must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord* § 1395i-3(b)(4)(C)(i).

The Rule unlawfully substitutes CMS's policy views for Congress' considered judgment. It inflexibly mandates that each facility in each state meet an arbitrary numerical staffing threshold: "[a] minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides." 89 Fed. Reg. at 40996.

Like the 24/7 RN mandate, the HPRD requirements rely on general, catch-all authority requiring LTC facilities to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and "promote maintenance or enhancement of the quality of life of each resident." 89 Fed. Reg. at 40879, 40890-91; *see* 42 U.S.C. §§ 1395i-3(b)(1)(A), (b)(2), (d)(4)(B); 1396r(b)(1)(A), (b)(2), (d)(4)(B). These generalized provisions do not authorize CMS to impose nationwide HPRD requirements for RNs, NAs, and total nursing staff. CMS's general authority does not permit it to modify "matter[s] specifically dealt with in another part of the same

enactment." *RadLAX Gateway Hotel*, 566 U.S. at 646; *see also* 42 U.S.C. § 1302(a) (Secretary may not promulgate regulations "inconsistent with" statutes).

Congress carefully considered staffing, mandating that each facility maintain staffing levels "sufficient to meet the nursing needs of its residents." 42 U.S.C. §§ 1396r(b)(4)(C), 1395i-3(b)(4)(C). By negating and replacing Congress' judgment, Defendants exceed their authority.

c. Constitutional doubt

If the expansive authority Defendants claimed in the Rule exists, then the statute is likely unconstitutional. If Congress authorized CMS to implement a regulation that costs at least $43 billion and overrides a specific statute, then it supplied no intelligible principle to guide how that power. In other words, if CMS's interpretation aligns with Congress's, that would present serious nondelegation concerns. *See Kentucky v. Biden*, 23 F.4th 585, 607 n.14 (6th Cir. 2022).

The constitutional doubt canon means this Court should interpret the Rule to avoid these severe constitutional problems. As the Supreme Court has explained, "the nondelegation doctrine principally has been limited to the interpretation of statutory texts, and, more particularly,

to giving narrow constructions to statutory delegations that might otherwise be thought to be unconstitutional." *Mistretta v. United States*, 488 U.S. 361, 373, n.7 (1989). The Supreme Court thus reads statutes with this principle in mind. *See, e.g.*, *Gundy v. United States*, 139 S.Ct. 2116 (2019). This Court should do the same and reject Defendants' expansive claim of authority.

4. The Rule is arbitrary and capricious

Defendants acted arbitrarily and capriciously because they (1) engaged in a sharp departure from past practice without reasonable explanation, (2) failed to consider reliance interests, and (3) failed to consider important aspects of the problem.

The APA's arbitrary-and-capricious standard requires agency action be "reasonable and reasonably explained." *E.g.*, *Texas v. United States*, 40 F.4th 205, 226 (5th Cir. 2022) (quoting *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021)). So, this Court "must set aside any action premised on reasoning that fails to account for relevant factors or evinces a clear error of judgment." *Id.* An agency acts arbitrarily and capriciously when it departs sharply from prior practice without reasonable explanation or ignores alternatives to its action or

the affected communities' reliance on the prior rule. *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 30 (2020). It also acts arbitrarily and capriciously when it "relie[s] on factors which Congress has not intended it to consider, entirely fail[s] to consider an important aspect of the problem, offer[s] an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *In re Operation of Mo. River Sys. Litig.*, 421 F.3d 618, 628 (8th Cir. 2005).

And when an agency changes a longstanding policy, it must show "good reasons for the new policy" and "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221-22 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

a. Sharp departure

For over 50 years, Defendants did not impose any minimum staffing requirements beyond the statutory ones. *See* R. Doc. 30 at 25. And when they issued the Rule, Defendants did not even acknowledge

they were changing positions. An agency must "display awareness that it *is* changing position" and "may not . . . depart from a prior policy *sub silentio* or simply disregard rules that are still on the books." *Fox Television Stations, Inc.*, 566 U.S. at 515. In other words, an explanation cannot be reasoned if there is no acknowledgment that it is a change to begin with. Because Defendants failed to acknowledge this departure, the Rule is arbitrary and capacious.

Attempting to provide some justification, Defendants commissioned an expedited study (the Abt Study) to tell them what they wanted to hear, and then issued the Rule. *See generally* Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023) ("Abt Study"), available at https://tinyurl.com/b2ehy528.

Even the Abt Study was inconclusive—it did "not identif[y] a minimum staffing level to ensure safe and quality care." Abt Study at 115. But it did find that "[n]ursing homes [would] face barriers to hiring, primarily [with] workforce shortages and competition from staffing agencies." *Id.* at xi. The Abt Study cannot save Defendants' decision.

While an agency may depart from past practice, it must recognize

this departure and demonstrate good reason for doing so. *Encino Motorcars, LLC,* 579 U.S. at 221-22. Defendants did neither.

b. Failure to consider reliance interests

After the flexible staffing mandate (set by Congress) was implemented decades ago, States set staffing requirements tailored to their citizens' needs. *See* R. Doc. 30 at 26. In turn, LTCs devoted resources to meeting state requirements and working with local lawmakers to achieve a workable standard. CMS admits its 24/7 RN requirement imposes a one-size-fits-all requirement. 89 Fed. Reg. at 40,908. This approach is unworkable in a nation of diverse states, and it upends deliberate Congressional policy setting a minimum standard states might adapt to their needs.

When an agency upends decades of state laws and practices upon which States and LTCs have relied, it must seriously consider those reliance interests. *Encino Motorcars, LLC,* 579 U.S. at 221-22. Instead, Defendants focused only on increased staffing benefits, without considering how States and LTCs invested in alternative staffing arrangements that balanced high quality care with realistically achievable staffing levels. It was arbitrary and capricious to ignore

those reliance interests.

c. Failure to consider important aspects of the problem

Finally, the Rule is arbitrary and capricious because it fails to consider the virtual impossibility of compliance and its staggering costs. It is nearly impossible for many LTCs to comply with the Rule.[8] Defendants acknowledge the new requirements "exceed the existing minimum staffing requirements in nearly all States" and will require increased staffing "in more than 79 percent of nursing facilities nationwide." 89 Fed. Reg. at 40877. But they say nothing about how a nationwide staffing shortage can fixed by mandating even more staff.

Defendants estimate LTC facilities will need to hire an additional 15,906 RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement, plus an additional 77,611 NAs to meet the 2.45 NA HPRD requirement and 3.48 total nurse HPRD requirement. *See id.* at 40,958, 40,977-80. That is unattainable.[9]

Faced with evidence of the staffing shortages Defendants

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[8] *See, e.g.*, R. Doc. 30-18 at 7-14; Appx. 200-07; R. Doc. 30-20 at 3-9; Appx. 224-30; R. Doc. 30-11 at 7-11; Appx. 128-33.

[9] *See generally* R. Doc. 30-15; Appx. 165; R. Doc. 30-11; Appx. 122; R. Doc. 30-18; Appx. 194; R. Doc. 30-20; Appx. 222.

irrationally asserted that "[a] total nurse staffing standard will guard[] against" it. 89 Fed. Reg. at 40,893; *see* 88 Fed. Reg. at 61,366, 61,369. Defendants "fully expect[ed] that LTC facilities will be able to meet [the Final Rule's] requirements," 89 Fed. Reg. at 40894, but Plaintiffs' evidence conveys reality, *see* R. Doc. 30 at 28-32.

CMS's "hardship exemption" does not fix the problem. *First*, the exemption is available only to facilities that have already failed to meet the new staffing standards. *See* 89 Fed. Reg. at 40,902. Instead of being able to proactively seek an exemption, facilities that cannot satisfy the Rule will face a perpetual risk of sanction.

Second, the Rule fails to reasonably consider its staggering costs. According to CMS, the Rule will cost over $5 billion per year to implement once fully phased in, *see* 89 Fed. Reg. at 40,949, 40,970, while other estimates place costs as high as $7 billion per year, *see id.* at 40,950. The Rule does not provide any additional Medicare or Medicaid funding. *See id.* at 40,949.[10]

[10] *See, e.g.*, R. Doc. 30-11 at 9-10; Appx. 130-31 (estimated costs for Kansas LTCs to comply with minimum staffing standards range between $64 million and $92.7 million in the first year, at an average annual cost of $211,905 per facility); R. Doc. 30-8 at 5-6; Appx. 102-03 (estimating total cost of $20 million for South Dakota facilities to comply with Rule).

CMS's massive, unfunded staffing mandate, despite the ongoing workforce crisis and economic realities, is neither "reasonable" nor "reasonably explained."

IV. The public interest and the equities favor Plaintiffs, and a nationwide injunction is appropriate

The public has no interest in an unlawful rule. *See League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016). The Rule is unlawful, so the public interest and equities favor Plaintiffs. *See id.*; *Shawnee Tribe v. Mnuchin*, 984 F.3d 94, 102 (D.C. Cir. 2021).

And because the entire Rule is unlawful and must be vacated, this Court should issue a nationwide injunction. *See D.C. v. U.S. Dep't of Agric.*, 444 F. Supp. 3d 1, 46-48 (D.D.C. 2020). Additionally, a nationwide injunction will be more manageable, provide certainty, and ensure all LTCs nationwide are competing in the same market. *See Nebraska v. Biden*, 52 F.4th 1044, 1048 (8th Cir. 2022).

CONCLUSION

This Court should enjoin the Rule nationwide pending appeal.

Dated: January 23, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that on this 23rd day of January 2025, I electronically filed the foregoing document with the Clerk of the Court using the CM/ECF system, which will send a notice of electronic filing to all counsel of record.

/s/ Abhishek Kambli
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CERTIFICATE OF COMPLIANCE

The foregoing document complies with the type-volume limit of Federal Rule of Appellate Procedure 27(d)(2)(A) because it contains 5,119 words. It also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 27(d)(1)(E) because it was prepared using Word in Century Schoolbook 14-point font, a proportionally spaced typeface.

Pursuant to Circuit Rule 28A(h)(2), I further certify that the foregoing has been scanned for viruses, and the foregoing is virus free.

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ADDENDUM FOR

MOTION FOR INJUNCTION PENDING APPEAL

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, et al., Plaintiffs, vs. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	No. C24-110-LTS-KEM **ORDER ON MOTION FOR PRELIMINARY INJUNCTION**

I. INTRODUCTION

This case is before me on the plaintiffs'[1] motion (Doc. 30) for preliminary injunction. The defendants[2] filed a resistance (Doc. 72) and the plaintiffs filed a reply (Doc. 78). On December 5, 2024, I heard oral arguments by teleconference.

II. PROCEDURAL AND FACTUAL HISTORY

On October 8, 2024, the plaintiffs filed a complaint (Doc. 1) alleging that the Biden-Harris administration's Final Rule – "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional

[1] The plaintiffs include 20 states, 17 affiliates of LeadingAge (a trade association of non-profit nursing facilities) and two Kansas nursing home facilities. I will refer to all of the plaintiffs collectively as "the plaintiffs," the state plaintiffs as "the States" and the non-state plaintiffs as "the Organizations."

[2] The named defendants are Xavier Becerra, in his official capacity as Secretary of the United States Department of Health and Human Services, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services and Chiquita Brooks-Lasure, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. I will refer to all of the defendants collectively as "the Government."

Payment Transparency Reporting" (Final Rule) – violates various provisions of the Administrative Procedure Act (APA). 89 Fed. Reg. 40876 (May 10, 2024). Specifically, the plaintiffs argue that the Final Rule (1) lacks statutory authority, (2) is contrary to law and (3) is arbitrary and capricious. Doc. 1 at 42-61. The plaintiffs filed their motion for a preliminary injunction on October 22, 2024.

A. Medicaid and Medicare Statutes

In 1965, Congress established the Medicaid and Medicare programs by amending the Social Security Act. Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965). Medicare provides health insurance to "nearly 60 million aged or disabled Americans." *Northport Health Servs. of Ark., LLC v. U.S. Dep't of Health & Hum. Servs.*, 14 F.4th 856, 863 (8th Cir. 2021) (quoting *Azar v. Allina Health Servs.*, 587 U.S. 566, 569 (2019)); *see also* 42 U.S.C. § 1395 *et seq*. Medicaid is a joint federal-state program in which the federal government provides approximately $600 billion in financial assistance to states to offer healthcare coverage to low-income individuals. *See* 42 U.S.C. § 1396 *et seq*.; *see also Northport*, 14 F.4th at 863. The Secretary of the Department of Health and Human Services (HHS) administers both programs through the Centers for Medicare and Medicaid Services (CMS), a sub-agency of HHS. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, CMS.gov (last visited Jan. 5, 2025).

Nursing homes that participate in Medicare and Medicaid must comply with certain statutory requirements. *See* 42 U.S.C. § 1395i-3 (Medicare); *see* 42 U.S.C. § 1396r (Medicaid). As these statutory requirements under Medicare and Medicaid are largely the same, these nursing homes are often collectively known as "long-term care" (LTC) facilities. In addition, LTC facilities must comply with CMS's regulations, as they are applicable to all LTC facilities that participate in Medicare and/or Medicaid. *See* 42 C.F.R. §§ 483.1-.95; *see also Northport*, 14 F.4th at 863.

B. CMS Rulemaking Process and the Final Rule

On February 22, 2022, the Biden-Harris administration announced its intent to implement several reforms to "improve the safety and quality of nursing home care, hold nursing homes accountable for the care they provide, and make the quality of care and facility ownership more transparent so that potential residents and their loved ones can make informed decisions about care." *FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's NursingHomes*, THE WHITE HOUSE (Feb. 28, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/. To this end, the administration directed CMS to "conduct a new research study to determine the level and type of staffing needed to ensure safe and quality care and [] issue proposed rules within one year." *Id.* CMS commissioned Abt Associates to complete this research study. *See* ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report (June 2023), https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

Abt Associates' study (the study) found that increased staffing improves patient welfare in LTC facilities but also recognized the pervasive staffing challenges in the industry. Specifically, the study found that nursing homes with higher staff-to-resident ratios provide better care and addressed the COVID-19 pandemic more successfully. *Id.* at 1; Doc. 72 at 17. However, the study noted that existing literature "does not provide a clear evidence basis for setting a minimum staffing level." ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report at xi. The study also found that increases in the nurse hours per resident per day result in a "corresponding increase in potential quality and safety improvements, and a decrease in expected delayed and omitted care." *Id.* at xiii; Doc. 72 at 17. Although Abt Associates found that increased staffing will lead to better care, the study recounted that nursing homes are struggling to hire and retain workers. Additionally, stakeholders expressed a variety of concerns, including

lack of adequate staffing as well as workforce and cost constraints. ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report at xii. Moreover, some stakeholders suggested that resident acuity should be considered when setting a minimum staffing requirement. *Id.*

Upon completion of the study, CMS issued a notice of a proposed rule in September 2023. The proposed rule contained four main proposals: (1) a requirement that a registered nurse (RN) must be on site 24 hours per day, 7 days a week, (2) minimum nurse staffing standards of 0.55 hours per resident day (HPRD) for RNs and 2.45 HPRD for Nurse Aids (NAs), (3) enhanced facility assessment (EFA) requirements and (4) Medicaid reporting requirements. Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 88 Fed. Reg. 61352 (proposed Sept. 6, 2023). CMS received 46,520 comments in response to the proposed rule. *See* Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40883 (May 10, 2024).

CMS's Final Rule, promulgated on May 10, 2024, largely mirrors the proposed rule. 89 Fed. Reg. 40876. The Final Rule includes: (1) a requirement that a RN be on site 24 hours per day, 7 days per week, (2) a minimum nursing staffing standard of 3.48 HPRD of nursing care, with at least 0.55 RN HPRD and at least 2.45 NA HRPD, (3) revision of the existing facility assessment requirements and (4) Medicaid institutional payment transparency reporting requirements. 89 Fed. Reg. 40877. To ease some of the Final Rule's financial burden, CMS has dedicated over $75 million "to launch an initiative to help increase the long-term care workforce." 89 Fed. Reg. 40885. Moreover, the Final Rule provides additional time and flexibility for LTC facilities to implement the changes, including staggered implementation dates over a five-year period and providing for some exemptions from the minimum staffing standards. 89 Fed. Reg. 40886.

In its Final Rule, CMS asserts that various provisions in Sections 1819 and 1919 of the Social Security Act [42 U.S.C. §§ 1395i-3 and 1396r] grant it authority for the issuance of the HPRD and 24/7 RN requirements.[3] *See* 89 Fed. Reg. 40890-91. First, CMS states that §§ 1819(d)(4)(B) and 1919(d)(4)(B) of the Social Security Act support its authority to establish these requirements, as these sections "instruct the Secretary to issue such regulations relating to the health, safety, and well-being of residents as the Secretary may find necessary." 89 Fed. Reg. 40890. Moreover, CMS contends that §§ 1819(b)(2) and 1919(b)(2) provide additional support for CMS's authority to establish these requirements, as those sections "require facilities to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." *Id.*

Finally, CMS states that §§ 1819(b)(1)(A) and 1919(b)(1)(A) "require that a SNF [skilled nursing facility] or NF [nursing facility] must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the safety and quality of life of each resident," which it asserts provides further support for the Final Rule's staffing requirements. 89 Fed. Reg. 40891. However, as the plaintiffs assert and the Government concedes in its brief, the only provisions of the Social Security Act that expressly permit the promulgation of additional requirements by the Secretary are §§ 1395i-3(d)(4)(b) and 1396r(d)(4)(B), which state that LTC facilities must "meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary." *See* Doc. 30-1 at 23; *see also* Doc. 72 at 21-22.

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[3] The Medicare and Medicaid statutes speak directly to staffing requirements as well. They require LTC facilities to "provide 24-hour licensed nursing service which is sufficient to meet the nursing needs of its residents" and "use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *see also* 42 U.S.C. § 1396r(b)(4)(C)(i) (Medicaid) (same). Both statutes permit waivers for these requirements. *See* 42 U.S.C. § 1395i-3(b)(4)(C)(ii) (Medicare) *and* 42 U.S.C. § 1396r(b)(3)(C)(ii) (Medicaid).

Although the statutory basis for CMS's promulgation of new Medicaid reporting requirements do not appear to be contested by the plaintiffs (*see* Doc. 30-1 at 6), CMS asserts that it relied on two main provisions of the Social Security Act to issue these requirements – §§ 1902(a)(30)(A) and 1902(a)(6). 89 Fed. Reg. 40914 (noting that § 1902(a)(30)(A) "requires State Medicaid programs to ensure that payments to providers are consistent with efficiency, economy, and quality of care. . ." and § 1902(a)(6) "requires State Medicaid agencies to make such reports. . . as the Secretary may from time to time require, and to comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports.").

The statutory basis for the EFA requirement appears similarly uncontested by the plaintiffs. *See* Doc. 30-1 at 6. Prior to the promulgation of the Final Rule, LTC facilities were already required to complete facility assessments. The Final Rule relocated the facility assessment requirement from a subpart to a stand-alone provision and added new substantive requirements. CMS did not articulate the statutory basis for the new substantive requirements in the Final Rule. *See* 89 Fed. Reg. 40905.

Each requirement of the Final Rule has a different implementation timeline. The 24/7 RN requirement must be implemented by May 11, 2026, for non-rural facilities and by May 10, 2027, for rural facilities as defined by the Office of Management and Budget. The HRPD requirements must be implemented by May 10, 2027, for non-rural facilities and by May 10, 2029, for rural facilities. The EFA requirement took effect on August 8, 2024, for all facilities. The Medicaid transparency reporting requirements must be implemented by all States and territories with Medicaid-certified facilities by May 10, 2028. 89 Fed. Reg. 40876.

Despite these different implementation timelines, the Final Rule acknowledges that costs will be incurred before the respective effective implementation dates. CMS estimated that the staffing requirements will result in an estimated cost of approximately $53 million in year one, $1.43 billion in year two and $4.38 billion in year three. 89

Fed. Reg. 40949. Additionally, CMS estimates that the Medicaid reporting provision will cost states $183,851 for the first four years. 89 Fed. Reg. 40991.

III. ANALYSIS

The plaintiffs seek entry of a preliminary injunction as to the entire Final Rule. They assert that the Final Rule exceeds CMS's statutory authority, violates the major questions doctrine and is arbitrary and capricious. *See* Doc. 30-1 at 20-35. Additionally, the plaintiffs assert that they are suffering irreparable harm from the financial burdens of the Final Rule and contend that the balance of equities and the public interest favor injunctive relief. *Id.* at 35-38. Finally, they request that the injunction apply nationwide to "preserve[] the national status quo and protect[] Plaintiffs from the Final Rule's destabilizing effects on nursing homes across the country." Doc. 30-1 at 39.

A. Preliminary Injunction Standard

The purpose of a preliminary injunction is to "preserve the relative positions of the parties until a trial on the merits can be held." *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). The Eighth Circuit Court of Appeals has stated:

> When evaluating whether to issue a preliminary injunction, a district court should consider four factors: (1) the threat of irreparable harm to the movant; (2) the state of the balance between this harm and the injury that granting the injunction will inflict on other parties; (3) the probability that the movant will succeed on the merits; and (4) the public interest.

Roudachevski v. All–American Care Centers, Inc., 648 F.3d 701, 705 (8th Cir. 2011) (citing *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc)). In this circuit, these are often referred to as the *"Dataphase"* factors. While no single factor is dispositive, the Eighth Circuit has stated that "likelihood of success on the merits is most significant." *Laclede Gas Co. v. St. Charles Cnty., Mo.*, 713 F.3d 413, 419 (8th Cir. 2013) (quoting *Minn. Ass'n of Nurse Anesthetists v. Unity Hosp.*, 59 F.3d 80, 83 (8th Cir. 1995)).

In applying these factors, the court must keep in mind that a preliminary injunction is "an extraordinary remedy never awarded as of right." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1016 (8th Cir. 2023) (citation omitted). As such, the party seeking injunctive relief bears the burden of proving that it is appropriate. *Roudachevski*, 648 F.3d at 705. "When there is an adequate remedy at law, a preliminary injunction is not appropriate." *Watkins Inc. v. Lewis*, 346 F.3d 841, 844 (8th Cir. 2003) (citing *Modern Computer Sys., Inc. v. Modern Banking Sys., Inc.*, 871 F.2d 734, 738 (8th Cir. 1989)).

B. Irreparable Harm

Although likelihood of success on the merits is often described as the most significant factor in a preliminary injunction analysis, a failure to show irreparable harm may be dispositive. *Adventist Health Sys./SunBelt, Inc. v. United States Dep't of Health & Hum. Servs.*, 17 F.4th 793, 806 (8th Cir. 2021) ("The failure to show irreparable harm is an 'independently sufficient basis upon which to deny a preliminary injunction.'") (citation omitted); *see also Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 371 (8th Cir. 1991) (irreparable harm is a "threshold inquiry" in granting or denying preliminary injunction). I will begin my analysis with this factor because, for the reasons discussed in detail below, it largely dictates the outcome of the plaintiffs' motion for a preliminary injunction.

To demonstrate irreparable harm, "a party must show that the harm is certain and great and of such imminence that there is a clear and present need for equitable relief." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1017 (8th Cir. 2023) (quoting *Dakotans for Health v. Noem*, 52 F.4th 381, 392 (8th Cir. 2022); *see also Tumey v. Mycroft AI, Inc.*, 27 F.4th 657, 665 (8th Cir. 2022) ("The movant must show that 'irreparable injury is *likely* in the absence of an injunction,' not merely a 'possibility' of irreparable harm before a decision on the merits can be rendered.") (emphasis in original) (quoting *Winter v. Natural Resources Defense*

Council, Inc., 555 U.S. 7, 22 (2008)). The irreparable harm requirement is demanding. *See Am. Meat Inst. v. U.S. Dep't of Agric.*, 968 F. Supp. 2d 38, 75 (D.D.C. 2013) ("There is no doubt that '[t]he irreparable injury requirement erects a very high bar for a movant.'") (quoting *Coalition for Common Sense in Gov't Procurement v. United States*, 576 F. Supp. 2d 162, 168 (D.D.C. 2008)).

1. The Parties' Arguments

The Organizations argue that they will suffer irreparable harm from the Final Rule because of the financial strain that it imposes, workforce shortages, current compliance costs and the burdensome EFA requirements. Doc. 30-1 at 35-36. First, they argue that the Final Rule will cost each LTC facility hundreds of thousands of dollars to implement.[4] *Id.* at 35. Further, they contend that the additional hiring required by the Final Rule is nearly impossible considering the healthcare workforce shortages, which are more exacerbated in the long-term care setting. *Id.* at 35-36. Because of these workforce challenges, the Organizations assert that many LTC facilities must start complying with the staffing mandates now to ensure that they will meet the requirements by the designated implementation dates. *Id.* at 36. Finally, they argue that the Final Rule's EFA requirement, which is already in effect, imposes significant costs and administrative burdens. *Id.*

The States contend that they will experience many of the same harms as the Organizations. First, they argue that state-run LTC facilities will experience the similar financial hardships as the organizational LTC facilities with the increased staffing requirements, workforce shortages and the EFA requirements. *Id.* at 36-37. The States assert that they will incur additional Medicaid and Medicare expenses and costs due to

[4] For example, the plaintiffs assert that in South Carolina the estimated implementation cost is over $550,000 per nursing home. This cost is even higher in Pennsylvania, with an estimated cost of $689,000 per provider. Doc. 30-1 at 35.

the Medicaid reporting requirement and the increased staffing costs at LTC facilities. *Id.* at 37. Finally, the States argue that they will incur additional administrative costs with complaints and waiver requests as they predict that LTC facilities will be unable to comply with the Final Rule. *Id.*

The Government asserts that because the 24/7 RN requirement and HPRD requirements will not be implemented for several years, the plaintiffs will not experience irreparable harm without an injunction. Doc. 72 at 60. The Government does not address irreparable harm regarding the EFA and Medicaid reporting requirements, as it contends that the plaintiffs do not substantively challenge those provisions.[5] *Id.* The Government asserts that the Final Rule has a staggered implementation for both the 24/7 RN requirement and the HPRD requirements. *Id.*; *see* 89 Fed. Reg. 40894 (discussing "phased implementation up to 5 years for rural facilities and up to 3 years for non-rural facilities"). The Government further notes that the earliest any facility could be harmed by the Final Rule is in two years—when the 24/7 RN rule will take effect in urban areas. Doc. 72 at 60; *see* 89 Fed. Reg. 40910. It asserts that this multi-year delay in implementation does not create irreparable harm, as the merits of the plaintiffs' challenge can be resolved in less than two years. Doc. 72 at 60. Moreover, the Government contends that the harms alleged by the plaintiffs are "purely economic," "self-inflicted" and, as to the plaintiffs' argument regarding workforce shortages—not caused by the Final Rule. *Id.* at 61. Finally, the Government argues that the plaintiffs' delay in filing

[5] In their reply brief and during oral argument, the plaintiffs maintained that they are challenging the entirety of the rule – not just the 24/7 RN requirement and the HPRD requirements. *See* Doc. 78 at 20-21; *see also* Doc. 94 at 26. However, the plaintiffs did not address either the EFA requirement or the Medicaid reporting requirement in their discussion of likelihood of success in their briefs. *See* Doc. 30-1 at 20-35; *see also* Doc. 78 at 4-17. Nonetheless, the plaintiffs assert that they made sufficient arguments as to likelihood of success as they contended that the EFA provision was "vague" and "unreasonable." Doc. 78 at 21. The Government maintains that the plaintiffs did not address likelihood of success on the merits with respect to the EFA requirement, but it asserts that in any case, the deadline for compliance with this requirement has already passed so irreparable harm cannot be alleged. Doc. 72 at 62.

the present motion for a preliminary injunction also undercuts their assertion that they are suffering irreparable harm. *Id.* at 62.

In response, the plaintiffs first contend that the economic nature of the harm is not a barrier to the court's entry of a preliminary injunction, as monetary damages cannot be recovered from the federal government due to sovereign immunity. Doc. 78 at 19. Additionally, they assert that the harms from the EFA requirement are continuous and ongoing. *Id.* Moreover, they dispute that they are engaged in "self-harm" by beginning to hire staff to meet the Final Rule's requirements, as they contend that the delayed implementation period was specifically designed for this purpose. *Id.* at 20. Finally, they assert that their delay in seeking injunctive relief was not unreasonable. *Id.* at 22.

2. Substantive Provisions of the Final Rule

Because the plaintiffs' allegations of irreparable harm primarily concern compliance costs associated with the Final Rule, I will first address that matter. There appears to be a circuit split as to whether compliance costs constitute irreparable harm. Some circuits have held that "compliance costs do not qualify as irreparable harm because they commonly result from new government regulation." *See Commonwealth v. Biden*, 57 F.4th 545, 556 (6th Cir. 2023) (recognizing that many of their "sister circuits" have held that compliance costs are not irreparable harm but holding that "the peculiarity and size of a harm affects its weight in the equitable balance") (citing *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 115 (2d Cir. 2005), *Am. Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1331 (7th Cir. 1980), *and A.O. Smith Corp. v. FTC*, 530 F.2d 515, 527 (3d Cir. 1976)). Other circuits have found that complying with a regulation later held invalid almost always produces irreparable harm from nonrecoverable costs. *See Texas v. EPA*, 829 F.3d 405, 433 (5th Cir. 2016); *see also Crowe & Dunlevy, P.C. v. Stidham*, 640 F.3d 1140, 1157 (10th Cir. 2011).

Although this issue has never been squarely addressed by the Eighth Circuit, the court has stated that "[t]he importance of preliminary injunctive relief is heightened"

when monetary damages are unavailable because of sovereign immunity. *Entergy, Arkansas, Inc. v. Nebraska*, 210 F.3d 887, 899 (8th Cir. 2000). I hold that the compliance costs incurred to comply with a potentially invalid regulation, such as the Final Rule, may constitute irreparable harm. I will address each aspect of the Final Rule in turn.

a. 24/7 RN Requirement and HPRD Requirements

At this stage of the case, I will assume that the Final Rule's 24/7 RN requirement and HPRD requirements will impose tremendous costs on LTC facilities that could result in closures if compliance is not economically feasible. Additionally, the economic nature of the plaintiffs' alleged harms does not preclude relief. Although economic loss is not irreparable harm if damages are available, losses will not be recoverable from the Government due to sovereign immunity. *See Gen. Motors Corp. v. Harry Brown's LLC*, 563 F.3d 312, 319 (8th Cir. 2009) ("economic loss is not irreparable harm so long as losses are recoverable"); *see also Entergy, Arkansas, Inc.*, 210 F.3d at 899 ("[t]he importance of preliminary injunctive relief is heightened" when monetary damages are unavailable because of sovereign immunity).

However, because the 24/7 RN requirement and the HPRD requirements do not take effect until May 2026, at the earliest, I find that the plaintiffs' challenges to the financial and compliance burdens presented by those requirements are too speculative to constitute irreparable harm for purpose of a preliminary injunction.[6] In seeking injunctive relief, a party must show that the injury alleged is "of such *imminence* that there is a

[6] Additionally, the plaintiffs' argument that workforce shortages in the healthcare industry constitute irreparable harm is misplaced. The Final Rule did not create the workforce shortage in the healthcare industry. Such an argument is proper in challenging CMS's action as arbitrary and capricious—not in alleging that the Final Rule causes irreparable harm. *See McClung v. Paul*, 788 F.3d 822, 828 (8th Cir. 2015) (finding an agency decision arbitrary and capricious if an agency "entirely failed to consider an important aspect of the problem").

clear and present need for equitable relief." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1018 (8th Cir. 2023) (emphasis in original) (quotations omitted) (citations omitted). The plaintiffs allege that LTC facilities are bearing the costs of the 24/7 RN requirement and the HPRD requirements now because of the workforce shortages in the healthcare industry. Doc. 30-1 at 36. However, the extent to which LTC facilities are incurring hiring costs now to ensure compliance with the Final Rule is unclear. Indeed, while 26 plaintiffs submitted declarations, only a few state that they are currently engaged in hiring and incurring costs to ensure compliance with the minimum staffing requirements.[7] *See* Doc 30-22 at 9, ¶ 11 ("At least several of our nursing homes are already making staffing changes, attempting to hire additional RNs rather than LPNs, and increasing hiring efforts in preparation for the Final Rule's staffing mandates going into effect."); Doc. 30-10 at 8, ¶ 9 (LTC facilities in Iowa "are attempting to hire RNs over LPNs whenever possible. . . . and engaging in aggressive recruitment strategies such as sign-on and recruitment bonuses. . ."); Doc. 30-12 at 3-4, ¶ 6 ("our members have already begun to plan for the elimination of LPN positions"). While these declarations suggest that planning and attempts for hiring are currently taking place, the financial burden of these undertakings is unclear. None of the plaintiffs submitted data or cost breakdowns as to their *current* hiring efforts.

Instead, most of the declarations detail costs that the various plaintiffs will incur in the future. Indeed, many plaintiffs provided a wide range of potential costs. *See, e.g.*, Doc. 30-2 at 3, ¶ 9 (estimating that the total average costs for Idaho-operated LTC facilities to comply with the Final Rule's minimum staffing requirements to be $800,000

[7] The plaintiffs assert that a declaration from LeadingAge South Carolina provides additional support for their assertion that many providers are already expending resources towards hiring. Doc. 30-1 at 36 (citing Doc. 30-20 at 3, ¶ 4). However, LeadingAge South Carolina's declaration merely asserts that it is currently experiencing staffing shortages and that one facility has had an open RN position for over a year. Doc. 30-20 at 3, ¶ 4.

per facility); *see also* Doc. 30-8 at 5, ¶ 7 (asserting that the South Dakota Association of Health Care Organizations estimated that costs associated with temporary/travel nurses to be between $300,000 and $1,600,000 per year and estimates that this cost will increase "exponentially if the Final Rule's staffing mandate goes into effect"); *see* Doc. 30-22 at 2, ¶ 5 (stating that the "significant and irreparable harm that the Final Rule imposes on Virginia nursing home providers will be especially severe in rural and underserved areas"). These wide ranges demonstrate that while the staffing requirements of the Final Rule will certainly impose financial burdens, the extent of the harm is simply too uncertain at this point, as the earliest any facility could be subject to the Final Rule is May 11, 2026. This weighs against a finding of irreparable harm. *See S.J.W. ex rel. Wilson v. Lee's Summit R-7 Sch. Dist.*, 696 F.3d 771, 779 (8th Cir. 2012) ("Speculative harm does not support a preliminary injunction."); *see also Mock v. Garland*, 697 F. Supp. 3d 564, 577 (N.D. Tex. 2023) ("Irreparable harm must also be concrete, non-speculative, and more than merely de minimis.") (emphasis omitted).

Further, many of the plaintiffs' declarations note that the compliance costs associated with the Final Rule's staffing mandate could greatly vary depending on their use of contracting agencies to recruit staff. *See* Doc. 30-2 at 3, ¶ 10 (noting that hiring costs could be "higher or lower" depending on the state's reliance on contractor agencies); *see also* Doc. 30-8 at 6, ¶ 8 ("The cost for facilities will be even greater if contract staff are needed to meet the standards of the mandate."); Doc. 30-11 at 9, ¶ 12 ("Nursing homes will incur substantial costs, potentially requiring them to rely on contracted nursing agencies, which are significantly more expensive."). This also weighs against a finding of irreparable harm. *See, e.g.*, *Cayuga Nation v. Zinke*, 302 F. Supp. 3d 362, 373 (D.D.C. 2018) (finding that where "injuries depend on actions that may or may not be taken by. . . non-parties over which this Court does not have control, they are not certain[]" which "counsel[s] against granting preliminary injunctive relief.").

Nonetheless, some of the plaintiff declarations provided more precise estimates of future costs. *See, e.g.*, Doc. 30-9 at 3, ¶ 6 (Final Rule's requirements "will cost each

Colorado provider. . . an average of $399,123 per year"); *see also* Doc. 30-11 at 3, ¶ 6 (staffing mandate will cost each Kansas provider an average of $211,905 per year); *see also* Doc. 30-12 at 2, ¶ 5 (staffing mandate will cost each nursing home in Maryland an additional $642,000 per year); *see* Doc. 30-3 at 3, ¶ 10 (noting that over 70 percent of facilities in Iowa will be affected by the increased staffing requirements, which will cause an estimated state financial impact of over $25 million); *see* Doc. 30-10 at 3-4, ¶ 4a (noting that staffing requirements would result in $2.16 million annual costs on their members). While I appreciate the detailed assessments provided by many of the plaintiffs, I again find that because of the delayed implementation of the Final Rule, the plaintiffs have not adequately shown irreparable harm as to the staffing requirements. *See Wyoming v. United States Dep't of the Interior*, No. C16- 0280–SWS, 2017 WL 161428, at *11 (D. Wyo. Jan. 16, 2017) (holding that even though the Regulatory Impact Analysis stated that the Rule's requirements "would necessitate *immediate* expenditures," because many of the Rule's requirements "do not take effect for a year[,] . . . any alleged expenses associated with 'immediate action to begin Rule implementation and compliance planning' are simply too uncertain and speculative to constitute irreparable harm") (emphasis in original) (citation omitted); *cf. Chlorine Inst., Inc. v. Soo Line R.R.*, 792 F.3d 903, 915 (8th Cir. 2015) (noting that "[a]ppellants' assertion" that a harm would "inevitably result" was "too speculative" and thus insufficient to show irreparable harm).

The merits of the plaintiffs' challenges to the 24/7 RN requirement and the HPRD requirements can be addressed before May 2026, when the first staffing requirements of the Final Rule are to take effect. *See Am. Meat Inst. v. U.S. Dep't of Agric.*, 968 F. Supp. 2d 38, 75 (D.D.C. 2013) ("Perhaps the single most important prerequisite for the issuance of a preliminary injunction is a demonstration that if it is not granted the applicant is likely to suffer irreparable harm before a decision on the merits can be rendered."). The plaintiffs have not demonstrated that injunctive relief is necessary to prevent irreparable harm as to those aspects of the Final Rule.

b. EFA Requirement

The EFA requirement took effect on August 8, 2024. 89 Fed. Reg. 40876. As the initial compliance date for the EFA requirement has already passed, the Government asserts that the plaintiffs cannot demonstrate irreparable harm with respect to this aspect of the Final Rule. Doc. 72 at 62.

The Eighth Circuit has found that prior harm weighs against entering injunctive relief when a plaintiff can recover damages. *See CDI Energy Servs. v. West River Pumps, Inc.*, 567 F.3d 398, 403 (8th Cir. 2009) ("[I]t was appropriate for the district court to view the irreparable-harm factor as weighing against the issuance of a preliminary injunction. The harm that had already occurred could be remedied through damages."); *see also Adam–Mellang v. Apartment Search, Inc.*, 96 F.3d 297, 300 (8th Cir. 1996) (declining to enter a preliminary injunction when a plaintiff had "an adequate remedy at law, namely, the damages and other relief to which she will be entitled if she prevails"). Here, of course, the plaintiffs cannot recover damages from the Government due to sovereign immunity. Moreover, the Final Rule requires facilities to "review and update that assessment, as necessary, and at least annually." 89 Fed. Reg. 40999. Thus, the costs of compliance with the EFA requirement will recur on an ongoing basis. These factors tend to add some support for a finding that the EFA requirement will cause irreparable harm absent injunctive relief.

Because the plaintiffs have made a more feasible showing of irreparable harm with regard to the EFA requirement, I will consider their likelihood of success on their challenge to this provision. Ultimately, I agree with the Government that because the plaintiffs addressed the likelihood of success element only with respect to the 24/7 RN requirement and the HPRD requirements, they have not demonstrated that a preliminary injunction is appropriate with respect to the EFA requirement.

The plaintiffs raise only a few conclusory arguments regarding likelihood of success as to that requirement. First, they claim that they asserted that the EFA requirement is "vague" and "unreasonable." Doc. 78 at 21. During oral argument, the

plaintiffs asserted that the Final Rule is not severable and their arguments regarding the "arbitrary and capricious" nature of the Final Rule apply to the EFA requirement. Doc. 94 at 26-27. Moreover, the plaintiffs assert that *Missouri v. Biden*, 112 F.4th 531 (8th Cir. 2024), stands for the proposition that "irreparable harm does not need to be tied to any particular aspect of the rule that's being challenged." Doc. 94 at 26-27, 59.

These arguments are not compelling. The plaintiffs' conclusory argument that the EFA requirement is "vague" and "unreasonable" is insufficient to support a finding of likelihood of success on the merits.[8] Additionally, I do not find *Missouri v. Biden* to be particularly helpful. In that case, the Eighth Circuit stated the "district court only enjoined the ultimate forgiveness of loans, finding that States had not shown irreparable harm" with respect to two other provisions of the rule. *Biden*, 112 F.4th at 535. Notwithstanding the district court's injunction, the Government continued to forgive loans through a new "hybrid rule," which combined parts of the non-enjoined rule as well as provisions in another regulation. The Eighth Circuit noted that this hybrid rule "effectively rendered that injunction a nullity." *Id.* at 535.

Although the Eighth Circuit ultimately enjoined the entire rule, it did so only because the Government created a hybrid rule that made the district court's injunction useless. *Missouri v. Biden* does not stand for the proposition that a plaintiff may cherry-pick portions of a final rule, arguing likelihood of success as to some and irreparable harm as to others. Given plaintiffs' failure to make any serious argument that they are likely to succeed on their challenge to the EFA requirement, I find that they have failed to demonstrate that a preliminary injunction as to that requirement is appropriate.

[8] Indeed, "[w]hen a party seeks to enjoin a government regulation that is 'based on presumptively reasoned democratic processes,'. . . we apply a 'more rigorous threshold showing' than just a 'fair chance' of success on the merits. *Firearms Regul. Accountability Coal., Inc. v. Garland*, 112 F.4th 507, 517 (8th Cir. 2024) (quoting *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 730, 732 (8th Cir. 2008) (en banc). Therefore, such conclusory arguments do not come close to meeting the required showing.

c. Medicaid Transparency Reporting Requirements

The Medicaid institutional transparency reporting requirement does not take effect until May 10, 2028. 89 Fed. Reg. 40876. As with the 24/7 RN and the HPRD requirements, I find that this long-delayed effective date renders the alleged expenses associated with immediate action too uncertain and speculative to qualify as irreparable harm. Indeed, many of the plaintiffs' declarations make conclusory statements about the future economic harm they will incur. *See, e.g.*, Doc. 30-4 at 3, ¶ 8 ("Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Nebraska well before that."); Doc. 30-3 at 3, ¶ 8 (same); Doc. 30-27 at 3, ¶ 8 (same); Doc. 30-7 at 3, ¶ 7 (same). Moreover, the merits of the plaintiffs' challenge to this provision can be resolved before this requirement takes effect. *See infra* Section III.B.2.a.[9]

d. Plaintiffs' Delay

Finally, the Government argues that the plaintiffs' delay in bringing a motion for a preliminary injunction of the Final Rule weighs against a finding of irreparable harm. For the reasons set forth above, it is largely unnecessary to address the "delay" argument. In short, the Government argues that the five-month delay between publication of the Final Rule and the request for a preliminary injunction was excessive and weighs against a finding of irreparable harm. The Government notes the Texas Health Care Association and several Texas-based LTC facilities filed suit challenging the Final Rule on the same grounds as the plaintiffs "less than two weeks after the promulgation of the Final Rule." Doc. 72 at 62*; see Am. Health 52 Care Ass'n v. Becerra*, 24C-114-Z-BR (N.D. Tex.) (filed May 23, 2024). Further, it asserts that the Eighth Circuit has held that a delay of

[9] Additionally, as with the EFA requirement, the plaintiffs did not make any arguments regarding the likelihood of success on the merits with respect to the Medicaid reporting requirement. *See generally* Doc. 30-1 *and* Doc. 78. Therefore, even if I found that the plaintiffs made a showing of irreparable harm, injunctive relief would not be appropriate. *See infra* Section III.B.2.b.

five months in seeking a preliminary injunction was sufficient to affirm the denial of a preliminary injunction. Doc. 72 at 63*; see Phyllis Schlafly Revocable Trust v. Cori*, 924 F.3d 1004, 1010, n.4 (8th Cir. 2019).

The plaintiffs contend that their delay was less than two months, as the EFA requirement did not take effect until August and they sought injunctive relief in October. Doc. 94 at 58. Additionally, they assert that the length of the delay is not outcome-determinative but, instead, turns on the facts of the case. Doc. 78 at 22. They argue that they were "forced to walk a tightrope," as if they challenged the rule earlier, the Government would have argued that their harms were speculative and uncertain. *Id.* By waiting, they contend that their harms are concrete because the EFA requirement took effect and many LTC facilities are beginning to take measures to ensure they can meet the staffing requirements. *Id.*

The "mere length of the delay is not determinative of whether the delay was reasonable." *Ng v. Board of Regents of University of Minnesota*, 64 F.4th 992, 998 (8th Cir. 2023) (noting that the Eighth Circuit has found delays of seven and eight months to be reasonable but has found delays of five and seventeen months to be unreasonable). And there can be little doubt that a comprehensive challenge to an agency final rule requires time and significant resources to litigate. *See McKinney ex rel. N.L.R.B. v. S. Bakeries, LLC*, 786 F.3d 1119, 1125 (8th Cir. 2015) (noting that "[c]omplicated labor disputes like this one require time to investigate and litigate"). Nonetheless, many of the plaintiffs participated in the rulemaking process and submitted analyses of the expected costs and hardships of the rule. This participation suggests that waiting five

months to challenge the rule was unnecessary, as many had already conducted research to assess the costs and harms that they would face.[10]

On the other hand, the delay in this case was not as egregious as delays seen in other cases. *See, e.g.*, *Adventist Health Sys.*, 17 F.4th at 805 (holding that the district court did not abuse its discretion in finding no irreparable harm where the plaintiffs did not challenge the Final Rule for a year after its adoption and fewer than five days before its scheduled implementation); *see also Novus Franchising, Inc. v. Dawson*, 725 F.3d 885, 894 (8th Cir. 2013) (finding that a delay of 17 months "rebuts any inference of irreparable harm"). Indeed, it appears that five months is the shortest time period that the Eighth Circuit has found to be unreasonable.

Ultimately, I find the plaintiffs' delay seeking a preliminary injunction is largely a non-factor that, at most, adds some additional, marginal support for the conclusion that the plaintiffs failed to demonstrate irreparable harm.

C. Summary

As noted above, a preliminary injunction is "an extraordinary remedy never awarded as of right." *Morehouse Enterprises, LLC*, 78 F.4th at 1016. With regard to nearly every aspect of the Final Rule, the plaintiffs have failed to demonstrate that a preliminary injunction is necessary in order to preserve the status quo and prevent irreparable harm during the pendency of these proceedings. The only potential exception involves the Final Rule's EFA requirement. However, the plaintiffs advanced no viable

[10] *See generally* "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," Regulations.gov, https://www.regulations.gov/document/CMS-2023-0144-0001/comment (Sept. 6, 2023); *see, e.g.*, Leading Age Nebraska, CMS-2023-0144-25564 (Nov. 3, 2023), https://www.regulations.gov/comment/CMS-2023-0144-25564 *and* Leading Age PA, CMS-2023-0144-25410 (Nov. 3, 2023), https://www.regulations.gov/comment/CMS-2023-0144-25410.

argument that they are likely to succeed on the merits of their challenge to that requirement.

Under these circumstances, I conclude that the issuance of a preliminary injunction is not appropriate.[11] I do find, however, that the interests of justice will be best served by proceeding quickly to the dispositive motions stage of this case, thus allowing the parties to address the merits directly, rather than through the lens of a motion for a preliminary injunction. In particular, the plaintiffs have raised substantial issues and concerns about Final Rule's 24/7 RN requirement and HPRD requirements. A schedule for dispositive motion briefing will be set forth below.

IV. CONCLUSION

For the reasons set forth herein, the plaintiffs' motion (Doc. 30) for a preliminary injunction as to the Final Rule is **denied**. The following schedule is hereby established with regard to dispositive motions:

1. Any dispositive motions must be filed on or before **March 3, 2025**.
2. Resistances must be filed on or before **April 3, 2025**.
3. Reply materials must be filed on or before **April 24, 2025**.

IT IS SO ORDERED this 16th day of January, 2025.

Leonard T. Strand
United States District Judge

[11] I will therefore not address the remaining *Dataphase* factors. I find it equally unnecessary to address the parties' arguments regarding severability at this time, as I have found that the plaintiffs are not entitled to injunctive relief as to any aspect of the Final Rule. Similarly, it is not necessary for me to address the plaintiffs' contention that any preliminary injunction should apply on a nationwide basis. *See* Doc. 30-1 at 38-40.

Appendix for Motion for Injunction Pending Appeal

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. _____ **COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

INTRODUCTION

Senior citizens and other vulnerable members of society rely on nursing homes and similar facilities to meet their needs when family members cannot. Although the nursing home industry certainly has had its share of challenges, it fills a vital need in our communities that cannot be replaced. Instead of addressing the legitimate challenges nursing homes face, the Defendants put forward a heavy-handed mandate through its Final Rule entitled, "*Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*" ("the Final Rule"). *See* 89 Fed. Reg. 40876 (May 10, 2024). This Final Rule poses an existential threat to the nursing home industry as many nursing homes that are already struggling will have no choice but to go out of business. And the main victims will be the patients who will have nowhere else to go. Plaintiffs represent a diverse group of States and industry organizations who aim to prevent this from happening.

This Final Rule represents not only another attempt from the Biden-Harris administration to impose its policy preferences on the rest of the country but is also monumentally costly and nearly impossible to comply with. During the public comment period, an outside study found that: (1) nursing homes will need to hire more than 100,000 additional full-time employees; (2) the Final Rule will cost nursing homes approximately $6.8 billion per year (higher than CMS's own estimate of $4 billion per year); (3) 94 percent of current skilled nursing facilities will be out of compliance with at least one of the three staffing requirements; and (4) more than 285,000 nursing home beneficiaries (or one-fourth of total nursing home residents) will be at risk of losing necessary care if nursing homes are unable to increase their workforce to meet these new standards. *See* CliftonLarson Allen LLP,

CMS Proposed Staffing Mandate, 6 ("CLA Study"), *available at* https://tinyurl.com/yc2v4t3h (July 8, 2024).

Beyond the costs, the latest Rule from the Biden-Harris Centers for Medicare & Medicaid Services (CMS) is not even close to lawful. Over forty years ago, Congress established two basic staffing requirements for nursing homes participating in both Medicare and Medicaid. *First*, nursing homes participating in these programs "must use the services of a registered professional nurse [("RN")] for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord id.* § 1395i-3(b)(4)(C)(i). *Second*, Congress established the flexible staffing standard that requires a nursing home "[to] provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents." *Id.* § 1396r(b)(4)(C)(i); *accord id.* § 1395i-3(b)(4)(C)(i). For decades, Congress, CMS, and its predecessors have considered—and rejected—proposals to replace the flexible staffing standards with a one-size-fits-all requirement. *See e.g.*, 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974); 45 Fed. Reg. 47368, 47371 (July 14, 1980); 52 Fed. Reg. 38583, 38586 (Oct. 16, 1987); 80 Fed. Reg. 42168, 42201 (July 16, 2015); 81 Fed. Reg. 68688, 68755 (Oct. 4, 2016).

Nevertheless, CMS proposed and promulgated the Final Rule that is unlawful and threatens the health, safety, and well-being of millions of nursing home patients across the country. The Final Rule departs from the longstanding staffing requirement in two ways. *First*, the Final Rule conspicuously *triples* the statutory nursing home staff requirement. It replaces Congress's directive for an RN to be present for 8 hours per day, 7 days a week, with a new mandate to have an RN "onsite [for] 24 hours per day, for 7 days a week" ("24/7 requirement"). 89 Fed. Reg. 40876, 40898. *Second*, the Final Rule abandons the flexible statutory staffing standard that is "Sufficient to meet the nursing needs" of each facility's

residents, 42 U.S.C. 1396r(b)(4)(C)(i); *accord id*. § 1395i-3(b)(4)(C)(i), in favor of a three part national requirement—irrespective of facility needs, current staffing capacity, or State law minimum staffing standards. The Final Rule requires (1) total nurse staffing of at least 3.48 hours per resident day ("HPRD"); (2) a mandate for RN staffing of at least 0.55 HPRD; and (3) nurse aid ("NA") staffing of at least 2.45 HPRD. 89 Fed. Reg. at 40877. HPRD is defined as the "total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS." *Id*. Essentially, the Final Rule abandons Congress's *qualitative* and flexible staffing standard for CMS's *quantitative r*equirement that does not account for resident acuity nor individual nursing home staff capacity.

Instead of pointing out where in the applicable Congressional statute they have the authority to promulgate this Final Rule, CMS takes the audacious approach of ignoring the statute altogether. CMS points to broadly worded provisions and a "miscellaneous" rulemaking provision that allows the Secretary of Health and Human Services to impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary." 42 U.S.C. § 1395i-3(d)(4)(B); *accord id*. 42 U.S.C. § 1396r(d)(4)(B) as justification for the Final Rule.

The wafer-thin reliance on a vague statutory provision does not allow CMS to promulgate a Final Rule that conflicts with a separate Congressional statute. But CMS's illegality is more apparent because this is a Major Questions Doctrine case. Implementing such a broad mandate that would result in *at least* $43 billion of compliance costs for nursing homes nationwide over the next ten years, without Congress "speak[ing] clearly" to the issue, is a flagrant violation of the Major Questions Doctrine. *See Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin.*, 595 U.S. 109, 117 (2022). And surely

Congress did not intend CMS to pull such an "elephant" of a mandate out of the "mouseholes" of either the Medicare or Medicaid Acts. *See Whitman v. Am. Trucking Associations*, 531 U.S. 457, 468 (2001). This is especially true given both Congress's and CMS's longstanding policy positions for maintaining a flexible staffing standard for nursing homes.

Beyond the statutory problems with the Final Rule, it is also the very definition of arbitrary and capricious rulemaking because (1) it represents a sharp departure from past CMS policy without reasoned explanation, (2) CMS did not consider reliance interests when promulgating the Final Rule and (3) CMS did not consider important aspects of the problem such as the cost of, and impossibility of complying with, the Final Rule. In short, there is no universe in which this Final Rule is lawful.

The Final Rule also causes harm to both organizational and State plaintiffs in this case, and much of that harm is irreparable. As noted above, the costs are impossible for many nursing homes to comply with. And although the Final Rule claims to have an extended implementation period, many nursing homes bear those costs *now*. This is because CMS requires nursing homes to conduct unreasonable enhanced facility assessments (EFA) within 60 days of publication of the Final Rule. These assessments are costing each nursing significant amounts of money and labor in order to comply. And even though the staffing requirements have a 2-3-year implementation period depending on the region, the reality of a tight labor market requires nursing homes to hire *immediately* because the available supply of nurses will dwindle as the implementation date approaches. Some nursing homes have had to immediately increasing their staffing and incurred significant costs. Similarly, states have their own enhanced reporting requirements for their Medicaid programs. Although CMS

claims to have a delayed implementation period for this portion of the Final Rule, states have also had to start immediately implementing these requirements. The Final Rule acknowledges as much by pointing to costs states will incur in year one.

Plaintiffs have no option but to seek relief through this Court and request this Court to vacate, set aside, and permanently enjoin the Final Rule. In the interim, the Plaintiffs will seek to preliminary enjoin the Final Rule to spare them the irreparable harm they are already facing and will continue to face in the future.

THE PARTIES

1. Plaintiff Alabama is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Alabama brings this suit through its attorney general, Steve Marshall, who is the chief legal officer for the State and is "authorized to institute and prosecute, in the name of the state, all civil actions and other proceedings necessary to protect the rights and interests of the state." Ala. Code § 36-15-12.

2. Plaintiff Alaska is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Alaska brings this suit through its Attorney General, Treg R. Taylor. He is authorized by Alaska law to sue on the State's behalf.

3. Plaintiff Arkansas is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Arkansas brings this suit through its attorney general, Tim Griffin. General Griffin is authorized to "maintain and defend the interests of the state in matters before the United States Supreme Court and all other federal courts." Ark. Code Ann. § 25-16-703.

4. Plaintiff the State of Florida is a sovereign State and has the authority and responsibility to protect its sovereign interests and the health, safety, and welfare of its citizens. As the State's Chief Legal Officer, Attorney General Ashley Moody is authorized to represent the interests of the State in civil suits. § 16.01(4), (5), Fla. Stat.

5. Plaintiff State of Georgia is a sovereign state of the United States of America. Georgia sues to vindicate its sovereign, quasi-sovereign, and proprietary interests, including its interests in protecting its citizens, businesses and employees. Georgia brings this suit through its Attorney General, Christopher Carr. He is the chief legal officer of the State of Georgia and has the authority to represent the State in federal court.

6. Plaintiff State of Idaho is a sovereign State of the United States of America. Idaho sues to vindicate its sovereign, quasi-sovereign, and proprietary interests, including its interests in protecting its citizens. The Final Rule will harm Idaho and its citizens. Idaho brings this suit through its attorney general, Raúl Labrador, the State's chief legal officer. He is authorized by Idaho law to sue on the State's behalf under Idaho Code § 67-1401. His address is 700 W. Jefferson Street, P.O. Box 83720, Boise, Idaho 83720.

7. Plaintiff Indiana is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Indiana brings this suit through its attorney general, Theodore E. Rokita. He is authorized to "represent the state in any matter involving the rights or interests of the state." Ind. Code § 4-6-1-6.

8. Plaintiff Iowa is a sovereign state of the United States of America. Iowa sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Iowa brings this suit through its attorney general, Brenna Bird. She is authorized by Iowa law to sue on the State's behalf under Iowa Code § 13.2.

9. Plaintiff Kansas is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Kansas brings this suit through its attorney general, Kris W. Kobach. He is the chief legal officer of the State of Kansas and has the authority to represent Kansas in federal court. Kan. Stat. Ann. 75-702(a).

10. Plaintiff Commonwealth of Kentucky is a sovereign state of the United States of America. Russell Coleman is the duly elected Attorney General of the Commonwealth of Kentucky with the constitutional, statutory, and common-law authority to bring a suit on behalf of the Commonwealth and its citizens. *See* Ky. Rev. Stat §§ 15.020, 15.255(a), 15.260; *see also Commonwealth ex rel. Beshear v. Commonwealth ex rel. Bevin*, 498 S.W.3d 355, 362 (Ky. 2016).

11. Plaintiff Missouri is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Missouri brings this suit through its attorney general, Andrew Bailey. He is the chief legal officer of the State of Missouri and has the authority to represent Missouri in federal court. Mo. Rev. Stat. § 27.060.

12. Plaintiff Montana is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Montana brings this suit through its attorney general, Austin Knudsen. He is the chief legal officer of the State of Montana and has the authority to represent Montana in federal court. Mont. Rev. Code § 2-15-501.

13. Plaintiff Nebraska is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Nebraska brings this suit through its attorney general, Mike Hilgers. He is the chief legal officer of the State of

Nebraska and has the authority to represent Nebraska in federal court. Neb. Rev. Stat. § 84-203.

14. Plaintiff Oklahoma is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Gentner Drummond is the duly elected Attorney General for the State of Oklahoma. Being "the chief law officer of the state," OKLA. STAT. tit. 74, § 18, General Drummond is empowered "[to] appear for the state and prosecute and defend all actions and proceedings in any of the federal courts in which the state is interested as a party." *Id.* at § 18b(A)(2).

15. Plaintiff North Dakota is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Drew Wrigley is the Attorney General of North Dakota and is authorized to "[i]nstitute and prosecute all actions and proceedings in favor or for the use of the state." N.D.C.C. § 54-12-01(2).

16. Plaintiff South Carolina is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. South Carolina brings this suit through its attorney general, Alan Wilson. He is the chief legal officer of the state of South Carolina and has the authority to represent South Carolina in federal court. *State ex rel. Condon v. Hodges*, 349 S.C. 232, 239-40, 562 S.E.2d 623, 627 (2002) (the South Carolina Attorney General "may institute, conduct and maintain all such suits and *proceedings as he deems* necessary for *the enforcement of the laws of the State*, the *preservation of order*, and the *protection of public rights*.") (emphasis in original) (quoting *State ex rel. Daniel v. Broad River Power Co*., 157 S.C. 1, 68, 153 S.E. 537, 569 (1929), *aff'd* 282 U.S. 187 (1930)).

17. Plaintiff South Dakota is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. South Dakota brings this suit through its Attorney General, Marty J. Jackley. He is the duly elected Attorney General of South Dakota with the authority, per SDCL 1-11-1(1), to prosecute and defend all actions, civil or criminal, in which the state is an interested party.

18. Plaintiff Utah is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Utah brings this suit through its attorney general, Sean D. Reyes. He is the chief legal officer of the State of Utah and has the authority to represent Utah in federal court. Utah Const. art. VII, § 16; Utah Code § 67-5-1(1)(b).

19. Plaintiff Commonwealth of Virginia is a sovereign State of the United States of America. Jason Miyares, the Attorney General of Virginia, is authorized by statute to "represent the interests of the Commonwealth … in matters before or controversies with the officers and several departments of the government of the United States." Va. Code § 2-2.513.

20. Plaintiff State of West Virginia is a sovereign State of the United States of America. Patrick Morrisey is the Attorney General of the State of West Virginia. The Attorney General "is the State's chief legal officer," *State ex rel. McGraw v. Burton*, 569 S.E.2d 99, 107 (W. Va. 2002), and his express statutory duties include "appear[ing] as counsel for the state in all causes pending . . . in any federal court[] in which the state is interested," W. Va. Code § 5-3-2.

21. Plaintiff LeadingAge Kansas is a state trade association that has operated for 70 years with over 150 not-for-profit and mission driven aging services providers, including 116 nursing homes. LeadingAge Kansas represents a significant number of small, rural, and stand-

alone nursing homes who will not be able to absorb the cost of the Final Rule year-after-year as they continue to rely on historically underfunded Medicaid and Medicare reimbursement.

22. Among the nursing homes that are members of Plaintiff LeadingAge Kansas are Plaintiffs Dooley Center and Wesley Towers. These and others are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

23. Plaintiff Dooley Center is a 44-person licensed nursing facility located in Atchison, Kansas, that accepts Medicaid and private pay only. It cares for the retired Benedictine Sisters of Mount St. Scholastica. Its mission is "the care of the sick rank above and before all else, so they may truly be served as Christ." It is harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

24. Plaintiff Wesley Towers is a continuing care retirement community located in Hutchinson, Kansas. It currently has 185 employees and 300 residents, 50 of whom are cared for in its nursing home. It is harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

25. Plaintiff LeadingAge South Carolina is an association that represents 30 non-profit mission driven skilled nursing communities in South Carolina. These communities, which include Presbyterian Communities of South Carolina, Lutheran Homes of South Carolina, The Woodlands at Furman, Wesley Commons, Westminster Towers, Bishop Gadsden Episcopal Community, Saluda Nursing & Rehabilitation, The Cypress of Hilton Head, Park Pointe Village, The Seabrook of Hilton Head, Rolling Green Village, South

Carolina Baptist Ministries of Aging, and Still Hopes Episcopal Retirement Community, are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

26. Plaintiff LeadingAge Colorado is a statewide trade association that represents the continuum of senior living and aging services providers including not-for-profit nursing homes. It represents 12 nursing communities, including Eben Ezer Lutheran Care Center, which are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

27. Plaintiff LeadingAge Iowa is a trade association that represents not-for-profit aging services providers in Iowa, including 60 nursing homes, nearly half of which are located in this District. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

28. Plaintiff LeadingAge Maryland is a membership association representing not-for-profit aging services organizations in Maryland. It represents 30 nursing communities, with its members including Coffman Nursing Center, Fahrney Keedy Home and Village. These and other members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are impossible to meet without reducing services or further limiting access to care.

29. Plaintiff LeadingAge Michigan is a state trade association with over 200 not-for-profit and mission-driven aging services providers, including 51 nursing homes. These

members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

30. Plaintiff LeadingAge Minnesota is a state trade association that has over 1100 mission-driven aging services providers, including 239 nursing homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

31. Plaintiff LeadingAge Missouri is a membership association for 125 Missouri aging services providers, including 44 nursing homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

32. Plaintiff LeadingAge Nebraska is a statewide trade association supporting nursing home and other providers of long-term care services in Nebraska. It represents 47 nursing home providers, including Florence Home, which are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

33. Plaintiff LeadingAge New Jersey/Delaware is a state trade association with over 140 mission driven senior living and services provider members, including over 30 nursing communities. These members, including United Methodist Communities, are harmed by the Final Rule because of significant costs and mandatory staffing requirements are impossible to meet without reducing services or further limiting access to care.

34. Plaintiff LeadingAge Ohio is an association that represents 112 nonprofit, mission-driven skilled nursing communities in Ohio, with its member including Shepherd of the Valley communities in Poland, Boardman, Girard and Howland; Community First Solutions, which operates three facilities in Hamilton, Ohio. These and other members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

35. Plaintiff LeadingAge Oklahoma is a state trade association with over 100 not-for-profit and mission driven aging services providers, including 58 nursing homes. These and other members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

36. Plaintiff LeadingAge PA is an association representing more than 400 non-profit and mission-driven providers of senior services in Pennsylvania, with its membership encompassing 182 of the more than 600 skilled nursing facilities in Pennsylvania. These and others members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are impossible to meet without reducing services or further limiting access to care.

37. Plaintiff LeadingAge South Dakota Association of Healthcare Organizations ("SDAHO") is a state trade association serving South Dakota's hospitals, nursing homes, home health, hospice and assisted living providers through advocacy, education and quality integration. Its membership includes 57 hospitals, 47 nursing homes, 77 assisted living facilities, and approximately 18 home health and hospice providers. Many of its members,

including The Neighborhoods at Brookview in Brookings, SD, Bethesda Home of Aberdeen, South Dakota, and Winner Regional Healthcare Center in Winner, SD, are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

38. Plaintiff LeadingAge Southeast is a state trade association with over 250 mission driven communities. Their members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

39. Plaintiff LeadingAge Tennessee is a state trade association with 20 not-for-profit nursing home members serving the State of Tennessee. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

40. Plaintiff LeadingAge Virginia is a state trade association with over 90 mission driven provider members, including over 46 homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are impossible to meet without reducing services or further limiting access to care.

41. Defendant Xavier Becerra is the Secretary of Health & Human Services. Defendant Becerra oversees the Medicare and Medicaid programs and approved the Final Rule at issue in this litigation. *See* 89 Fed. Reg. at 41000. Defendant Becerra is sued in his official capacity.

42. Defendant United States Department of Health and Human Services ("HHS") is a federal agency organized under the laws of the United States. It is responsible for

administering federal healthcare policy and is the cabinet-level department of which the Centers for Medicare & Medicaid Services ("CMS") is a part.

43. Defendant CMS is a federal agency within HHS responsible for the federal government's administration of Medicare and Medicaid.

44. Defendant Chiquita Brooks-Lasure is the Administrator of CMS and is sued in her official capacity.

JURISDICTION AND VENUE

45. This Court has jurisdiction over this action under 28 U.S.C. § 1331 and has authority to grant the relief requested under the Administrative Procedure Act, 5 U.S.C. §§ 701-706, and the Declaratory Judgment Act, 28 U.S.C. §§ 2201-2202.

46. The Court is authorized to set aside the challenged agency actions, postpone their effective date pending judicial review, hold them unlawful, grant preliminary and permanent injunctive relief, and award the declaratory and injunctive relief requested below. 5 U.S.C. §§ 705-06 (2018); 28 U.S.C. §§ 1361, 2201-02 (2018).

47. Venue is proper under 5 U.S.C. § 703 and 28 U.S.C. § 1391(e) because (1) Plaintiff State of Iowa and members of LeadingAge Iowa reside in this judicial district and no real property is involved in this action.

48. Plaintiffs are challenging a final agency action pursuant to 5 U.S.C. §§ 551(13) and 704 (2018).

BACKGROUND

A. Medicare and Medicaid Statutes

49. In 1965, Congress established the Medicare and Medicaid programs by amending the Social Security Act. *See* Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965).

50. Medicare is a federal program that provides healthcare coverage to individuals 65 or older, as well as those with certain disabilities or conditions. *See* 42 U.S.C. § 1395c.

51. Medicaid, on the other hand, is a joint federal-state program offering healthcare coverage to low-income individuals. *See* 42 U.S.C. §§ 1396-1, 1396a.

52. Nursing homes that wish to participate in Medicare must comply with the statutory requirements for "skilled nursing facilities" ("SNFs") provided for at 42 U.S.C. § 1395i-3.

53. Those participating in Medicaid must meet similar requirements for "nursing facilities" ("NFs") set forth at 42 U.S.C. § 1396r.

54. Together, "skilled nursing facilities" covered under Medicare, and "nursing facilities" covered under Medicaid are often collectively referred to as "long-term care" ("LTC") facilities. *See, e.g*. 87 Fed. Reg. 22720, 22790 (Apr. 15, 2022). Referring to both types of facilities as LTCs is convenient because the statutory language for both Medicare and Medicaid requirements are largely parallel.

55. CMS has issued consolidated regulations applicable to all LTC facilities participating in either or both Medicare and Medicaid. *See e.g.* 42 C.F.R. § 483.1.

56. Under the Medicaid statute, a state may waive the staffing requirements for an LTC facility if it cannot meet them, provided certain conditions are met: (1) the LTC facility must demonstrate to the state that, despite diligent efforts, it was unable to recruit suitable personnel; (2) granting a waiver will not compromise the health or safety of the LTC facility's residents; (3) during times when an RN is unavailable, an RN must be able to respond to calls from the LTC facility; (4) the state agency must notify the state long term care ombudsman

about the waiver; and (5) the LTC facility must inform its residents and family about the waiver. *See generally* 42 U.S.C. § 1396r(b)(4)(C)(ii)(I)-(V).

57. Similarly, under the Medicaid statute, LTC facilities are addressed in 42 U.S.C. § 1396r(b)(4)(C), also entitled "Required nursing care." This section mandates that LTC facilities provide necessary services and activities to achieve or maintain the highest practical well-being of each resident. Both the Medicare and the Medicaid emphasize the importance of quality care.

58. LTC facilities participating in either Medicare or Medicaid are required to utilize the services of a registered professional nurse for "at least 8 consecutive hours a day, 7 days a week." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *accord id.* § 1396r(b)(4)(C)(i)(II) (Medicaid).

59. They are required to provide 24-hour licensed nursing services that are "sufficient to meet the nursing needs of their residents." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *accord id*. § 1396r(b)(4)(C)(i)(I) (Medicaid).

60. Under the Medicare statute, the Secretary of HHS is authorized to waive the requirement for LTC facilities to employ an RN for more than 40 hours per week if: (1) the facility is "located in a rural area where the supply of skilled nursing services is insufficient to meet the needs" of local residents; (2) "the facility has one full-time RN who is regularly on duty at the [LTC] for 40 hours [per] week"; (3) the LTC facility has patients whose physicians have indicated that they do not require an RN or physician for 48 hours, or it has arranged for an RN or physician to provide necessary services when the full-time nurse is unavailable; (4) "the Secretary provides notice of the waiver to the State long-term care ombudsman …"; and

(5) the facility that is granted the waiver notifies residents of the LTC facility and their families of the waiver. *See generally* 42 U.S.C. § 1395i-3(b)(4)(C)(ii)(I)-(V).

61. Waivers of staffing requirements under the Medicaid statute are subject to annual review by the State and Secretary of HHS. *Id.* If a state is found to regularly grant waivers without facilities making diligent efforts to meet staffing requirements, the Secretary "shall assume and exercise the authority of the State to grant waivers." *Id.*

62. Neither the Medicare nor Medicaid statutes grant the Secretary the authority to establish a uniform HPRD requirement across all LTC facilities, irrespective of the actual needs of their residents or the idiosyncrasies of each facility. Rather, these statutes require nursing services that "are sufficient to meet the nursing needs" of each facility's residents. *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id.* 42 U.S.C. § 1396r(b)(4)(C)(i)(I).

63. Neither statute authorizes the Secretary to impose standardized HPRD requirements for RN staffing at every LTC facility across the country, regardless of their residents' specific needs or the idiosyncrasies of each LTC facility. *Id.*

64. Neither statute authorizes the Secretary to impose standardized HPRD requirements for NA staffing at every LTC facility across the country, regardless of their residents' specific needs or the idiosyncrasies of each LTC facility. *Id.*

65. Neither statute authorizes the Secretary to alter or increase the hour requirement for LTC facilities to employ the services of a registered professional nurse beyond "at least 8 consecutive hours a day, 7 days a week." *Id.*

B. Statutory and Regulatory History of Nursing Staff Requirements

66. For over fifty years, Congress has been at the helm of deciding the requisite staffing requirements for nursing homes participating in Medicare and Medicaid. In 1972,

Congress amended the Social Security Act to declare that all LTC facilities participating in Medicare or Medicaid provide "24-hour nurse service[s] which is sufficient" to meet patient needs, including employing at least one registered professional nurse full-time. Pub. L. No. 92-603, § 278, 86 Stat. 1329, 1424-27 (1972).

67. The amendments also introduced nurse-staffing waiver provisions for rural facilities under specific conditions. *See id.* § 267, 86 Stat. at 1450.

68. The Department of Health, Education and Welfare (predecessor of HHS), through its Social Security Administration ("SSA"), proposed regulations in 1973 that aligned with these statutory requirements. *See* 38 Fed. Reg. 18620 (July 12, 1973).

69. At the same time, during the notice-and-comment period, the SSA received public input urging it to deviate from Congress's flexible (qualitative) approach for a staffing requirement that all nursing homes implement a rigid (quantitative) nurse-to-patient ratio. *See* 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974).

70. Despite calls for these specific nurse-to-patient ratios, the SSA rejected such a uniform approach, citing the variability in facility needs and the potential negative impacts of arbitrary staffing quotas. *Id*.

71. SSA reasoned that "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs and the services necessary to meet those needs precludes setting [a specific ratio]." *Id*. Moreover, "[a] minimum ratio could result in all facilities striving only to reach that minimum and could result in other facilities hiring unneeded staff to satisfy an arbitrary ratio figure." *Id*.

72. Later, in 1980, HHS took over the administration of Medicare and Medicaid services. It proposed a "general revision" of the regulation governing the participation of LTC facilities in the Medicare and Medicaid programs. *See* 45 Fed. Reg. 47368 (July 14, 1980).

73. However, HHS declined to implement any specific staffing ratios, but rather "retain[ed] the language in the existing regulations" that mirrored those statutes which called for "adequate staff to meet patient needs" *Id*. at 47371; *see also id*. at 47387 (requiring "24-hour nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of the patient," and a registered nurse working full time for 7 days a week).

74. In 1987, Congress—and not HHS—redefined nursing home categories and imposed uniform staffing requirements on LTC facilities under Medicare and Medicaid by requiring a registered nurse on duty for at least eight hours per day, seven days a week. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4201(a), 101 Stat. 1330-161; *accord id*. § 4211(a), 101 Stat. 1330-186 (Dec. 22, 1987).

75. Congress further refined nursing home legislation by introducing waiver provisions and commissioning studies to analyze staffing requirements. These studies aimed to "determine the appropriateness of establishing minimum caregiver to resident ratios" for LTC facilities. *See* Pub. L. No. 101-508, §§ 4008(h), 4801(a), 104 Stat. 1338 (1990)).

76. Yet no mandatory ratios or staffing requirements were implemented, and CMS continuously administered the staffing standards established by Congress without incident. *See* 42 C.F.R. § 483.35(a)-(b) (2016).

77. In 2016, CMS once again dismissed the push for mandatory staffing ratios in LTC facilities and for the 24/7 RN requirement. *See* 81 Fed. Reg. 68688, 68754-56 (Oct. 4, 2016).

78. It concluded that a "one-size-fits-all approach" to staffing was not only "inappropriate[,]" but also that "mandatory ratios" and a "24/7 RN presence" were concerning. *Id*. at 68754-56, 68758; *see also* 80 Fed. Reg. 42168, 42201 (July 16, 2015) (emphasizing the importance of taking resident acuity levels into account").

79. Specifically, CMS expressed concerns about mandatory ratios and the 24/7 requirement because "LTC facilities [vary] in their structure and in their resident populations." *Id*.

80. CMS determined that the "focus" of its regulations "should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care." 80 Fed. Reg. at 42201. And "establishing a specific number of staff or hours of nursing care could result in staffing to that number rather than to the needs of the resident population." *Id.*

81. CMS also found that having a 24/7 RN requirement "could negatively impact the development of innovative care options, particular[ly] in smaller, more home-like settings," and that "geographic disparity in supply could make such a mandate particularly challenging in some rural and underserved areas." 81 Fed. Reg. at 68755.

82. Indeed, LTC facilities differ and vary across the country. CMS found that obvious when it succinctly explained its rejection of the one-size-fits-all staffing requirement: "The care needs of each of these populations are different. Facilities range in size from the very small to the very large. The capabilities of these facilities are [] different." *Id*. at 68755.

83. Because of the variation in LTC facility needs across the country, LTC facility minimum staffing requirements are handled differently across states. As CMS acknowledged,

there is "widespread variability in existing minimum staffing standards" adopted by 38 States and the District of Columbia. *See* 89 Fed. Reg. at 40880.

THE FINAL RULE

84. In February 2022, the Biden-Harris Administration departed from these decades of practice to establish a "reform" that would "establish a minimum nursing home staffing requirement." White House, FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes (Feb. 28, 2022) ("White House Fact Sheet").[1]

85. In doing so, the administration directed CMS to conduct a research study to determine the level and type of staffing needed to ensure safe and quality care. *Id.*

A. The Abt Study

86. In response to this directive, CMS contracted with a private firm, Abt Associates, to perform a "mixed-methods Nursing Home Staffing Study" as a party of CMS's goal of identifying a minimum staffing requirement.[2] The goal was to issue proposed rules by February 2023 and establish minimum standards for staffing adequacy. *See Supra*, White House Fact Sheet.

87. However, the truncated Abt Study was "conducted on a compressed timeframe" with data collected between June of 2022 through December of 2022. Abt Study at xix. Strikingly, "the short duration reflect[ed] the time-sensitive nature of the study and CMS's timeline for proposing a minimum staffing requirement in support of the Presidential initiative." *Id.*

[1] The White House, *FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes* (Feb. 28, 2022), available at https://tinyurl.com/3626wt8k
[2] Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023) ("Abt Study") at viii, available https://tinyurl.com/b2ehy528

88. The study was completed and published in June of 2023. Consistent with the decades of prior practice and contrary to the directive of the Biden-Harris Administration, the Abt Study did "not identif[y] a minimum staffing level to ensure safe and quality care." Abt Study at 115.

89. According to the study, if a minimum staffing level was to be implemented, "[n]ursing homes [would] face barriers to hiring, primarily [with] workforce shortages and competition from staffing agencies." *Id*. at xi; *see also*, *e.g*., *id*. at xii, xiv, 19, 31-32, 115.

90. Furthermore, it concluded that between 43 and 90 percent of nursing homes would have to add more staff to comply with a federal minimum staffing requirement. *Id*. at 113. It also predicted that a federal minimum staffing requirement could cost the nursing home industry up to $6.8 billion in compliance costs each year. *Id*. And that annual total salaries per nursing home would have to increase from as low as $316,000 to $693,000 in order to comply. *Id*. at 113-14.

91. Nowhere in the study did Abt Associates conclude that a minimum staffing requirement would result in *definitive* benefits. The Abt Study provides data for only "*potential* minimum staffing requirement benefits" and for "potential barriers to and unintended consequences of [an] implementation." Abt Study at 121 (emphasis added).

92. Nowhere in the study did Abt Associates conclude that a federally mandated minimum staffing requirement would *actually* provide better healthcare outcomes for nursing home residents. Rather, the reviewed literature "underscored" that there was no "clear eviden[tiary] basis for setting a minimum staffing level." Abt Study at xi.

93. Moreover, the staffing study did not find the implementation of a federally mandated minimum staffing requirement to be feasible without considering factors such as

variations in resident acuity, ongoing staffing shortages, compliance costs, and the diverse circumstances affecting quality patient care. *Id.* at 32.

94. That is not surprising given CMS's past positions that rejected calls to impose a one-size-fits-all approach. *See e.g.* 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974) (explaining that the variation in patients' needs is a valid basis to reject setting a specific staff-to-patient ratio); 45 Fed. Reg. 47368, 47371 (July 14, 1980) (rejecting nursing staff ratios or minimum number of nursing hours per patient day because of the lack of conclusive evidence supporting the implementation of a minimum staffing requirement); 52 Fed. Reg. 38583, 38586 (Oct. 16, 1987) (explaining that a 24-hour nursing requirement would be impractical and that a nurse staffing requirement should be sensitive to the "patient mix") ; 80 Fed. Reg. 42168, 42201 (July 16, 2015) ("We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and staffing abilities including professional characteristics, skill sets and staff mix."); 81 Fed. Reg. 68688, 68755 (Oct. 4, 2016) ("[w]e do not agree that we should establish minimum staffing ratios at this time . . . [t]his is a complex issue and we do not agree that a 'one-size-fits-all' approach is best . . . [o]ur approach would require that facilities take into account the number of residents in the facility, those residents' acuity and diagnosis.").

95. As a result, the Abt Study never came to a definitive conclusion that supported a national, one-size-fits-all approach to minimum staffing requirements that the Biden-Harris Administration was hoping to achieve.

96. Rather, there was no "specific evidence" that a minimum nursing staff level could be feasibly implemented. *Id*. at 111. Troublingly, the study disregarded the ongoing "national health care staff shortages" and "current hiring challenges" that present barriers to nursing homes—which would make compliance with a new federal staffing requirement impractical. *Id*. at xxi.

97. The study acknowledged but ultimately ignored several potential unintended consequences of implementing a national minimum staffing requirement. These include: (1) the possibility that nursing homes might be unable to achieve the one-size-fits-all staffing levels; (2) LTC facilities could be limited in resident admissions because of staff-to-patient ratios; or (3) nursing homes might even close down entirely, thereby potentially reducing access to care. *Id*.

B. Promulgation of the Final Rule

98. In lockstep with marching orders from the Biden-Harris Administration, CMS issued a proposed rule in September of 2023 that introduced new minimum staffing standards for LTC facilities. *See* 88 Fed. Reg. 61352 (Sept. 6, 2023).

99. Despite the 46,000 public comments—some of which informing CMS that the proposed rule exceeded CMS's statutory authority, contravened Congress's considered decision to keep flexible staffing standards, and failed to consider the barriers nursing homes would face with compliance—CMS published the Final Rule in May of 2024. *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).

100. CMS claims that the minimum staffing standard is supported by "literature evidence, analysis of staffing data and health outcomes, discussions with residents, staff, and industry." *See* 89 Fed. Reg. at 40877.

101. Citing the inconclusive and truncated six-month Abt Study, CMS claims that this was enough to conclude that an overly-broad and onerous staffing requirement was necessary. *See* 89 Fed. Reg. at 40881, 40877.

102. Yet, CMS acknowledges that "[t]here is no clear, consistent, and universal methodology for setting specific minimum staffing standards" as evidenced by the 38 states and the District of Columbia that have adopted their own nurse-to-patient ratios. *Id*. at 40881.

103. Notwithstanding the variability across the minimum staffing requirements different states employ, the inconclusive determination of the Abt Study, or the consistent rejection of a one-size-fits-all staffing requirement for over fifty years, CMS published the Final Rule.

104. CMS asserts that "various provisions" across 42 U.S.C. §§ 1395i-3 and 1396r contain "separate authority" to impose the Final Rule. *See* 89 Fed. Reg. at 40879, 40890-9.

1. The Secretary may impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary." 42 U.S.C. § 1395i-3(d)(4)(B); *accord id*. § 1396r(d)(4)(B).

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

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

C. The Final Rule's Provisions

105. The Final Rule imposes two mandatory minimum-staffing requirements on LTC facilities.

106. *First*, the Final Rule *triples* the required hours per day of RN services. Both the Medicare and Medicaid statutes require that LTC facilities "[u]se the services of [an RN] for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id.* § 1396r(b)(4)(C)(i). But the Final Rule requires LTC facilities to have an RN "onsite 24 hours per day, for 7 days a week that is available to provide direct resident care" ("24/7 requirement"). 89 Fed. Reg. at 40997.

107. *Second,* the Final Rule abandons the flexible, qualitative statutory requirement that LTC facilities "provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id.* § 1396r(b)(4)(C)(i). Instead, the Final Rule now requires that "[t]he facility must meet or exceed a minimum of 3.48 hours per resident day ('HPRD') for total nurse staffing," which must include a "minimum of 0.55 [HPRD] for registered nurses," and a "minimum of 2.45 [HPRD] for nurse aides." 89 Fed. Reg. at 40996.

108. Before publication of the Final Rule, federal regulations mirrored Congress's *qualitative* statutory requirements to keep nursing staff available 24-hours per day. *See* 42 C.F.R. § 483.30.

109. Those regulations never specified a *quantitative* staffing requirement. *Id.*; *Cf.* 89 Fed. Reg. 40876, 40996-97. But by departing from the flexibility of both the Medicare and Medicaid statutes, the Final Rule now requires national compliance from LTC facilities "regardless of the individual facility's resident case-mix." 89 Fed. Reg. at 40877.

110. Regarding the statutory waivers, the Final Rule permits Medicare participants to qualify for a statutory waiver of the 24/7 RN requirement, but not the HPRD requirements. *Id.* at 40997-98.

111. The Final Rule also permits Medicaid participants to qualify for the statutory waiver concerning the new 24/7 RN requirement and 0.55 RN HPRD requirement, but not for the 3.48 total nurse HPRD nor 2.45 NA HPRD requirements. *Id.* at 40997.

112. The Final Rule proposes a "hardship exemption," ostensibly allowing partial relief from the 24/7 requirement and minimum HPRD requirements. *Id.* at 40998. However, this exemption is riddled with stringent criteria that make it virtually unattainable for most facilities to achieve.

113. To qualify for a "hardship exemption," the facility must establish that it meets *all four* regulatory requirements: (1) proving a significant local shortage of health care staff; (2) demonstrating unsuccessful recruitment efforts despite offering competitive wages; (3) documenting financial expenditures on staffing relative to revenue; and (4) qualified facilities must publicly disclose their exemption status. *Id.* at 40998.

114. This façade of an exemption is not only limited in scope, but explicitly departs from the statutory waiver criteria already laid out by Congress. Even *if* granted on the case-by-case determination, *see* 89 Fed. Reg. at 40886, the exemption only provides an 8-hour reprieve from the 24/7 RN requirement, leaving facilities with the requirement to staff for a minimum of 16 hours per day, 7 days per week. *Id*. at 40998.

115. Even the narrow allowance of a "hardship exemption" can still be denied if a facility is designated as a "Special Focus Facility," or those with recent staffing-related

citations. *Id*. Ultimately, LTC facilities currently struggling with staffing recruitment or retention will be incapable of qualifying for even a "hardship exemption."

D. CMS Fails to Explain the Final Rule

116. In the Final Rule, CMS fails to explain why it implemented the 24/7 requirement and departed from the statutory requirements of both the Medicare and Medicaid Acts that only require onsite RN services for only 8 hours per day, 7 days a week (hereinafter "8/7 requirement").

117. Nowhere in the Abt Study does it suggest that LTC facilities across the country should require an on-site RN 24 hours per day, 7 days per week.

118. CMS fails to explain how it determined its 3.48, 0.55, or 2.45 HPRD requirements. It claims that the 3.48, 0.55, and 2.45 HPRD levels "were developed using case-mix adjusted data sources." 89 Fed. Reg. at 40877.

119. CMS claims that the 0.55 and 2.45 levels, but not the 3.48 level, were discussed during the notice of proposed rulemaking. *See* 88 Fed. Reg. 61352 (Sept. 6, 2023); 89 Fed. Reg. at 40891.

120. In the notice of proposed rulemaking, CMS indicated that based on findings from the Abt Study, additional data sources, "two listening sessions," and literature reviews, they proposed minimum staffing levels of 0.55 HPRD for RNs and 2.45 HPRD for NAs. 88 Fed. Reg. at 61369.

121. However, the Abt Study does not substantiate these specific levels. Moreover, a "review of existing literature" does not provide a valid evidentiary basis for establishing these requirements.

122. CMS also fails to establish how other data assessments support the published staffing levels.

123. CMS provides no rationale for the 3.48 HPRD requirement in either the notice of proposed rulemaking or the Final Rule, aside from vaguely stating it was developed using "case-mix adjusted data sources." 89 Fed. Reg. at 40877. This explanation departs from those used to establish other staffing levels in the notice of proposed rulemaking.

124. Moreover, CMS's minimum staffing ratios require LTC facilities to ignore the variability in resident acuity and needs across different facilities. Some facilities with higher acuity residents may need increased staffing, while others with lower acuity residents may not require an RN present 24/7. CMS fails to explain why requiring facilities with lower acuity residents to maintain higher staffing than needed is necessary for increasing quality of care.

125. CMS's rationale for the Final Rule is premised on truncated data that does not accurately capture the staffing realities in nursing homes. The Final Rule requires the use of Payroll Based Journaling ("PBJ") data to monitor and enforce the HPRD and 24/7 requirements. *See* 89 Fed. Reg. at 40882-83.

126. However, PBJ data fails to accurately account for the specific periods when LTC staff are working and need to comply with the Final Rule. For instance, if an LTC facility employs three RN's who each work 8-hour dayshifts but no overnight shifts, it would appear on paper that they meet the 24/7 requirement. But in reality, they are not. CMS thus fails to explain how PBJ data is an accurate metric of tracking compliance.

127. CMS fails to account for the ongoing shortage of nursing staff across the country—one that will surely be exacerbated by CMS's mandate that will make compliance virtually impossible in rural areas.

128. Instead of addressing the reality of the nationwide workforce shortage, CMS would rather throw $75 million to help "increase the [LTC] workforce" that it "expects" will be used for "tuition reimbursement." 89 Fed. Reg. 40885-86. This $75 million is only a miniscule fraction of what is *needed* to comply or alleviate many of the affected LTC facilities. Moreover, $75 million does not address the foundational problem.

129. Ultimately, CMS's explanation for the determination of these levels lacks transparency and does not adequately explain how such arbitrary figures and standards were determined.

HARM TO THE PLAINTIFFS

A. Financial Burden

130. The Final Rule imposes a monumental financial burden on LTC facilities, with costs (conservatively) projected to exceed $5 billion per year after the Final Rule is fully implemented. 89 Fed. Red. at 40970, tbl. 22; *see id.* at 40949. Outside studies point that number even higher—upwards of $7 billion per year by some estimates. *Id.* at 40950.

131. All of Plaintiff States' LTC facilities that receive Medicare and Medicaid will incur financial costs with the implementation of this Final Rule.

132. LTC facilities in Kansas are a prime example of how the Final Rule creates a daunting financial burden.

133. The total cost for Kansas nursing facilities to comply with the Final Rule's minimum staffing requirement—in the first year alone—ranges between $64 million and $92.7 million, with an average cost of $211,905 per facility.

134. In Indiana, the Indiana Health Coverage Program and Indiana PathWays for Aging provide coverage for long-term care services provided to eligible members with an

applicable level-of-care determination. CMS estimates that complying with the 24/7 RN Requirement will cost over $10.9 million annually in Indiana. 89 Fed. Reg. at 40962, tbl. 18. Statewide, CMS estimates that complying with this rule will cost Indiana long-term care facilities $151.2 million. *Id.* at 40984, tbl. 28. Much of this cost will be passed on to health plans, like Indiana Health Coverage Program and Indiana PathWays for Aging. So Indiana will face increased costs to cover long-term care services.

135. Plaintiff LeadingAge Kansas represents a significant number of small, rural, and stand-alone nursing homes who will be unable to absorb the incessant compliance costs.

136. LTC facilities operated by LeadingAge Kansas have historically relied on underfunded Medicaid and Medicare reimbursement while serving senior citizens in their communities who can already ill afford escalating costs of healthcare.

137. The estimated financial burden caused by the Final Rule will also include costs for both employing new staff and the use of contracted nursing agency workers—which is significantly more expensive.

138. For example, the average contracted RN rate is estimated at $72 per hour, while the average W2 RN employee rate is around $40 per hour. The averaged contracted NA rate is $38 per hour, while the average W2 NA employee rate is around $19 per hour.

139. For LeadingAge South Carolina, each LTC facility is estimated to have to pay $550,818 in compliance costs, which will potentially close most facilities.

140. Wesley Commons, one of LeadingAge South Carolina's LTC facilities, had to hire two additional RNs to comply with the Final Rule—incurring costs of $14,650, excluding night and weekend shifts.

141. Additionally, for compliance with the Final Rule, it reinstated two full-time nursing assistants to meet the HPRD requirement—adding an additional $66,560 per year.

142. These changes were necessary to comply with the Final Rule, despite previously meeting both state and federal requirements. Moreover, to retain and recruit more staff due to the new requirements, Wesley Commons increased pay, costing an additional $164,428 per year.

143. Facilities in rural areas that are operated by LeadingAge South Carolina will struggle to compete with urban LTC facilities.

144. For example, South Carolina Baptist Ministries of Aging paid over $1.25 million in 2022 to staffing agencies. In 2024 alone, and in order to come into compliance with the Final Rule, it paid an additional $500,000 to staffing agencies ahead of time to come into compliance.

145. Another LTC operated by LeadingAge South Carolina—The Woodlands at Furman—had to raise its pay rates by over 20% in the past year.

146. It is now forced to compete with private hospital systems that are continuously raising their RN and NA pay rates. Thus, the Final Rule's staffing mandate has had the downstream effect of creating a market where LTC facilities will have to limit their offerings or even shut their doors to elderly patients who need care.

147. The financial strain, along with inadequate Medicaid reimbursement rates, threatens many LTC facilities with closure, especially in rural communities with thin operating margins.

148. CMS has allocated only $75 million for nursing program tuition reimbursement—far less than what is needed. The Final Rule's cost burden will affect providers, private facilities, and Plaintiff States' taxpayers.

149. For example, 60 percent of nursing home residents in Kansas are on Medicaid. Since the COVID-19 Pandemic, Kansas lost 1,273 nursing home beds and 47 facilities closed or reduced services. Thus, the Final Rule will place a crippled LTC industry in dire straits.

B. Administrative Burdens

i. Staffing Issues

150. Not only is the Final Rule costly, but compliance will impact an overwhelming majority of LTC facilities across the country. Indeed, even by CMS's own estimate, more than 79 percent of LTC facilities in the United States will have to find additional staff just to comply with the new minimum-staffing requirements. 89 Fed. Reg.at 40877. This "exceed[s] the existing minimum staffing requirements in nearly all states." *Id*.

151. By CMS's estimates, LTC facilities across the country will have to hire almost 15,906 additional RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement. 89 Fed. Reg. at 40958, 40977-80.

152. Additionally, LTC facilities will have to hire 77,611 NAs to meet the 2.45 NA HPRD requirement and the 3.48 total nurse HPRD requirement. *Id*. Hiring 90,000 new staff to fall in compliance with the Final Rule is practically impossible when LTC facilities are already experiencing staffing shortages, recruitment issues, and employment retention.

153. Kansas is a prime example of how the Final Rule's adverse effects will irreparably harm Plaintiffs. According to CMS data, the state of Kansas will need an

additional 230 RNs to comply with both the 24/7 Requirement and 0.55 RN HPRD requirement for LTC facilities. *See* 89 Fed. Reg. at 40059, 40077-79.

154. CMS has already indicated that 109 LTC facilities are out of compliance with the 24/7 RN requirement. 89 Fed. Reg. at 40062. Furthermore, Kansas will have to hire an additional 523 NAs to comply with the Final Rule's HPRD ratios. *See id.* at 40077-79.

155. Nearly 85,000 Kansans live in areas with only one LTC facility within a 30-minute drive, and the closure of such facilities would significantly increase travel time, creating a lack of access to care and essential services.

156. Additionally, with the aging population in Kansas projected to grow by 208,000 by 2036, the capacity to provide adequate care will be severely strained if more facilities are forced to reduce capacity or close entirely.

157. LTC facilities in Kentucky, according to the CMS data, will need to hire an additional 185 RNs and to comply with both the 24/7 requirement and the 0.55 RN HPRD requirement. See 89 Fed. Reg. 40965, 40977-80.

158. Furthermore, CMS estimates that Kentucky facilities will need to hire an additional 1336 NA staff just to comply with the Final Rule's HPRD ratios. *See id.* at 40977-80.

159. CMS data estimates that 211 LTC facilities in Kentucky do not currently meet the Final Rule's staffing requirements.

160. The Kentucky Association of Health Care Facilities, which represents skilled nursing facilities and personal care homes in Kentucky, estimates that only 6% of nursing homes currently have sufficient nursing staff to comply with all the Final Rule's requirements. Yet, a workforce survey report by the Kentucky Hospital Association predicted a worsening

shortage of nursing staff available in Kentucky for LTCs to hire. *See* Morgan Watkins, *New studies show scope of Kentucky's health care worker shortage, as a coalition promotes solution*s, available at https://perma.cc/XLT5-TMR9.

161. Most of Montana consists of health professional shortage areas (HPSAs). Many of these LTC facilities are located in small towns or remote areas of Montana and likely have difficulty hiring RNs or contracting for visiting nursing staff to meet the minimum staffing requirements in the Final Rule.

162. LTC facilities in South Carolina, according to CMS data, will need to hire an additional 159 RNs to comply with both the 24/7 requirement and the 0.55 RN HPRD requirement. *See* 89 Fed. Reg. 40958, 40978-80.

163. Furthermore, South Carolina facilities will need to hire an additional 1,045 NA staff just to comply with the Final Rule's HPRD ratios. *See id.* at 40978-80. However, these numbers are low.

164. Based on LeadingAge South Carolina's data, facilities in South Carolina will need to hire 411 additional RNs and over 1170 NAs to meet the minimum staffing ratio provision in the Final Rule.

165. South Carolina is also projected to have the 4th largest nurse shortage by 2030. The additional hiring necessitated by the Final Rule will thus make compliance virtually impossible for LTC facilities.

166. According to the South Carolina Workforce Publication on Nursing, 53% of RNs work in hospital settings, whereas only 4.4% of RNs work in LTC settings.

167. Virginia's HPRD requirement, which goes into effect on July 1, 2025, is more than ten percent less than the Final Rule's requirement. Senate Bill No. 1339, 2023 Gen

Assemb., Reg. Sess. (Va.), https://tinyurl.com/c3f58meh (to be codified at Va. Code § 32.1-127(B)(32)) (requiring nursing homes "to provide at least 3.08 hours of case mix-adjusted total nursing staffing hours per resident per day on average").

168. Accordingly, any kind of required increase in staffing will have to account for (1) the national shortage in the healthcare labor force, and (2) the detraction of nurses from hospital settings. Ultimately, detrimental negative externalities cascade from the Final Rule and jeopardize the health care system, state agencies, and state hospitals.

ii. Enhanced Facility Assessment ("EFA")

169. The Final Rule's EFA implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. 89 Fed. Reg. 40881, 40906.

170. Specifically, the Final Rule mandates LTC facilities to ensure the "active involvement" of direct care staff and their representatives, and to "solicit and consider input" from residents, their representatives, and family members. *Id*. at 40908. LeadingAge Kansas has requested guidance from the state survey agency contracted by CMS to carry out healthcare surveys of nursing home providers in Kansas on this provision but did not receive adequate guidance.

171. The Final Rule requires facilities to "review and update" the EFA at least annually, without clear guidance on when updates are "necessary"—thus, leading to potential civil penalties. *Id*. at 40999.

172. LTC facilities must also create "contingency planning," despite already having emergency plans in place. *Id*. at 41000. Overall, the EFA imposes significant administrative burdens and vague requirements that could result in fiscal penalties.

173. Furthermore, staff hours and costs for the EFA vary facility-to-facility. For LeadingAge Kansas members like Wesley Towers and the Dooley Center, the initial EFA ranged from 16 hours to 89 hours.

174. The estimated cost for each update to comply with the assessment ranges from $400 to $600. The Final Rule's vague language requiring continual updates means that costs can quickly escalate.

175. Most importantly, the significant amount of time needed for the EFA detracts from the essential administration and direct resident care necessary for quality and safety. The EFA is a significant burden on staff because it diverts time away from direct resident care to maintain overburdensome compliance updates.

176. CMS estimates the cost at $4,955 per facility, *see* 89 Fed. Reg. at 40939, but that number is woefully low. The Final Rule requires EFAs conducted on all LTC facilities without considering the acuity and needs of the residents to determine staffing levels or evaluate unique circumstances. These factors, coupled with the lack of clear guidance and the risk of civil penalties, significantly contribute to the administrative burden imposed by the Final Rule.

C. Harm to Plaintiff States

177. Many Plaintiff States have their own state-run nursing homes.

178. For example, Arkansas has a state-operated 310-bed psychiatric nursing home, the Arkansas Health Center, which would be required to comply with these new minimum staffing quotas. See Ark. Code Ann. § 25-10-401.

179. Idaho has at least five state-run nursing homes, all which receive Medicaid payments. Four of the nursing homes are run by the Idaho Division of Veterans Services, and one is run by the Idaho Department of Health and Welfare.

180. Montana operates several LTC facilities that receive CMS fund and that would be subject to CMS regulations.

181. West Virginia's Department of Health Facilities operates four nursing homes: Hopemont Hospital, John Manchin, Sr. Health Care Center, Lakin Hospital, and Welch Community Hospital. *See* West Virginia Department of Health Facilities, https://tinyurl.com/3ykbt2tw (last visited Oct. 4, 2024). Altogether, West Virginia's state-run nursing homes have 312 beds. *See id.*

182. Those States facilities would incur the same harm as any LTC as noted above.

183. Non-State-run nursing homes would incur the same harm as any LTC as noted above. The resulting burdens may result in nursing homes closing, causing harm to state citizens.

184. Alaska is largely a frontier and rural state, with uniquely difficult workforce shortage challenges. According to a recent report, "hospital-based registered nurses had a vacancy rate of 21%, and it took an average of 118 days to fill a vacant position. Alaska is competing with the rest of the country for a limited number of healthcare workers. Projections indicate Alaska is expected to have the most significant shortages moving forward of any state. In 2022, Alaska programs graduated fewer than 900 healthcare workers in key positions, while the number of healthcare workers needed for those positions was 3,232. Travel nurses can be used to meet short-term staffing needs; however, this solution comes at a higher cost. In 2023, traveling registered nurses in Alaska earned 57% more pay on average than non-

traveling RNs." Alaska Hospital & Healthcare Association, *2023 Alaska Healthcare Workforce Analysis*, 1 (Dec. 2023), https://www.alaskahha.org/_files/ugd/ab2522_bde54b435a474ca48101c58d9239da21.pdf.

185. The Final Rule's 24/7 RN requirement will exacerbate the nursing workforce shortage.

186. The Final Rule's requirements disincentivize nursing homes from accepting Medicaid and Medicare, placing vulnerable Alaskans at risk of losing access to needed care.

187. The State of Alaska provides licensing oversight for LTCs. The Final Rule would impose additional financial costs and resource burdens on state agencies monitoring compliance and reviewing waivers under section 483.35(f).

188. The Final Rule also requires states, through their Medicaid agencies, to provide "institutional payment transparency reporting" which means they must provide to the Defendants a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40,995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40,990.

189. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on States well before that. The Final Rule acknowledges as much by estimating the cost to the States in *year one* to be $183,851. *Id.*

CLAIMS FOR RELIEF

COUNT ONE

(APA – Lack of Statutory Authority)

190. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

191. Under the APA, a court shall "hold unlawful and set aside agency action, findings, and conclusions found to be . . . in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C).

192. CMS, like all administrative agencies, is a "creature[] of statute," and accordingly "possess[es] only the authority that Congress has provided." *Nat'l Fed'n of Indep. Bus. v. Dep't of Labor*, 595 U.S. 109, 117 (2022); *see also, e.g.*, *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986) ("[A]n agency literally has no power to act . . . unless and until Congress confers power upon it.").

193. The Final Rule exceeds CMS's statutory authority in violation of the APA, 5 U.S.C. § 706(2)(C) in multiple ways.

A. The 24/7 RN Requirement

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

195. The Final Rule ignores this by stating an LTC "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40997.

196. CMS acknowledges that the statutory provisions establishing the 8/7 requirement for RN staffing do not authorize it to adopt the 24/7 RN requirement. *See* 89 Fed. Reg. at 40891.

197. CMS nevertheless asserts that "various provisions" elsewhere in §§ 1395i-3 and 1396r contain "separate authority" for this novel requirement, *id.* at 40879, 40890-91, pointing to provisions stating that: (1) The Secretary may impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary," 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B); (2) An LTC facility "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care," 42 U.S.C. § 1396r(b)(2), *accord* 42 U.S.C. § 1395i-3(b)(2); and (3) An LTC facility "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A); *accord* 42 U.S.C. § 1395i-3(b)(1)(A).

198. The only provision that arguably allows authority for CMS to engage in rulemaking is 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B), that requires LTCs 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." (emphasis added).

199. That statutory provision is in a broader subsection that refers to "[r]equirements relating to *administration and other matters*." *See* 42 U.S.C. § 1396r(d), *accord* 42 U.S.C. § 1395i-3(d) (emphasis added).

200. Drilling down further the subsection right above this rulemaking authority CMS latches onto is entitled "Miscellaneous." *See* 42 U.S.C. § 1396r(d)(4), *accord* 42 U.S.C. § 1395i-3(d)(4).

201. Finally, the specific statutory subsection relied on for authority is entitled "other" and refers to "other requirements relating to the health and safety…as the Secretary may find necessary." 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B).

202. The best reading of the only statutory authority CMS relies on for rulemaking is that it is related to administrivia for the health and safety of LTC patients that the rest of the Medicare and Medicaid statute does not already cover.

203. Congress covered the mandatory hours for nurse staffing for LTCs in a separate statutory provision and as such, there is no universe where they gave authority to CMS to alter that through rulemaking in a "miscellaneous" statutory provision.

204. None of the other general provisions CMS relies on allows it to impose a 24/7 statutory requirement either when a more specific statute only requires 8/7 nursing services. That's because "[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." *E.g.*, *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)).

205. Yet that is what the Final Rule does. Even CMS recognizes that the Final Rule "revises" the statutory 8/7 RN requirement codified at 42 U.S.C. §§ 1395i-3(b)(4)(C)(i) and 1396r(b)(4)(C)(i) by replacing it with CMS's 24/7 RN requirement. *See* 89 Fed. Reg. at 40898.

206. Congress did not leave that decision open for CMS to make. CMS lacks statutory authority to impose the 24/7 RN requirement, and the Final Rule must be set aside. *See* 5 U.S.C. § 706(2).

B. The HPRD Requirements

207. The same is true for the Final Rule's HPRD requirements. Congress carefully considered whether to enact quantitative staff-to-patient ratios for LTC facilities, and it chose not to do so.

208. Instead, Congress opted for a qualitative standard, leaving quantitative staff-to-patient ratios to the states: LTC facilities must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord* § 1395i-3(b)(4)(C)(i).

209. The Final Rule unlawfully substitutes CMS's current policy views for Congress' considered judgment. Instead of accommodating the wide variation of resident needs in different states, the Final Rule inflexibly mandates that each facility in each state meet an arbitrary numerical staffing threshold: "[a] minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides." 89 Fed. Reg. at 40996.

210. Once again, CMS does not rely on § 1395i-3(b)(4)(C) or § 1396r(b)(4)(C) as authority for these new requirements.

211. And once again, CMS invokes the Secretary's "miscellaneous" authority to make "other" rules that Congress did not already cover for the health and safety of residents, as well as provisions requiring LTC facilities to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and "promote

maintenance or enhancement of the quality of life of each resident." 89 Fed. Reg. at 40879, 40890-91; *see* 42 U.S.C. §§ 1395i-3(b)(1)(A), (b)(2), (d)(4)(B); 1396r(b)(1)(A), (b)(2), (d)(4)(B).

212. But none of those general provisions authorizes CMS to impose nationwide HPRD requirements for RNs, NAs, and total nursing staff. CMS's general authority over Medicare and Medicaid does not permit it to modify "matter[s] specifically dealt with in another part of the same enactment." *RadLAX Gateway Hotel*, 566 U.S. at 646; *see also* 42 U.S.C. § 1302(a) (the Secretary may not promulgate regulations that are "inconsistent with" statutory requirements).

213. Congress carefully considered what staffing levels to require from LTC facilities, and it decided to require that each facility maintain staffing levels "sufficient to meet the nursing needs of its residents." 42 U.S.C. §§ 1396r(b)(4)(C), 1395i-3(b)(4)(C).

214. CMS cannot utilize general authority to supersede Congress' judgment with its own arbitrary numerical requirements. Simply put, CMS does not have the authority to override Congress' judgment.

C. Major Questions Doctrine

215. The Final Rule also flunks the Major Questions Doctrine. The history of Congress' actions in this area, the "breadth of the authority" CMS now asserts, and "the economic and political significance" of that asserted authority confirm that CMS does not have the power to impose these new staffing mandates. *West Virginia v. EPA*, 597 U.S. 697, 721 (2022).

216. CMS proposes to revamp the entire nursing home industry to the tune of *at least* $43 billion dollars in compliance costs. The actual cost is likely much higher. The Supreme

Court has held that $50 billion qualifies as a Rule of vast economic significance. *Alabama Association of Realtors v. Department of Health and Human Services*, 594 U.S. 758, 764 (2021).

217. Beyond the costs, the breath of authority CMS now asserts is monumental. The Final Rule would fundamentally alter the landscape of the nursing home industry in a manner that impacts 97% of all nursing homes and will put many of them out of business. Furthermore, it would exceed the minimum staffing requirements for nursing homes in "nearly all states." 89 Fed. Reg. 40,877.

218. Finally, because Congress only required 8/7 staffing requirements and allowed flexibility for LTCs based on the needs of their facilities, states have moved to fill that void. The Final Rule acknowledges that 38 states and the District of Columbia have adopted their own staffing standards that vary between them. *See* 89 Fed. Reg. 40,881.

219. "When an agency claims the power to regulate vast swaths of American life, it not only risks intruding on Congress's power, it also risks intruding on powers reserved to the States." *West Virginia*, 597 U.S. at 744. (Gorsuch, J. concurring). CMS has "intruded" on powers traditionally reserved to the States by forcing this staffing rule on them.

220. When the major questions doctrine is triggered, as it is in this case, "clear authorization" and not some "vague statutory grant" is required in order for a court to find it lawful. *Id.* at 732.

221. CMS fails this test because they rely *exclusively* on a vague statutory grant and do not come close to clear authorization as the Final Rule *conflicts* with a separate Congressional statute.

222. The Final Rule flunks the Major Questions Doctrine and should be set aside.

D. Constitutional Doubt

223. If Congress truly gave CMS the authority to implement a regulation that costs at least $43 billion to comply with and overrides another one of its provisions, then it supplies no intelligible principle to guide how that power should be exercised.\

224. If CMS' interpretation was accepted as the one Congress intended it would present serious nondelegation concerns. *See Kentucky v. Biden*, 23 F.4th 585, 607, n.14 (6th Cir. 2022). ("If the government's interpretation were correct—that the President can do essentially whatever he wants so long as he determines it necessary to make federal contractors more 'economical and efficient'—then that *certainly* would present non-delegation concerns.")

225. The constitutional-doubt canon requires this Court to interpret the Rule to avoid these severe constitutional problems.

226. As the Supreme Court has explained, its "application of the nondelegation doctrine principally has been limited to the interpretation of statutory texts, and, more particularly, to giving narrow constructions to statutory delegations that might otherwise be thought to be unconstitutional." *Mistretta v. United States*, 488 U.S. 361, 373, n.7 (198

227. The Supreme Court thus reads statutes with this principle in mind, *see, e.g.*, *Gundy v. United States*, 139 S.Ct. 2116 (2019), and this Court should do the same.

COUNT TWO

(APA – Contrary to Law)

228. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

229. The Final Rule is not in accordance with law in violation of the APA, 5 U.S.C. § 706(2)(A). Even if CMS had *some* authority to set staffing requirements through vague statutory provisions, it could not utilize that limited authority to contradict what Congress had already put into place.

230. "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). The Final Rule is a crude attempt by CMS to play sorcerer.

A. The 24/7 RN Requirement

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

232. *First*, it triples the hours of mandatory RN staffing. It does this by replacing the 8/7 RN requirement enacted by Congress with a mandate that all LTC facilities "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40997.

233. As noted above, Congress only requires 24-hour nursing staff sufficient to meet the needs of nursing home patients. 42 U.S.C. §1396r(b)(4)(C)(i)(I)

234. This indicates that there are at least *some* situations where Congress did not expect nursing homes to require 24-hour nursing staff without seeking a waiver.

235. By requiring 24-hour nurse staffing for *all* nursing homes, CMS has directly contradicted the statute it claims to interpret. This they cannot do.

236. *Second*, the Final Rule replaces the statutorily set scope of services to be rendered by RNs. It does so by changing the requirement to "use the services of" an RN, including in administrative or supervisory roles, with a new requirement to have an RN "available to provide direct resident care." *Id.*

237. The Final Rule effectively rewrites this statutory provision to fit the views of CMS. This is an attempt to play sorcerer which the agency cannot do.

B. The HPRD Requirements

238. Under existing law, each LTC facility must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord* § 1395i-3(b)(4)(C)(i). The States are then free to set their own HPRD requirements. As CMS acknowledges, "38 States and the District of Columbia have minimum nursing staffing standards" for nursing homes. 89 Fed. Reg. at 40880.

239. But instead of accommodating the wide variation of resident needs in different states, the Final Rule inflexibly mandates that each LTC facility nationwide must meet an arbitrary numerical staffing threshold: "[a] minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides." 89 Fed. Reg. at 40996.

240. Because the Final Rule's nationwide one-size-fits-all HPRD requirements contradicts Congress's intended flexibility for LTC facility nursing services, the Final Rule is not in accordance with law and must be set aside. *See* 5 U.S.C. § 706(2).

COUNT THREE

(APA – Arbitrary and Capricious Agency Action)

241. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

242. Under the APA, a court shall "hold unlawful and set aside agency action, findings, and conclusions found to be … arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

243. The Final Rule is arbitrary and capricious in violation of the APA, 5 U.S.C. § 706(2)(A).

244. The APA's arbitrary-and-capricious standard requires agency action to be "reasonable and reasonably explained." *E.g.*, *Texas v. United States*, 40 F.4th 205, 226 (5th Cir. 2022) (quoting *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021)). This standard "is not toothless"; instead, "it has serious bite." *Id.*

245. The court "must set aside any action premised on reasoning that fails to account for relevant factors or evinces a clear error of judgment." *Id.* Failing to account for costs is failure to consider an important part of the problem. *Michigan v. EPA*, 576 U.S. 743, 752-53 (2015). ("Agencies have long treated cost as a centrally relevant factor when deciding whether to regulate. Consideration of cost reflects the understanding that reasonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions.")

246. And when an agency changes a longstanding policy, it must "show that there are good reasons for the new policy" and "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *Encino Motorcars,*

LLC v. Navarro, 579 U.S. 211, 221-22 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

247. By promulgating the Final Rule, CMS violated these requirements.

A. Sharp Departure from Past Practice

248. Over the past half century, CMS and its predecessors have consistently declined to deviate from the plain text of the Social Security Act by requiring nursing homes to provide "a specific ratio of nursing staff to patients." 39 Fed. Reg. at 2239 (In 1974, the Social Security Administration declined to adopt such a nationwide ratio requirement); *see also e.g.*, 45 Fed. Reg. at 47371 (In 1980, HHS expressly declined to propose "any nursing staff ratios or minimum number of nursing hours per patient per day.").

249. In 1986, an HHS-commissioned study concluded that "prescribing simple staffing ratios clearly is inappropriate."[3]

250. In 2002, the Secretary of HHS informed Congress that, after studying the issue for several years, it was not recommending the imposition of minimum-staffing ratios on LTC facilities.[4]

251. Most recently, in 2016, CMS again rejected requests to adopt minimum-staffing rules, reiterating that it is not reasonable to adopt "a 'one size fits all' approach" toward LTC facilities. 81 Fed. Reg. at 68755; *see id.* at 68754-56, 68758.

[3] *See* Inst. of Med., *Improving the Quality of Care in Nursing Homes* 102-03 (Mar. 1986), https://archive.ph/KFNCi.

[4] Letter from Tommy G. Thompson, Sec'y of Health & Human Servs., to J. Dennis Hastert, Speaker of House of Representatives 1 (Mar. 19, 2002) ("Thompson Letter"), reprinted in *Office of Asst. Sec'y for Planning & 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 (Nov. 2003), https://archive.ph/wip/KQWPt.

252. With that longstanding position in view, CMS failed to provide a reasoned explanation for departing from it, especially when the study they utilized to justify the mandates did not provide sufficient evidence for it. This is arbitrary and capricious.

B. Failure to Consider Reliance Interests

253. In addition to failing to reasonably explain its sharp departure from prior practice, CMS also failed to consider reliance interests in its decision-making.

254. Longstanding policy has left decisions on staffing primarily up to the states. And States responded by crafting their own staffing requirements. Both States and LTCs have relied on this flexibility for decades.

255. State Medicaid rates for nursing home services vary from $170 per day to over $400 per day. AHCA Cmt.6. Some States have a relatively steady supply of RNs and NAs, while other States are facing a massive shortage. *See, e.g.*, 89 Fed. Reg. at 40957, 40976; 81 Fed. Reg. at 6755 (noting "geographic disparity in supply" of nursing staff).

256. Rather than "highlight[ing] the need for national minimum-staffing standards," the "widespread variability in existing minimum staffing standards" adopted by 38 States and the District of Columbia underscores that "different local circumstances . . . make different staffing levels appropriate (and higher levels impracticable) in different areas of the country." *Compare* 89 Fed. Reg. at 40880, *with* AHCA Cmt.6.

257. By imposing rigid nationwide requirements that "exceed the existing minimum staffing requirements in nearly all States," 89 Fed. Reg. at 40877, CMS not only ignored Congress but also state governments whose state-law minimum staffing requirements reflect local conditions.

258. Arkansas sets a general HPRD monthly standard lower than the Final Rule and does not establish specific quotas for RNs and NAs. See Ark. Code Ann. § 20-10-1402(a)(2) (requiring "direct care services by direct care staff equivalent to at least three and thirty-six hundredths (3.36) Average Direct Care Hours Per Resident Day").

259. Kentucky does not set a numerical staffing requirement for nursing homes. Rather, Kentucky adopts a flexible approach requiring "twenty-four (24) hour nursing services with a sufficient number of nursing personnel on duty at all times to meet the total needs of residents." 902 Ky. Admin. Reg. 20:048, § 3(2)(a). Although Kentucky requires a charge nurse to be always on duty, a licensed practical nurse may serve in that role if a registered nurse is on call. *Id*. at § 2(10)(l).

260. Missouri's minimum staffing requirements for skilled nursing facilities and residential care facilities are set by the Missouri Code of State Regulations. 19 C.S.R. § 20-85.042; *id.*§ 30-86.042 & .043. Skilled nursing facilities must have an RN on duty in the facility for the day shift, and either an LPN or RN for both evening and night shifts. An RN also must be on call any time only an LPN is on duty. And all residential care facilities must have at least one employee for every forty residents. In addition, Missouri residential care facilities must employ a licensed nurse for eight hours per week per thirty residents to monitor each resident's condition and medication.

261. North Dakota has, for decades, set a minimum staffing requirement obligating facilities to have an RN on duty for eight hours per day. *See* N.D. Admin. Code § 33-07-03.2-14 (effective July 1, 1996). And as of the first quarter of 2023, only *one* of North Dakota's 76 nursing facilities would comply with the Rule's new HPRD standards.

262. South Carolina requires each nursing home to have one RN on call, but not on site, whenever residents are present in the facility. S.C. Code Ann. Regs. 61-17.

263. And South Carolina's HPRD requirement for FY 2024-2025 is less than half of that required by the Final Rule. S.C. Gen. Approp. Bill § 31.18 (requiring South Carolina nursing homes to provide "one and sixty-three hundredths (1.63) hours of direct care per resident per day from the non-licensed nursing staff" and requiring nursing homes to "maintain at least one licensed nurse per shift for each staff work area.") (https://tinyurl.com/3kjw4mtv).

264. West Virginia requires each nursing home in the State to have an RN on duty in the facility for at least eight consecutive hours, seven days a week. W. Va. Code R. § 64-13-8.14.4. If there is not an RN on duty, West Virginia law requires an RN to be on call. *Id.* § 64-13-8.14.5. West Virginia also requires nursing homes to provide at least "2.25 hours of nursing personnel time per resident per day." *Id.* § 64-13-8.14.1.

265. CMS concedes that its 24/7 RN requirement imposes a one-size-fits-all requirement, 89 Fed. Reg. at 40908. And CMS acknowledges that "more than 79 percent of nursing facilities nationwide" cannot meet the new requirements with their current staff, but its own findings belie the notion that anywhere close to 79 percent of U.S. nursing homes are failing to meet "minimum baseline standards for safety and quality." 89 Fed. Reg. at 40887.

266. Yet CMS's own survey process indicates that "roughly 95 percent of facilities" are already "providing 'sufficient nursing staff'" without the new requirements. AHCA Cmt.25.

267. CMS's explanation for abandoning its decades-old rejection of one-size-fits-all staffing requirements boils down to this: Some LTC facilities are chronically understaffed,

and "evidence demonstrates the benefits of increased nurse staffing in these facilities." 89 Fed. Reg. at 40881; *see id.* at 40893-94.

268. The general proposition that increased staffing in understaffed facilities can lead to better outcomes is not a reasonable consideration of the reliance interests of both states and LTCs who have had flexibility for decades. Such a failure is arbitrary and capricious.

C. Failure to Consider Important Aspects of the Problem

269. The Final Rule is arbitrary and capricious for another reason as well: It fails to consider important aspects of the problems, and it does so in two ways.

270. *First*, it fails to consider the possibility that it is virtually impossible for LTCs to comply with the Final Rule.

271. As detailed in various comments on the proposed rule, it will be nearly impossible for many LTC facilities to implement CMS's new minimum-staffing requirements because of the inadequate supply of RNs and NAs. *See* AHCA Cmt.1-2, 5, 11-13, 18; LeadingAge Cmt.1-2, 4; THCA Cmt.1-2.

272. Even CMS acknowledges the new requirements "exceed the existing minimum staffing requirements in nearly all States" and will require increased staffing "in more than 79 percent of nursing facilities nationwide." 89 Fed. Reg. at 40877.

273. And CMS estimates that LTC facilities will need to hire an additional 15,906 additional RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement (an increase of about 11.8%), plus an additional 77,611 NAs to meet the 2.45 NA HPRD requirement and 3.48 total nurse HPRD requirement (an increase of about 17.2%). *See id.* at 40958, 40977-80.

274. Those increases are unattainable at a time when many LTC facilities are already experiencing extreme difficulty finding qualified RNs and NAs to fill vacant positions, and when staffing shortages are expected only to worsen. *See, e.g.*, AHCA Cmt.5; LeadingAge Cmt.1. Put simply, "staffing mandates do not create more caregivers, nor do they drive caregivers to work in long term care." AHCA Cmt.1.

275. The Final Rule also irrationally discounts the vital role of LPNs/LVNs, who hold nearly 230,000 jobs in LTC facilities across the country and undisputedly "provide important services to [their] residents." 89 Fed. Reg. at 40881; *see* AHCA Cmt.6; LeadingAge Cmt.2.

276. As commenters pointed out, the Final Rule creates an incentive for LTC facilities "to terminate LPN/LVNs and replace them with . . . [less qualified] nurse aides" in order to meet the 2.45 NA HPRD requirement.

277. CMS recognized this problem in both the proposed rule and the Final Rule, but concluded that "[a] total nurse staffing standard will guard[] against" it. 89 Fed. Reg. at 40893; *see* 88 Fed. Reg. at 61366, 61369.

278. But that's wrong. For example, a facility that already provides high-quality care through average staffing of 0.55 RN HPRD, 1.25 LVN/LPN HPRD, and 1.7 NA HPRD would satisfy the 3.48 total nurse HPRD requirement but would need an additional 0.75 NA HPRD to satisfy the 2.45 NA HPRD requirement.

279. The Final Rule thus pressures LTC facilities to replace experienced LPNs/LVNs with less-qualified new hires to meet CMS's arbitrary quota of 2.45 NA HPRD.

280. The Final Rule does not deny that there are not nearly enough RNs and NAs available to enable the 79 percent of LTC facilities that are not presently in compliance with the agency's new mandates.

281. CMS asserts that the Final Rule's phase-in period will "allow all facilities the time needed to prepare and comply with the new requirements specifically to recruit, retain, and hire nurse staff as needed." 89 Fed. Reg. 40894.

282. But delaying the deadline for compliance does nothing to fix the underlying problems. Regardless of whether it goes into effect tomorrow or two or three years from now, the Final Rule is a multi-billion-dollar unfunded mandate that many LTC facilities will have no realistic way to meet. And there is no reason to think that the shortage of RNs and NAs will ease over the next two to three years.

283. In fact, it is projected to become even worse, as "hundreds of thousands are expected to retire or leave the health care profession entirely in the coming years." AHCA Cmt.5; *see id.* at 2 ("The phase-in provisions are frankly meaningless considering the growing caregiver shortage."); LeadingAge Cmt.7 (similar).

284. CMS says that it "fully expect[s] that LTC facilities will be able to meet [the Final Rule's] requirements," 89 Fed. Reg. at 40894, but it fails to cite any evidence to support this wishful thinking.

285. Moreover, the staggered implementation timeframe risks "pit[ting] urban and rural areas against each other as staff are first recruited away from rural areas to fulfill the needs of urban nursing homes, then 1-2 years later rural areas are scrapping to bring staff back." LeadingAge Cmt.7.

286. Finally, CMS's "hardship exemption" process is a wholly inadequate response to the staffing shortage and economic constraints facing LTC facilities.

287. For one thing, such exemptions are available only to facilities that have been surveyed and cited for failure to meet the new staffing standards—and "facilities cannot

request" (or receive) "a survey specifically for the purpose of granting an exemption." 89 Fed. Reg. at 40902.

288. Thus, instead of being able to proactively explain why it should be entitled to an exemption, facilities that cannot meet CMS's arbitrary requirements will face a perpetual risk of being sanctioned for non-compliance. *See* AHCA Cmt.6, 33-34; LeadingAge Cmt.6 (criticizing CMS's approach as "unnecessarily punitive").

289. In all events, the waivers are "no solution for the ongoing nationwide shortage in nursing staff" or the lack of funds available to implement the new requirements. AHCA Cmt.7.

290. CMS repeatedly emphasizes that the hardship exemption is meant for "limited circumstances," 89 Fed. Reg. at 40894, and that many facilities in areas of the country with severe shortages of available RNs and NAs would not qualify for an exemption because there are so many "other requirements" that must be met "to obtain an exemption." *Id.* at 40953.

291. *Second*, the Final Rule fails to reasonably consider the staggering costs, which underscores its arbitrary and capricious nature.

292. According to CMS, the Final Rule will cost over $5 billion per year to implement once fully phased in, *see* 89 Fed. Reg. at 40949, 40970. Other estimates place the costs as high as $7 billion per year, *see id.* at 40950.

293. The Final Rule does not provide any additional funding for Medicare or Medicaid, so CMS "assume[s] that LTC facilities . . . will bear the[se] costs." *Id.* at 40949.

294. And LTC facilities are in no position to take on this huge financial burden. AHCA Cmt.5; LeadingAge Cmt.1-2; THCA Cmt.3. Almost 60 percent of LTC facilities already have negative operating margins; more than 500 LTC facilities closed over the course of the

COVID-19 pandemic; and the costs associated with these new staffing mandates would likely force many more facilities to close. AHCA Cmt.5; *see* LeadingAge Cmt.1-2.

295. CMS's imposition of this massive, unfunded staffing mandate, despite the ongoing workforce crisis and economic realities, is neither "reasonable" nor "reasonably explained." *Cf. Texas*, 40 F.4th at 226.

296. It instead simply touts a new initiative that seeks to encourage people to pursue careers in nursing by "investing over $75 million in financial incentives such as tuition reimbursement." 89 Fed. Reg. 40894.

297. But this "one-time workforce effort" is "a drop in the bucket compared to the funding that will be needed to train [the] additional nursing staff" necessary to meet the new mandates. AHCA Cmt. 23; LeadingAge Cmt.1-2. It "is not going to fix the workforce crisis," and it does practically nothing to offset the $5 billion to $7 billion per year in costs that the Final Rule imposes on LTC facilities. AHCA Cmt.23; LeadingAge Cmt.1-2.

298. Additionally, LTC facilities are experiencing financial harms now. The Final Rule's EFA, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs.

299. This assessment imposes a significant burden on LTC facilities. CMS estimates the cost of the EFA to be around $4,955 per facility, but that number is likely low.

300. The Final Rule also requires each facility to "review and update that assessment, as necessary, and at least annually." The facilities lack further guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties.

301. The EFA also requires facilities to create "contingency planning," even though the facilities already are required to have emergency plans for, among other things, staffing issues.

302. In total, the EFA imposes hours upon hours of additional work and significant administrative burdens on the facilities and subjects them to vague requirements that could result in steep civil penalties.

303. The Final Rule is arbitrary and capricious agency action and must be set aside.

PRAYER FOR RELIEF

1. Plaintiffs pray for the following relief from the Court:

2. A declaration, pursuant to 28 U.S.C. §2201, that the 24/7 RN requirement exceeds CMS's statutory authority and is arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

3. A declaration, pursuant to 28 U.S.C. §2201, that the HPRD requirements exceed CMS's statutory authority and are arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

4. A declaration, pursuant to 28 U.S.C. § 2201, that the enhanced facility assessment exceeds CMS's statutory authority and is arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

5. An order vacating and setting aside the 24/7 RN requirement and permanently enjoining Defendants from taking any action to enforce that requirement.

6. An order vacating and setting aside the HPRD requirements and permanently enjoining Defendants from taking any action to enforce those requirements.

7. An order vacating and setting aside the enhanced facility assessment requirement and permanently enjoining Defendants from taking any action to enforce that requirement.

8. Any costs and reasonable attorneys' fees to which Plaintiffs may be entitled by law.

9. Any further relief that the Court deems just and proper.

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**Pro Hac Vice forthcoming*

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, et al., *Plaintiffs*, v. XAVIER BECERRA; et al., *Defendants*.	Civil Action No. 1:24-CV-110 **DECLARATION OF JULIET CHARRON, DEPUTY DIRECTOR OF IDAHO DEPARTMENT OF HEALTH AND WELFARE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUCTION**

I, Juliet Charron, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Idaho Department of Health and Welfare personnel. *See* 28 U.S.C. § 1746.

1. My name is Juliet Charron, and my business address is 450 W. State Street, Boise, Idaho, 83704. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Deputy Director of Idaho Department of Health and Welfare since June 2024 and previously served as the Idaho Medicaid Administrator since November 2021. I

have a Bachelor of Science in Public Policy, Planning, and Management from the University of Oregon and a Master of Public Health degree from the University of Arizona. My job responsibilities include oversight of the Idaho Medicaid program; oversight of state administered behavioral health services; and oversight of several state-run facilities, including a nursing home run by the Idaho Department of Health and Welfare. I do not oversee the state-operated Veterans nursing homes, though estimated costs for those have been included here.

Purpose of Declaration

3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").
4. I am familiar with the Final Rule and its impact on Idaho.

Impact on Idaho

5. Idaho operates five long term care (LTC) facilities that receive Medicare and Medicaid, and therefore the Final Rule governs conduct of Idaho.
6. We anticipate the Final Rule will create significant challenges and new costs given existing nurse workforce challenges and the resulting administrative burden for Idaho facilities in addition to state agencies reimbursing and overseeing facilities.
7. Idaho has one of the lowest nurse-to-state population ratios and most counties are designated as Health Professional Shortage Areas. Health care facilities, including nursing facilities, in addition to various state agencies compete for nursing staff from a limited

pool. The lack of available nursing staff is further exacerbated by the rural geography of the state and in communities where it is difficult to attract and retain qualified clinical staff.

8. Idaho also has a significant shortage of Certified Nursing Assistants (CNA) given the rural geography and small number of community colleges. Increased requirements for nurse aid hours per day further compound workforce concerns across nurse credentials.

9. The total average cost for Idaho-operated LTC facilities to comply with the Final Rule's minimum staffing requirement—in the first year alone—is estimated to be $800,000 per facility. This is an estimation developed using the cost of a state-run nursing facility under the Idaho Department of Health & Welfare and extrapolated for other facilities.

10. The estimated financial burden caused by the Final Rule includes costs for both employing new staff and the use of contracted nursing agency workers—which is significantly more expensive. The costs could be higher or lower than the estimated $800,000 depending on how much the state ultimately relies on contracting agencies to hire needed nursing staff.

11. To comply with the Final Rule's minimum staffing requirements, Idaho-operated LTC facilities will have to hire an estimated additional 25 Registered Nurses (RN) to comply with both the 24/7 Requirement and 0.55 RN Hours Per Resident Day (HPRD) requirements, as well as an estimated 35 additional Certified Nursing Assistants (CNA) to comply with the Final Rule's HPRD ratios.

12. Even if Idaho can allocate the money to fund the Final Rule's minimum staffing requirements, Idaho will struggle to comply with those requirements due to healthcare workforce shortages across the state and multiple healthcare settings competing to hire nursing staff to serve in critical care delivery roles.

13. Expansive federal overreach through increased minimum staffing ratios tied to administrative and financial penalties will not lead to improved quality of care and resolution of existing health and safety issues for Idaho facilities. For a state such as Idaho where a pool of available nursing staff simply does not exist, this will only create additional administrative burden via onerous reporting for state agencies and facilities leading to increased compliance costs without addressing the underlying workforce issues. While Idaho does not disagree with efforts to improve quality of care and health and safety for nursing facility residents, these new staffing requirements will not be attainable in the near future and may further exacerbate the problem as facilities and the state struggle with limited resources and capacity to comply.

14. Idaho anticipates that many facilities will qualify for the hardship exemption status. Required repeated reporting and review of documentation to support the exemption status ongoing will present new administrative burdens and costs to the state.

15. Required reporting outlined in 42 CFR § 442.43 will present further administrative burden and new costs to the state as we will be forced to use resources to compile and validate all information required for this annual reporting. 89 Fed. Reg. at 40914–40915. Although this requirement does not take effect until four years after the Final Rule is published, it is anticipated to impose costs on Idaho leading up to this date as the state prepares and works to obtain needed resources to comply. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.

16. It is my understanding that the Final Rule requires Idaho-operated LTC facilities to conduct an enhanced facility assessment (EFA) within 90 days of publication of the final rule. 89 Fed. Reg. at 40913. It is also my understanding that an EFA is a comprehensive evaluation

of an LTC facility, residents, and staff to determine staffing and other needs. 89 Fed. Reg. at 40999-41000.

17. CMS estimates that EFAs will cost $4,955 per LTC facility, but that number is grossly understated. The actual cost for the initial EFA per LTC facility operated by Idaho is estimated between $10,000 and $25,000 depending on the size of the facility. And subsequent annual EFAs are expected to cost $17,000. It is estimated that these annual EFAs will result in a $5,980 to about $6,578 increase in cost, per facility, compared to prior facility assessments (FAs). This is an estimation developed using the cost of a state-run nursing facility under the Idaho Department of Health & Welfare and extrapolated for other facilities.

18. Additionally, for LTC facilities operated by Idaho, the amount of staff time spent performing the initial EFA is estimated to range from 100 hours to 500 hours depending on the size of the facility. Subsequent annual EFAs are expected to require 250 hours of staff time. It is estimated that these annual EFAs will require 82 more hours of staff time compared to prior FAs.

19. The significant amount of time needed for the EFA detracts from the essential administration and direct resident care necessary for quality and safety. The EFA is a significant burden on staff because it diverts time away from direct resident care to maintain overburdensome compliance updates.

20. For Idaho, we anticipate the upfront implementation costs would be $4,021,238.25 for state run facilities alone due to increased employee costs such as benefits, education, training, onboarding expenses and wages, as well as the cost to perform the enhanced facility assessment (EFA) and costs associated with recruitment of staff. This does not include the

loss of revenue Idaho will fail to secure due to a higher bottom line. These costs of implementation may be higher if agency staff must be utilized. This is an estimation developed using the cost of a state-run nursing facility under the Idaho Department of Health & Welfare and extrapolated for other facilities.

Impact of a Preliminary Injunction

21. While a preliminary injunction would not restore the costs already incurred by Idaho because of the Final Rule, it would prevent Idaho from incurring further cost due to eliminating the future cost of the EFA and reducing labor and employee spending, and it would allow for increased state revenue due to a lower bottom line. The decrease of administrative costs associated with this rule would also be immediate. Increased state revenue could be used towards efforts to support workforce development and needed resources to oversee facilities ongoing.

This 16th day of October 2024.

Juliet Charron
Deputy Director
Idaho Department of Health and Welfare

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

State of Kansas; et al.,

Plaintiffs,

v.

Becerra; et al.,

Defendants.

Civil Action No. 1:24-cv-00110-LTS-KEM

DECLARATION OF
ELIZABETH MATNEY

I, Elizabeth Matney, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Iowa Department of Health and Human Services personnel:

1. My name is Elizabeth Matney, and my business address is 321 East 12th Street, Des Moines, IA 50319. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Iowa Medicaid Director since June 1, 2021. I have a bachelor's degree in psychology and philosophy from Texas State University and a master's degree in Rehabilitation Counseling from Drake University. Previously I served as the Medicaid Managed Care Director and health care policy adviser to Governor Kim Reynolds. My job responsibilities include providing strategic direction to the Medicaid program, leading the team through initiative development and implementation, engaging in discussions with elected officials and federal agency points of contact as well as ensuring the Medicaid program is financially sound.

Purpose of Declaration

3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").
4. I am familiar with the Final Rule and its impact on Iowa.

Impact on Iowa

5. The Iowa Department of Health and Human Services recognizes and appreciates the desire from CMS to optimize services and enhance the provision of care for those utilizing Medicare and Medicaid services.
6. The Final Rule has caused and is causing immediate harm to Iowa in the form of compliance costs.
7. First, the Final Rule requires Iowa, through its Medicaid agency, to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40990.
8. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Iowa well before that. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.
9. Further, while considering the implementation process in Iowa, there are concerns surrounding the new final rule and the adverse effects our members will experience.
10. According to calculated data, an estimated 70% of facilities in Iowa will be impacted with an estimated need increase of 66.77 RN FTEs and 483.09 Aide FTEs. This comes out to an estimated statewide financial impact of $25,321,782.09 annually.[1]
11. The new staffing requirements are untenable due to workforce limitations, along with the significant increase in financial obligations. If facilities are unable to meet the

[1] Data is a culmination of Q42022 CMS Metrics Data, May 2022 BLS Data and 7.1.2021-6.30.2022 HCRIS Cost Report Data.

requirements, there is concern surrounding the loss of facilities, leading to a decrease in our ability to provide care to Iowans in need.

Impact of a Preliminary Injunction

12. While a preliminary injunction would not restore the costs already incurred by Iowa because of the Final Rule, it would prevent Iowa from incurring further cost currently necessitated by the increased staffing ratio requirements.
13. To best protect the safety and access to care for Iowans, we urge you to reconsider your ruling.
14. This the 16th day of October 2024.

Elizabeth Matney
Director
Iowa Medicaid

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

KANSAS, et al.,

Plaintiffs,

v.

XAVIER BECERRA; et al.,

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF MATTHEW AHERN

I, Matthew Ahern, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Department of Health and Human Services personnel in the Divisions of Medicaid & Long-Term Care ("MLTC") and Public Health ("DPH"):

1. My name is Matthew Ahern, and my business address is 301 Centennial Mall South, Lincoln, NE 68509. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Interim Director of the Division of Medicaid and Long-Term Care since December 1, 2023. I have two master's degrees in Healthcare Administration and Business Administration from the University of Utah. My job responsibilities include overseeing the Division of Medicaid and Long-Term Care ("MLTC") within the Department of Health and Human Services ("NEDHHS") and administering the Nebraska Medical Assistance Program (called "Medicaid"). This includes overseeing contract management with Nebraska's Managed Care Organizations ("MCO" or "MCOs"), supervising those employees responsible for coordinating the care and placement of individuals in long-term care.

Purpose of Declaration

3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").
4. I am familiar with the Final Rule and its impact on Nebraska.

Harm to the State of Nebraska: Compliance Costs

5. First, the Final Rule has caused and is causing immediate harm to Nebraska in the form of compliance costs.

6. The Final Rule requires Nebraska, through its Medicaid agency, to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40990.

7. "The burden associated with the reporting requirements finalized in this rule would affect all 51 States (including Washington, DC)." 89 FR 40941.

8. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Nebraska well before that. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.

Harm to the State of Nebraska: Staffing Requirement Harm

9. Second, the Final Rule will cause significant harm to the State of Nebraska through the increased nurse staffing requirements.

10. The Final Rule requires (1) total nurse staffing of at least 3.48 hours per resident day ("HPRD"); (2) a mandate for RN staffing of at least 0.55 HPRD; and (3) nurse aid ("NA") staffing of at least 2.45 HPRD. 89 Fed. Reg. at 40877. HPRD is defined as the "total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS." *Id.*

11. Nebraska, unlike many other states, does not run any Long-Term Care ("LTC") facilities itself. But as the state agency overseeing Medicaid beneficiaries, it is closely involved in the care of those beneficiaries who reside at nursing facilities.

12. Nebraska has a significant rural population, and those communities already face difficulties in finding trained professionals who are willing to work and serve in remote locations. Nebraska has multiple programs attempting to remediate this, including programs for doctors and lawyers, but a critical shortage remains.

13. The increased staffing requirements of the Final Rule would cripple already straining facilities in rural Nebraska. Many facilities, especially rural, would be unable to meet the requirements, placing their patients at risk of uncertainty and diminished services.

14. In the near certain event that LTC facilities are forced to close because they cannot meet the increased nurse staffing requirements required by the Final Rule, the State (through its division of Medicaid and Long-Term Care) will be responsible for working with the MCOs to find suitable placement for the Medicaid beneficiaries at these facilities.

15. This will represent a significant investment of time and increased employee hours for both Nebraska and its MCOs, as well as causing extreme stress and confusion for beneficiaries and their families. Both the state and the MCOs would have to hope they could hire additional staff to cover this increased workload, or reassign existing employees to do so which would prevent them from performing other necessary work for the benefit of Nebraskans.

16. Even without further consequence, this impact of the Final Rule will put the State out of compliance with the requirements of *Olmstead v. LC*, 527 US 581 (1999), by moving beneficiaries out of their preferred settings to eligible receiving facilities which may be a

significant distance away, removed from their support systems and not in line with the beneficiary's preferred treatment location and community setting.

17. If a large enough number of LTC facilities are forced to close, a not insignificant possibility, Nebraska may be forced to seek placement for beneficiaries in neighboring states. This would represent an even greater harm to the state in terms of resources and employee hours, as well as even greater harm to the beneficiaries forced to move.

18. In this event, these beneficiaries would be removed from their preferred settings and communities. This could be seen as Nebraska being forced even further out of compliance than previously discussed with the requirements of *Olmstead*, as this would significantly limit their choice in treatment location and community setting.

19. The creation or addition of long-term care beds in a health facility is governed in Nebraska by the Nebraska Health Care Certificate of Need Act, Neb. Rev. Stat. 71-5801 *et seq*. The Certificate of Need Act requires DHHS approval, through a certificate of need, for an increase in long-term care beds by more than ten beds or more than ten percent of the total long-term care bed capacity of such a facility, whichever is less, over a two-year period. Neb. Rev. Stat. 71-5829.03. This application for a certificate of need costs one thousand dollars ($1000). Neb. Rev. Stat. 71-5837.

20. This limits the ability of other facilities in areas with sufficient available staffing to be able to prepare to absorb beneficiaries needing to be moved from other facilities, causing further harm as a result of the Final Rule.

Harm to the State of Nebraska: Additional Costs

21. Third, the Final Rule will cause harm to the State of Nebraska by increasing state General Fund ("GF") expenditures due to increased costs to LTC facilities.

22. The State of Nebraska is projected to spend approximately $517,576,502 in total funds on Nursing Facilities services in Medicaid for State Fiscal Year 2025.

23. Of that amount, approximately $294,299,613 is attributable to the Direct Nursing ("DN") cost, which is the category that would be affected by the Final Rule's staffing requirement.

24. Any increase to a Medicaid LTC facility's Direct Nursing cost will be reflected on their cost reports. These rates are rebased regularly based on provider cost reports. Historically, as costs have increased, LTC facilities and their associations have successfully pushed for an increase to cover those increased costs.

25. The Final Rule will, therefore, directly result in an increased cost to the State. This will require additional appropriations from the State's General Fund, funded by the taxpayers of the State.

26. The following are estimated GF expenditure increases based on a percentage increase in the Direct Nursing category:

    a. 5% DN increase: $6,211,193.33 expenditure increase.

    b. 25% DN increase: $31,055.966.66 expenditure increase.

    c. 50% DN increase: $62,111,933.32 expenditure increase.

27. Nebraska has an obligation to the citizens of its state to be a responsible steward of the revenue the state collects from them and works diligently to do so. Causing the citizens of Nebraska an additional tax burden for a program which will also cause some of its most vulnerable citizens to be moved from their facilities against their will is a significant harm to them.

Impact of a Preliminary Injunction

28. While a preliminary injunction would not restore the costs already incurred by Nebraska as a result of the Final Rule, it would prevent Nebraska from incurring further costs because it would keep the state from having to implement the reporting process; it would stop the state from having to oversee the associated relocation of Medicaid beneficiaries; and it would stop the increase in Direct Nursing costs, all as discussed previously in this declaration.

29. This the 18th day of October, 2024.

Matthew Ahern

Interim Director, Division of Medicaid and Long-Term Care

Nebraska Department of Health and Human Services

SUBSCRIBED AND AFFIRMED BEFORE ME THIS 18TH DAY OF OCTOBER, 2024.

Notary Public

GENERAL NOTARY - State of Nebraska
HAZEL J. BOERGER
My Comm. Exp. April 10, 2025

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, et al., Plaintiffs, v. XAVIER BECERRA; et al., Defendants.	Civil Action No. _____

DECLARATION OF LAWAYNE SALTER

COMMISSIONER
NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES

I, Lawayne Salter, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided available to me in the performance of my professional duties:

1. My name is Lawayne Salter (Wayne), and my business address is 600 East Boulevard Ave, Dept. 325, Bismarck, ND 58505. I am over the age of eighteen and competent to testify concerning the matters in this declaration.
2. I have served as the Commissioner of the North Dakota Department of Health and Human Services since January 22, 2024. I have a bachelor of science degree in management and an associate degree in business administration from the University of Phoenix. I have previously served as Deputy Executive Commissioner and Associate Commissioner of Access and Eligibility Services with Texas Health and Human Services, overseeing a workforce of over 9,000 team members responsible for the administration of public assistance and community-based services and support programs. Prior to my roles in Texas, I served seventeen years with the Florida Department of Children and Family

Services, where I held key leadership positions such as Quality Assurance Manager, Statewide Call Center Director, Bureau Chief of Program Policy, and Deputy Director for Florida's Public Assistance Division. As Commissioner, my professional responsibilities include overseeing divisions that regulate and reimburse long-term care facilities.

3. As Commissioner of the North Dakota Department of Health and Human Services, I am familiar with the final rule published by the United States Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, entitled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule"), and the effects that Rule will have on long-term care facilities in North Dakota.

Purpose of Declaration

4. I am submitting this declaration in support of the motion for a preliminary injunction and other legal challenges being brought against the Final Rule by the State of North Dakota and other plaintiffs in this litigation.

Impact of the Final Rule on North Dakota's Long-Term Care Facilities

5. The North Dakota Department of Health and Human Services believes that the likely and foreseeable impacts that the Final Rule will have on the continued operation of long-term care facilities in North Dakota will be severe.

6. In short, the Final Rule sets staffing requirements that are extremely unrealistic for long-term care facilities across the State, particularly in rural and tribal communities.

7. Based on the information received by the North Dakota Department of Health and Human Services using the most recent available data pulled from the CMS Payroll Based Journal Daily Nurse Staffing Q1 2024 report, North Dakota long-term care facilities were only able

to meet all of the CMS final regulations only 64% of the days in quarter 1. Only four facilities were able to meet the registered nurse (RN) requirement. The CMS rule requires full compliance with each element of the staffing regulation every day, and currently that is not a possibility for North Dakota long-term care facilities.

8. Due to a shortage of trained nursing staff in North Dakota (as in much of the country) it is highly unlikely that many, if not most, of the long-term care facilities in the State will be able to hire more staff in order to comply with the Final Rule's staffing mandates. It is a limitation of available and trained personnel.

9. The North Dakota Department of Health and Human Services estimates, based on the information that it has received using the most recent available data pulled from CMS Payroll Based Journal Daily Nurse Staffing Q1 2024 report, that for all of the State's existing long-term care facilities to come into compliance with the Final Rule's staffing mandates, only four of the long-term care facilities in the State would not need to hire additional RNs. According to an analysis published on June 23, 2023, conducted by nurse.org, North Dakota is one of the states identified to suffer from the highest percentage of unmet demand for RNs in 2030. North Dakota is only projected to meet 84% of the current demand for RNs by 2030. The analysis conducted by nurse.org was conducted prior to the passage of the Final Rule's staffing mandates. Recruiting additional RNs to long-term care facilities will be particularly challenging based on the projected statewide shortage of RNs.

10. Consequently, it is foreseeable that the impact of the Final Rule will be to force a significant number of long-term care facilities across the State to close, with patients and staff being consolidated into a small number of centralized long-term care facilities where feasible.

The North Dakota Department of Health and Human Services estimates based on the data it has received using the most recent available data pulled from CMS Payroll Based Journal Daily Nurse Staffing Q1 2024 report that as many as 16 long-term care facilities in the State are likely to be closed as a direct result of the Final Rule as those long-term care facilities using the Final Rule standards today would be non-compliant more than 30% of days for RNs.

11. The North Dakota Department of Health and Human Services strongly believes that forcing many residents of long-term care facilities to be transferred into a condensed number of long-term care facilities that are likely to be further away from those residents' families, communities, and support networks will be detrimental to the provision of long-term care for many people in the State, particularly in rural and tribal areas, far exceeding any benefits that will be gained by increasing the nursing staff levels in the reduced number of centralized facilities that are able to remain in operation in the State.

12. In short, despite its stated goal to increase the level of care provided to residents of long-term care facilities, the Final Rule's nationwide staffing mandate is not a workable solution for long-term care facilities in North Dakota. It is foreseeably going to cause a significant number of long-term care facilities and negatively impact the provision of long-term care for many people across the State.

Impact of the Final Rule on North Dakota's Department of Health and Human Services

13. The Final Rule requires the North Dakota Department of Health and Human Services to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed.

Reg. 40995. The Final Rule also requires that this information be posted on state websites. *See* 89 Fed. Reg. 40990.

14. Although this reporting requirement does not take effect until four years after the Final Rule is published, it will impose costs on North Dakota well before that. The Final Rule acknowledges as much by estimating the cost to the States in the first year after the Final Rule's finalization to be $183,851. *Id.* at 40991.

15. Currently, for North Dakota, CMS only funds the North Dakota Department of Health and Human Services, as the state survey agency, at a rate of approximately 84% to enforce the previously existing regulations. The State has been left to cover the additional 16% of the cost of an entirely federal program with state appropriations. CMS has failed to increase state survey agency funding since 2015, although the number of complaints and facility reported incidents regarding violations of the current regulations have increased by 347% since that time. It is reasonable to anticipate that CMS will also expect the State to fund this federally required program as well. This does not account for the cost to the North Dakota Department of Health and Human Services to investigate the number of complaints regarding violations of these staffing minimums, which CMS will likely also fail to fund as they have since 2015.

An Injunction Will Prevent Further Injury to the State

16. While a preliminary injunction would not restore the costs already incurred by the North Dakota Department of Health and Human Services due to the Final Rule, it would prevent the North Dakota Department of Health and Human Services from needing to incur further costs of hiring additional state survey staff to investigate and enforce the CMS 24/7 RN

staffing regulations and violations thereof. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed in Bismarck, North Dakota, on October 11, 2024.

Lawayne (Wayne) Salter
Commissioner
N.D. Dept of Health and Human Services

EXHIBIT 6

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF STEPHANIE MCGEE AZAR**

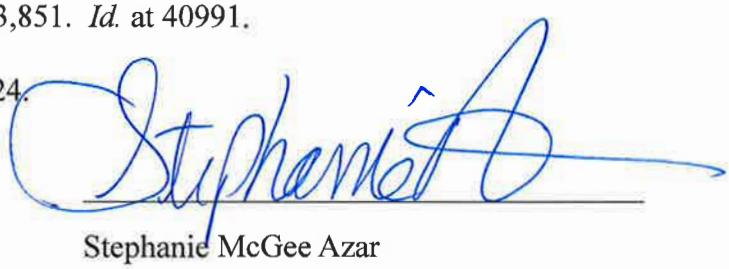
I, Stephanie McGee Azar, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Alabama Medicaid Agency personnel:

1. My name is Stephanie McGee Azar, and my business address is 501 Dexter Avenue, Montgomery, Alabama 36104. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Commissioner of the Alabama Medicaid Agency since 2012. I have a law degree from the University of Alabama School of Law. I am responsible for the management and operations of the Alabama Medicaid Agency.
3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").
4. I am familiar with the Final Rule and its impact.
5. The Alabama Medicaid Agency provides nursing facility room and board payments to nursing facilities for eligible Medicaid recipients residing in the facility.
6. Alabama Medicaid is funded by both state and federal dollars. The Final Rule will require nursing facilities to meet and maintain staffing levels consistent with the rule. This staffing will be delineated in cost reports utilized by the agency to set each nursing facility's per diem. If nursing facility staffing is increased as result of the Final Rule, a higher state fund rate would be the practical result. Thereby causing the Alabama tax payor to pay that increase with tax payor dollars.

7. Moreover, the Final Rule requires Alabama, through its Medicaid agency, to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40990.

8. Although this requirement does not take effect immediately, it will impose costs on Alabama prior to its effective date due to the preparation and ramp up needed to meet the reporting requirements. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.

9. This the 21st day of October 2024.



Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

KANSAS, et al.,

Plaintiffs,

v.

XAVIER BECERRA; et al.,

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF EMILY RICCI

I, Emily Ricci, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Alaska Department of Health personnel:

1. My name is Emily Ricci, and my business address is 3601 C Street, Suite 902, Anchorage AK, 99503. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Deputy Commissioner since November, 2022. I have a Master of Public Health degree from the University of Alaska Anchorage and have administered state health insurance plans and engaged in health policy issues for over 12 years. My job responsibilities include acting as Alaska's federally designated Medicaid Director and managing the different divisions and sections that make up Alaska's Medicaid program including the Division responsible for licensing skilled nursing facilities.

Purpose of Declaration

3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").
4. I am familiar with the Final Rule and its impact on Alaska.

Impact on Alaska: Reporting Requirement

5. The Final Rule has caused and is causing immediate harm to Alaska in the form of compliance costs.

6. First, the Final Rule requires Alaska, through its Medicaid agency, to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40990.
7. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Alaska well before that. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.
8. There is no process or infrastructure currently in place for Alaska to comply with this requirement.
9. The Final Rule provides no exceptions for states acting in good faith who are unable to obtain the necessary information from providers.
10. Complying with this requirement would require Alaska to acquire new technology systems and contract support and create additional staff positions.
11. Complying with this requirement will necessitate costly substantive system changes, including development of provider sanctions for failure to provide information, appeal processes, and administrative hearing proceedings.

Impact on Alaska: Staffing and Service Requirements

12. Alaska does not currently have any state-operated LTC facilities and relies on non-state facilities to provide care to Alaskans.
13. Alaska Medicaid operates in a fee-for-service environment and cannot compel providers to participate in the Medicaid program.

14. Alaska provides licensing oversight for LTCs.
15. Alaska's licensing and certification oversight includes activities to ensure compliance with state laws and standards as well as federal certification on behalf of CMS pursuant to an 1864 agreement.
16. Alaska state agency survey activity on behalf of CMS increased by 110% between 2013 to 2023.
17. Approximately 30% of Alaska's LTC facilities currently struggle to staff registered nurses 24/7.
18. The Final Rule would impose additional resource burdens and financial costs on state agencies monitoring compliance with the Final Rule.
19. 21. Increased complaint intakes will result in an increase in complaint surveys by the state, which will impact the state's ability to complete other Tier 2-4 work as required by CMS, and will increase agency staff time in surveys, report writing, quality report review, and revisits.
20. State agency staff time will be increased for each standard federal certification survey conducted by the state agency to account for the new requirements in §§ 483.71 (facility assessment), 483.40 (behavioral health services), 483.45 (pharmacy services), 483.55 (dental services), 483.60 (food and nutrition services), and 483.65 (specialized rehabilitative services), 483.75 (quality assurance and performance improvement), 482.80 (infection control) and 483.95 (training requirements).
21. The state agency will experience additional costs related to the staff time necessary to establish competency in the new requirements of the Final Rule.

22. Meeting the requirements of the Final Rule will require Alaska to divert already scarce resources from existing programs and obligations.

23. This the 17th day of October, 2024.

Emily Ricci

Deputy Commissioner

State of Alaska Department of Health

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF JUSTIN HINKER FOR SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS

I, Justin Hinker, declare as follows:

1. I am Justin Hinker. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as Vice President of Post-Acute Care for the South Dakota Association of Healthcare Organizations (SDAHO). In my role, I work to support member nursing facilities through advocacy, networking, and education. Before my role at SDAHO, I was a long-term care administrator at nursing facilities in South Dakota for 26 years serving in urban and rural communities. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
3. The South Dakota Association of Healthcare Organizations (SDAHO) is a South Dakota nonprofit corporation and tax-exempt trade association (described in section 501(c)(6) of the Internal Revenue Code) serving South Dakota's hospitals, nursing homes, home health, hospice and assisted living providers through advocacy, education and quality integration. Our membership includes 57 hospitals, 47 nursing homes, 77 assisted living facilities, and approximately 18 home health and hospice providers.

4. Among the members of SDAHO are The Neighborhoods at Brookview in Brookings, South Dakota, Bethesda Home of Aberdeen, South Dakota, and Winner Regional Healthcare Center in Winner, South Dakota. These and others we represent are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet. My colleagues and I have communicated with many of our members regarding the impact of the Final Rule, including The Neighborhoods at Brookview, Bethesda Home of Aberdeen and Winner Regional Healthcare Center; however, these three facilities represent only a few examples of the harm the Final Rule is causing and will cause to South Dakota healthcare providers.

5. The significant and irreparable harm that the Final Rule imposes on our South Dakota nursing home providers will be especially severe in rural and underserved areas. The imposition of this rule is based on flawed and incomplete data, lacks evidence-based justification, and will exacerbate existing workforce shortages, leading to devastating consequences for both providers and residents.

6. **Enhanced Facility Assessment.** The Final Rule's enhanced facility assessment, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. This assessment imposes an administrative burden on SDAHO's members and on other facilities in South

Dakota. Prior to August 8, 2024, these facilities already were subject to an existing facility assessment to consider their staffing needs. The Final Rule's enhanced facility assessment requires facilities to undertake additional steps that are unnecessary, and even inhibit, these facilities' ability to ensure a high level of resident care. In particular, the Final Rule requires facilities to allow for the "active involvement" of the direct care staff and their representatives and they must "solicit and consider input received from residents, resident representatives, and family members." With continual updates to the assessment required under the language of the rule, many administrative hours are taken away from direct resident care, when that staff attention and time is actually necessary for quality care and safety of the residents.

7. **Onerous Staffing Requirements**. Numerous SDAHO members reported they will have to add substantial and burdensome nursing hours to comply with the Final Rule's staffing mandate. These members have informed us that they will be harmed by the Final Rule because of the significant costs involved with onerous staffing requirements that are difficult if not impossible to meet, which will result in unintended consequences of closures and/or reduction in the number of people being served. The Neighborhoods at Brookview, Bethesda Home of Aberdeen and Winner Regional Healthcare Center have reported that even before implementation of the Final Rule, they have had Registered Nurse (RN) positions posted for approximately 3 years and have been utilizing expensive temporary or traveler nurse staff to fill those shifts. These facilities

estimate the costs associated with hiring these nurses to be between $300,000 and $1,600,000 per year, which will increase exponentially if the Final Rule's Staffing Mandate goes into effect. Some facilities are operating at a loss to serve a vital community need, but this is not sustainable on a long-term basis.

8. **Unfunded Mandate**. The Final Rule will have significant negative consequences as it is an unfunded mandate that will cause significant harm to facilities that are already struggling financially. South Dakota is a rural state with a total population of roughly 890,342, where 50.2% of people live in non-metro areas. There are only two counties in the state with a population over 100,000, which are Sioux Falls/Minnehaha County (Population 197,214) and Rapid City/Pennington County (Population 109,222). South Dakota has several health professional shortage areas (HPSA), and medically underserved areas (MUAs) as identified by the Public Health Service Act and the Secretary of Health and Human Services. The staffing mandate will be very difficult for facilities in South Dakota to comply with. Only 4% of South Dakota facilities are currently meeting (a) the 24-hour RN mandate included in the Final Rule and (b) the total nursing staffing standard included in the Final Rule. South Dakota's healthcare providers currently have approximately 1,200 open RN positions posted. The challenge for many South Dakota facilities is the inability to recruit RNs to fill these positions. A financial analysis conducted by LeadingAge New York and based on cost reporting and Payroll Based Journaling data, estimates this mandate will cost each South Dakota provider,

including SDAHO's members, an average of $205,000 per facility with the cost to meet the RN staffing mandate at $53,000 per facility. According to this analysis, the total cost for South Dakota facilities to comply with the Final Rule will be nearly $20,000,000. Many of our member facilities very likely will be forced to hire costly temporary or travel staff to comply with the mandate. The cost for facilities will be even greater if contract staff are needed to meet the standards of the mandate. 53% of facilities in South Dakota are currently using contract RNs, 59% of facilities are using contract Certified Nursing Assistants (C.N.A.s) and 44% are currently using contract Licensed Practical Nurses (LPNs). When the staffing mandate goes into effect, facilities almost certainly will be forced into hiring additional contract staff. The costs associated with contract labor are sometimes 50% to 200% higher than employed staff. The additional costs associated with contract labor will undoubtedly hurt these facilities' financial performance and will likely lead to additional facility closures. The CMS staffing mandate will be especially difficult for South Dakota facilities that are in rural and underserved areas. Recruiting professional nurses in South Dakota's rural areas has proven especially difficult. Many facilities in South Dakota have open nurse positions that either have been posted for a year or longer with no applicants, or turnover in those positions has required the positions to continue to be posted. The continued implementation of the Final Rule could be devastating for residents, families, and providers in our state.

9. **Arbitrary Requirements.** By establishing arbitrary thresholds for quality care, the minimum staffing ratios outlined in the Final Rule require facilities to ignore the variability that is inherently recognized in the enhanced facility assessment related to resident acuity and needs across varying settings. Some facilities with higher acuity residents may need increased staffing, while others with lower acuity residents may not require a 24/7 RN presence. Requiring facilities with such lower acuity residents to maintain higher staffing than needed substantially increases the facilities' costs without a corresponding increase in quality of care or life for residents. The CMS Staffing Mandate in the Final Rule puts the employment of some of our member facilities' LPNs, as well as other South Dakota facilities' LPNs, in jeopardy as the requirement for 24-hour RNs is implemented. LPNs who currently provide a vital role to our long term care workforce could be forced out of work and replaced by RNs in order comply with the staffing mandate. Several of our member facilities have reported they currently employ LPNs in nursing roles to staff their facilities. LPNs are critical to the care of long term care residents in South Dakota, especially in its rural areas where fewer RNs live. In addition, 61% of the nursing facilities in South Dakota are limiting their admissions due to lack of workforce and inability to fill nursing positions. One SDAHO member, located in Bennett County, South Dakota, between two Indian reservations, was forced to close its nursing home in 2023 due to a lack of RNs

and need for expensive travel staff.[1] Since 2020, the Bennett County Nursing Home watched its average travel nurse pay rates increase by 218%. This nursing home lost $1.3 million between January and July of 2023, resulting in the facility closing its doors in October 2023. Currently, Bennett County Hospital, the Bennett County Nursing Home's adjoining hospital, also struggles to survive. The harm of the staffing mandate extends beyond South Dakota's nursing homes. The nursing workforce crisis cuts across the entire health care system, and this arbitrary mandate will force further scarcity in South Dakota's health labor market, robbing patients in hospitals and other clinical settings of nursing services when and where they are desperately needed, only to force nursing homes to provide costly 24-hour RN monitoring even with no clinical need for it.

10. **Nursing Workforce Shortage**. The State of South Dakota is facing declining nursing program enrollment, while at the same time 42% of RNs are over the age of 46 and the average age of a nurse in South Dakota is 44. Without an adequate supply of nursing graduates, the increased need for professional nurses across the state will be detrimental to nursing facilities in the state. In 2022, a total of 429 spots were available for LPN students across South Dakota, but only 350 students accepted and enrolled, leaving 79 spots vacant. For RNs, there were 1,150 open spots available in nursing programs, but only 878 (78%)

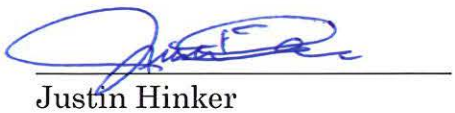
[1]Michael Christensen, Bennett County Nursing Home to Close, Lakota Times, Aug. 23, 2023, available at https://www.lakotatimes.com/articles/bennett-county-nursing-home-to-close/#:~:text=Unfortunately%2C%20the%20unimaginably%20low%20reimbursement,close%20effective%20October%2013%2C%202023.

accepted and enrolled, leaving 272 (24%) spots vacant. Between these two programs, 351 spots were left unfilled, which will continue to exacerbate the nursing shortage and further prevent both SDAHO's and other facilities from complying with the Final Rule.

11. **Risk of Noncompliance**. South Dakota healthcare providers have expressed concern about the staffing mandate's enforcement mechanisms tied to noncompliance with implementation. For SDAHO's members, survey deficiencies, denial of payment, Civil Monetary Penalties (CMPs) and potential decreases in 5-star ratings are all potential risks associated with noncompliance with the Final Rule. For providers who are making a good faith effort to provide quality care to their residents while complying with rules and regulations, these potential penalties present an additional strain on facilities.

12. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Sioux Falls, SD, this 16TH day of October 2024.



Justin Hinker

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF DEBORAH LIVELY FOR LEADINGAGE COLORADO**

I, Deborah Lively, declare as follows:

1. I am Deborah Lively. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the President & CEO of LeadingAge Colorado, which is a statewide trade association created in 1968 that represents the continuum of senior living and aging services providers including not-for-profit nursing homes. In my role I am responsible for collaboratively achieving the LeadingAge Colorado's mission and for oversight of the governance, administration, programs and strategic plan for the organization. Prior to this role, I served as the association's director of public policy and public affairs and was responsible for managing LeadingAge Colorado's legislative and regulatory advocacy efforts.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LeadingAge Colorado represents 12 nursing communities. Among our members is Eben Ezer Lutheran Care Center. This and our other members are being harmed by and will continue to be harmed by the Final Rule

because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

5. The Final Rule works against the goal of ensuring access to the highest quality care for our elderly and disabled residents, and instead puts residents at risk by failing to address reimbursement and the chronic workforce shortages plaguing nursing communities in Colorado. Because of the Final Rule, nursing homes will close or serve fewer residents because they will not be able to comply with the proposed minimum staffing mandate, resulting in reduced access to nursing home services needed by the most frail and vulnerable older adults in our state.

6. The Final Rule does not identify or provide a funding source that our members know is absolutely necessary for their nursing homes and other nursing communities to meet the minimum staffing requirements. This places the cost burdens on providers that rely heavily on Medicaid for funding. Because the cost of delivering quality care already exceeds Medicaid reimbursement, this unfunded mandate will further jeopardize Colorado's nursing homes' ability to continue to serve older adults. A financial analysis conducted by LeadingAge New York and based on cost reporting and Payroll Based Journaling data estimates this mandate will cost each Colorado provider, including our members, an average of $399,123 per year. The same data sources indicated the total cost for all Colorado's nursing homes is over $84 million. An amount that cannot be funded by our state budget as

economic forecasts indicate our state is facing a $700 to $800 million budget deficit for next fiscal year.

7. In Colorado, there simply aren't enough qualified people to fill open positions to meet the Final Rule's minimum staffing standards. Our state's unemployment rate hovers around 4 percent, limiting the number of available workers and resulting in an even smaller pool of workers qualified to provide care in nursing communities. Ninety percent of Colorado's nursing homes would not meet one or more of the staffing requirements, needing an additional estimated 144 RN FTEs and 1,072 nurse aides to achieve the minimum standards.

8. The damaging effects of the Final Rule are particularly harmful to rural nursing communities. One of our rural members is facing the difficult decision to close one or more sections of its nursing community due not only to costs associated with the mandated staffing ratios, but also to the related issue of a serious lack of qualified staff. The Colorado Center for Nursing Excellence reports that 22 rural counties in Colorado have only 37-74 Registered Nurses for every 10,000 residents, while 10 urban counties have 125-197 RNs per 10,000 residents. Because of this intense competition, acute care providers are paying RNs at least $14 an hour more than nursing communities can pay. Rural providers also rely more heavily on the contributions of LPNs which the Final Rule mostly does not recognize.

9. Our nursing home members are already feeling the strain of the Final Rule through its enhanced facility assessment. This requirement has burdened them with having to divert hours of staff time to administrative work that has vague requirements as to how they are to consider the views of staff and residents and their families and how often updates to the assessment are necessary. Because of the level of detail required by CMS in the Final Rule, the time and staff needed to create and maintain the enhanced facility assessment is extensive and expensive, especially for smaller, non-corporate providers. The enhanced facility assessment requires input from all areas of clinical services, which results in professionals diverting their attention away from direct resident care and focusing on paperwork compliance.

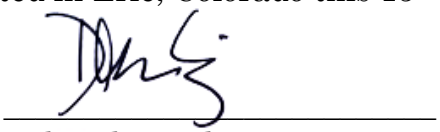
10. The existing workforce shortages that are impacting providers across Colorado's health care industry will be further heightened by the imposition of the staffing mandate. Both acute and post-acute sectors are seeking nurses and nurse aides from the same shrinking workforce pool leaving a caregiver void. The Colorado Workforce Development Center reported in their 2022 Talent Pipeline Report that openings associated with registered nurse occupations outpaced others, with 4,024 annual unfilled openings projected per year from 2022 through 2032. According to PHI, between 2020-2030 Colorado will have 31,800 unfilled job openings for nursing assistants. Hospitals will continue to be backed up with patients who can't be discharged to nursing homes. Home health providers are already rejecting referrals and

some face closure due to financial pressures and workforce shortages. There won't be anywhere for Colorado's older adults and families to access care and needed services.

11. The Final Rule includes an exemption process that is archaic and seems to be designed to severely limit the number of nursing communities that could meet the criteria, and our members would find it difficult if not impossible to qualify. In addition, the exemption process established in the Final Rule is designed to shame quality providers that manage to meet the arbitrary exemption requirements by posting online and in the nursing community that they are not meeting the staffing standard being imposed by CMS. This is harmful to residents and their families implying that the provider is not staffed appropriately, despite the quality services being offered to the resident.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Erie, Colorado this 15th day of October 2024.



Deborah Lively

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF KELLIE VAN REE FOR LEADINGAGE IOWA**

I, Kellie Van Ree, declare as follows:

1. I am Kellie Van Ree. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the Director of Clinical Services at LeadingAge Iowa. I hold an active license as both a nursing home administrator and registered nurse in the state of Iowa. I assist LeadingAge Iowa members with their regulatory and clinical questions as well as develop resources for members to support compliance with new and existing laws and regulations.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LeadingAge Iowa is the strong and distinct voice for not-for-profit aging services providers in Iowa as we strive to be the champion for advancement and innovation in aging services through education, resources, and advocacy. LeadingAge Iowa represents 60 not-for-profit nursing homes throughout the state of Iowa, with nearly half of these located in the Northern District of Iowa. Our members are not-for-profit, mission-driven, and focused on serving their local communities. The majority are single-site, faith-based, and locally

governed organizations with deep roots in the Iowa communities they serve. Our members, among others across the state, are already being harmed by and will continue to be harmed by the Final Rule due to the significant costs and strenuous staffing requirements that are difficult if not impossible to meet. The Final Rule imposes an undue burden on Iowa nursing home providers, and will be especially severe in rural and underserved areas. Even assuming that CMS shares with LeadingAge Iowa the goal of providing the highest quality care possible for older Iowans, using a staffing mandate without first ensuring financial security and workforce capacity of providers to achieve this is ill-advised, and has already been and will continue to be detrimental to aging services providers and Iowa's vulnerable older adults.

a. The Final Rule will impose significant financial strain on Iowa nursing home providers in an environment where they are already struggling. Data posted on CMS' Care Compare website for LeadingAge Iowa members identified that 31% of our nursing home members will be required to increase staffing to meet the minimum requirement. The financial impact based on hours per resident day (HPRD) for Certified Nurse Aide (CNA) minimums calculated at a mean wage of $18.45 according to Iowa Workforce Development is $4,687.96 per day. The financial impact for increasing Registered Nurse (RN) hours to meet the minimum standard at a mean wage of $35.87 per hour is $1,246.12 per day for our nursing home members. These together total more than

$2.16 million annually, imposed on an already struggling sector. In addition, 10% of our members reported less than 24 hours of RN coverage per day. These providers will be forced to increase RN hours per day, despite being over the 0.55 HPRD threshold. Iowa Workforce Development's most recent data from August 2024, has 3,461 RN and 634 CNA job openings. In the Final Rule, CMS anticipated the financial burden to be $1.43 billion by year two, $4.4 billion by year three, and $5.8 billion by year ten. Despite the increasing cost of providing care, the current reimbursement rates for both Medicare and Medicaid are significantly less than actual costs, which forces providers to rely on private pay residents to supplement the difference. This associated cost will quickly push private pay residents into the Medicaid system, causing both the State and Federal government significantly more in nursing home care for this vulnerable population.

5. Prior to implementation of the Final Rule's minimum staffing standards, nursing homes must provide nursing staff in sufficient quantities based on the resident's needs. Each nursing home serves a variety of residents, and most are not like the next. For example, one nursing home may have a high level of acuity and a large census whereas the next is a small rural provider, who serves those in their community who can no longer reside safely at home with ADL and IADL support. Yet, these two very different nursing homes are expected to maintain the same HPRD standard despite clear variances in

acuity. Staffing decisions should not be a one-size fits all approach and the assumption that all providers have the same staffing requirement is dangerous and detrimental, leading to an increased burden on our already struggling providers.

6. On top of the huge and devastating cost caused by the Final Rule, Iowa's current workforce crisis makes satisfying the mandated staffing levels almost impossible for our nursing home providers. According to the Iowa Board of Nursing, the number of RNs in Iowa went down by 5.5% (3,413) in FY2023 as compared to FY 2022. In 2022, 1,786 RNs passed the Licensure Examination meaning that Iowa only replaced roughly 1/3 of the RNs lost last year. Data also shows an increasingly aging nursing workforce, with 41% of Iowa's RNs over the age of 50 and more than 20% eligible to retire right now. Iowa Board of Nursing data also indicates that hospitals are the largest employer of RNs in Iowa at 46%, with Long Term Care at 7.5%. As of Q1 2024, employment in Nursing and Residential Care Facilities has decreased 6.7% from the start of the pandemic, while employment in Hospitals has increased 2.82%. Iowa is losing nurses rapidly, and with nursing home providers already at a significant disadvantage in the job market, this rule will have a cascading effect on the whole health care system including state agencies and hospitals. There are not enough licensed RNs in the state of Iowa to meet the increased demand of the Final Rule and the needs of the rest of the healthcare system in the state. Enforcing these staffing mandates without a strong workforce pipeline

throughout the healthcare system will push our members and other providers in the state into challenging positions, resulting in these providers being forced to shut down facilities or limit services just to comply with staffing requirements.

7. The first requirement of the Final Rule went into effect on August 8 of this year and required nursing homes to enhance their facility assessment. The Final Rule's required changes to the facility assessment created additional administrative burden for the nursing home staff such as ensuring sufficient documentation is maintained to prove that direct care staff, residents, and families were included in updating the assessment. Additionally, there is a lack of clarity on critical aspects of the assessment, such as what constitutes "continuous" updates or how to effectively "consider" feedback from residents, families, and staff. While many of our nursing homes already solicited feedback through a variety of methods in operating their nursing homes such as resident/family councils, surveys, and open offices, they were left questioning what proof they will need to maintain and how the vague standards will be applied to ensure compliance. In addition, the revised requirements called for a contingency staffing plan when nursing homes were already expected to have an emergency staffing plan. These tasks take and will continue to take a significant amount of time to complete, further reducing time that could have been spent providing direct care or working towards process improvements. The lack of specific guidance on these requirements can result in nursing

homes, already struggling financially and with workforce capacity, receiving expensive and burdensome Civil Money Penalties.

8. The Rule is already causing harm to providers as they struggle to find and retain staff in an unprecedented and unstable workforce environment. The looming threat of this rule has caused LeadingAge Iowa members to allocate significant funds to recruit adequate staff in preparation for its implementation. Most providers have already placed significant resources including staff time and financial resources into improving workplace culture, offering incentives such as tuition reimbursement, bonuses, and hiring bonuses to recruit staff. With the increasing cost of providing care and the shrinking labor market, providers are facing extreme financial burden. Since the beginning of 2022, 39 Iowa nursing homes are in the process of closing or have closed. Numerous nursing home providers have or are limiting admissions to accommodate current staffing levels, despite the need for services in their community. Nursing homes are already relying on staffing agencies which is causing significant financial strife. According to data posted on the Iowa Department of Inspections, Appeals, and Licensing website, as of Quarter 4 2023, staffing agencies were charging 112% above median RN wages, 93% LPN, and 95% nurse aide. The Iowa Health and Human Services Compilation Report ending December 31, 2023 reported, despite the robust efforts to recruit and retain staff, LeadingAge Iowa members spent over $7.6 million on licensed nurses (RN/LPN) and over $15.2 million on CNAs paid

directly to staffing agencies. If nursing homes are required to rely on staffing agencies to cover additional required hours, as is likely to the severe staffing shortage, the financial burden on nursing homes will be even more significant.

9. This Final Rule is only exacerbating the financial and workforce trials that make providing excellent and consistent care more difficult for LeadingAge Iowa members. Without the proper resources in place, this rule is causing and will continue to cause undue harm to the mission-driven aging services providers in Iowa, further exacerbating the workforce crisis and leaving providers with financial insecurity. Some of our members are having to take expensive measures now to try to be in compliance when the Final Rule is fully implemented, but these measures are not sustainable across the board. For example, they are attempting to hire RNs over LPNs whenever possible, reducing the use of medication aides as they transition these positions to nurse duty, attempting to retain staff by providing tuition assistance to return to school for registered nurse training, and engaging in aggressive recruitment strategies such as sign-on and recruitment bonuses to be competitive with local hospitals. Ultimately, the Final Rule will lead to providers needing to further limit admissions to nursing home settings, which will negatively affect the healthcare system as a whole and impact families seeking care for their loved ones. When nursing homes limit admissions, hospitals experience difficulty discharging patients that no longer require acute care but are not safe in the community. Iowa does not have the workforce infrastructure to accommodate

the constraints of the CMS Staffing Mandate, which will result in undue harm to the healthcare landscape of Iowa and add to the strife aging services providers are already facing.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Urbandale, Iowa, this 21st day of October 2024.

Kellie Van Ree

Kellie Van Ree

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF RACHEL MONGER FOR LEADINGAGE KANSAS

I, Rachel Monger, declare as follows:

1. I am Rachel Monger. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.

2. I currently serve as President/CEO of LeadingAge Kansas which is a state trade association that has operated for 70 years with over 150 not-for-profit and mission driven aging services providers, including 116 nursing homes.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services's ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule" or "the rule").

4. Among the members of LeadingAge Kansas are Dooley Center and Wesley Towers. These and others we represent are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet. Both the Dooley Center and Wesley Towers have provided descriptions of these harms in separate declarations, which I incorporate herein by reference.

5. The significant and irreparable harm that the Final Rule imposes on Kansas nursing home providers will be especially severe in rural and underserved areas. The imposition of this rule is based on flawed and incomplete data, lacks

evidence-based justification, and will exacerbate existing workforce shortages, leading to devastating consequences for both providers and residents.

6. **Insufficient Evidence and Data**: The formulation of the rule is grounded in data that fails to accurately reflect the realities of staffing in nursing homes. The use of Payroll Based Journaling (PBJ) data does not account for the specific periods during which staff are working, leading to a misleading understanding of compliance with staffing requirements. An example would be a nursing facility that has three RNs working 8 hours of dayshift coverage each day, but no overnight coverage. On paper it would reflect they are meeting 24-hour RN coverage, when in reality they are not. Furthermore, the Abt Associates 2022 Nursing Home Staffing Study explicitly states that no set number of staff can guarantee quality care, given the varying needs of residents and providers. A financial analysis conducted by LeadingAge New York and based on cost reporting and Payroll Based Journaling data estimates this mandate will cost each Kansas provider, including our members, an average of $211,905 per year. This amount is based up on the current prevailing wage for nursing staff in Kansas, and does not take into account the hyper wage inflation and temporary staffing agency price hikes that will inevitably occur if this staffing mandate is allowed to take effect in Kansas. Despite this, CMS has pushed this unfunded mandate forward without evidence-based data to justify a sweeping rule that will have devastating consequences on availability and access to nursing home care as increased costs without any corresponding financial support or access to adequate pools of nursing staff will cause providers to reduce the number of

residents they accept and services they provide.

7. **Enhanced Facility Assessment**: The Final Rule's enhanced facility assessment, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. This assessment imposes a significant burden on our member facilities and others in the state. The facilities already were subject to an existing facility assessment to consider their staffing needs. The Final Rule's enhanced facility assessment requires facilities to undertake an additional administrative burden that is unnecessary to ensuring a high level of resident care. As part of the enhanced facility assessment, facilities must consider outside views, but its terms are vague as to the specific standards. In particular, the Final Rule requires facilities to allow for the "active involvement" of the direct care staff and their representatives and they must "solicit and consider input received from residents, resident representatives, and family members." LeadingAge Kansas and its members have requested guidance from CMS contracted surveyors as to how to incorporate or "consider" these outside parties without avail. Similarly, the Final Rule requires the facility to "review and update that assessment, as necessary, and at least annually." The facilities lack further guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties. The enhanced facility assessment also requires facilities to create "contingency planning," even though the facilities already are required to have emergency plans for, among other things, staffing issues. In total,

the enhanced facility assessment imposes hours upon hours of additional work and significant administrative burdens on the facilities and subjects them to vague requirements that could result in steep civil penalties. The staff hours and costs associated with the enhanced facility assessment may vary widely by each facility. Wesley Towers and the Dooley Center represent a typical member of LeadingAge Kansas. The staff hours required for initial establishment of the enhanced facility assessment ranged from 16 hours to 89 hours. The estimated cost for each time they must update the assessment ranges from $400 to $600. With continual updates to the assessment required under the vague language of the rule, the costs associated with this overly burdensome piece of the staffing mandate rule quickly spiral. We will also note that the significant staff hours required to maintain this assessment are hours taken away from administration and direct resident care that are actually necessary for quality and safety.

8. The minimum staffing ratios also outlined in the Final Rule require facilities to ignore the same variability inherently recognized in the enhanced facility assessment in resident acuity and needs across different settings by establishing arbitrary thresholds for quality care. Some facilities with higher acuity residents may need increased staffing, while others with lower acuity residents may not require a 24/7 RN presence. Requiring facilities with such lower acuity residents to maintain higher staffing than needed substantially increases the facilities' costs without a corresponding increase in quality of care or life for residents. The Dooley Center in Atchison, Kansas is a perfect example of overly burdensome cost without benefit to

residents. Dooley Center currently cares for the fourth lowest case-mix index (CMI) acuity in Kansas at 0.8717. This means their residents have some of the lowest level of care needs in the state. In their most recent Facility Needs Assessment they found that highest need diagnosis in their facility was gastroesophageal reflux disease (GERD), which does not require the skills or presence of an RN for treatment and monitoring. Less than 24 hour RN staffing, supplemented by LPN charge nurses, is more than sufficient to provide high quality care to the residents of Dooley Center. The Final Rule will require Dooley Center to incur additional administrative burdens and to divert resources to unnecessary staff rather toward necessary operating expenses or actual enhancements to resident experience. The harm extends beyond our nursing homes. The nursing workforce crisis cuts across the entire health care system, and this mandate will force further scarcity in the health labor market, robbing patients in hospitals and other clinical settings of nursing services when and where they are desperately needed just to provide 24-hour RN monitoring at a nursing home with no clinical need for it.

9. The enhanced facility assessment imposes significant burden on our members' staff, diverting valuable time away from direct resident care to maintain continuous updates for compliance. CMS estimates the cost of the enhanced facility assessment to be around $4,955 per facility, but we know based on our own modeling their estimates tend to fall woefully low. In the Final Rule, an enhanced facility assessment is required of all nursing home facilities and the expectations of the assessment include evaluating the acuity and needs of the residents to determine

staffing levels, collecting input from staff including but not limited to contracted agency personnel or union representatives, collecting input from residents and their families, and creating a contingency plan to be utilized before an emergency staffing plan is needed. We and our members are concerned about the lack of clear guidance on critical aspects of the assessment, such as what constitutes "continuous" updates or how to effectively "consider" feedback from residents, families, and staff. These vague and arbitrary definitions could result in providers, despite acting in good faith, being unfairly penalized through Civil Money Penalties during complaint investigations or annual surveys.

10. **Exacerbation of Workforce Shortages**: The rule imposes a 24/7 RN requirement and minimum staffing ratios that are unattainable for our members given the current workforce crisis. Kansas needs an additional 312 RNs and 601 NAs to meet the minimum staffing ratios, on top of the existing 2,360 RN and 663 NA job openings as of September 2024. However, these estimates are based on CMS's flawed data analysis on 24/7 RN coverage, and we know the number of RNs needed are significantly higher due to PBJ data not reflecting actual shifts worked. The state is also facing declining nursing program admissions and an aging workforce, with roughly 42% of RNs aged 50 or older and nearing retirement. Nursing homes are already at a disadvantage in the labor market, where hospitals employ 65.27% of nurses compared to just 7.87% in nursing and residential care facilities. In hospital settings, nurses earn an average of $76,840 whereas in nursing and resident care settings, such as with our members, they earn an average of $68,450. Implementing these staffing mandates without a sufficient workforce

pipeline for the entire healthcare continuum will force our members and other providers in the state to make difficult choices, engaging in wage wars with other health care providers that are unsustainable and for many, impossible to win, or simply enacting closures or reductions in services in order to meet staffing ratios. The Dooley Center is once again an excellent example of a provider caught up in the impossibility of trying to implement a staffing mandate in the midst of a severe and entrenched workforce crisis. The Dooley Center relies heavily on Medicaid and outside fundraising efforts to pay for their nursing home care needs. Financially, they cannot compete with hospitals or other large nursing home companies in their area for RN pay. If the staffing mandate is implemented the Benedictine Sisters will be forced to decide whether to de-license the nursing home for their convent and attempt to find funding resources elsewhere, or close altogether. They will not be able to meet the 24/7 RN staffing requirement, and their operations cannot sustain the penalties and fines that will result from failure to comply with the staffing mandate regulation

11. **One-Size-Fits-All Approach**: The rule dangerously treats all nursing facilities as though they have identical needs, regardless of their size, location, or the complexity of care they provide. This blanket approach fails to recognize that in many smaller or rural settings, the demand for an RN's presence around the clock is not only unnecessary but impractical. Licensed Practical Nurses (LPNs), who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards NA or RN ratio time, exacerbating staffing shortages and leaving facilities with even fewer options for care. While CMS finalized the total staffing hours to

include LPNs to count towards 0.48 hours per resident per day, this limited inclusion is inadequate, arbitrarily forcing providers to eliminate use of LPNs. Our nursing home members and others in the state employ a large number of LPNs in Kansas, relying heavily on their labor availability and skills to provide high quality and safe care to residents. LPNs are particularly vital to the daily operations of nursing homes in rural parts of Kansas.

12. **Financial Burden and Unfunded Mandates: Estimated Costs:** The total estimated costs for Kansas nursing facilities to comply with Final Rule on minimum staffing standards range between $64 million and $92.7 million in the first year, at an average cost of $211,905 per Kansas facility per year. **LeadingAge Kansas** represents a significant amount of small, rural, and stand-alone nursing homes who will not be able to absorb this cost year after year as they continue to rely on historically underfunded Medicaid and Medicare reimbursement and serving seniors in their communities who can already ill afford the escalating cost of the care they need. This estimated cost includes the costs for both employing new staff and using contracted nursing agency workers. Nursing homes will incur substantial costs, potentially requiring them to rely on contracted nursing agencies, which are significantly more expensive. For example, the average contracted RN rate is estimated at $72 per hour, while the average W2 RN employee rate is around $40 per hour; the average contracted NA rate is $38 per hour, while the aerage W2 NA employee rate is around $19 per hour. This financial strain, coupled with limited and inadequate Medicaid reimbursement rates, will push many providers to the brink of

closure, and likely beyond, particularly in rural areas where operating margins are already razor thin. The federal government has allocated only $75 million across all states for nursing program tuition reimbursement and scholarships, a fraction of what is needed. This cost burden of this rule will not only fall on providers and private pay residents but will also fall on Kansas taxpayers, as approximately 60% of nursing home residents are on Medicaid. The proposed rule is likely to exacerbate already critical access to care issues, where the state of Kansas saw a reduction of 1,273 nursing home beds since the start of the pandemic, and the closure or reduction of services at 47 facilities, including at many of our members.

13. **Increased Risk of Care Deserts**: Nearly 85,000 Kansans live in areas with only one nursing and residential care provider within a 30-minute drive. The closure of a local provider would double the average drive time required to access care, pushing more residents into care deserts, and significantly limiting their access to essential services, friends, family, and loved ones. With the aging population in Kansas expected to grow by 208,000 by 2036, the capacity to provide care will be severely strained if more facilities close or reduce needed capacity.

14. **Harm to Licensed Practical Nurses (LPNs)**: The rule's exclusion of LPN care from the minimum staffing calculations will have severe consequences for the long-term care workforce. LPNs play a critical role in bridging the gap between CNAs and RNs, yet the rule effectively sidelines them, forcing many to either leave the profession or seek employment in other settings. This will further deplete the already limited workforce pool for aging services and reduce the quality of care

available to residents.

15. **Increased Risk of Noncompliance and Closure**: The enforcement mechanisms tied to the rule, including Civil Money Penalties (CMPs) and the potential for termination of provider agreements, are based on data and survey processes prone to human error and misinterpretation. Our members are gravely concerned by the risk of noncompliance, even when they are making good faith efforts to meet the standards. This risk is unacceptably high and further guarantees money needed to meet these regulations will be clawed back from providers attempting to provide quality care to residents. This presents another strain on our provider members' resources and burdens their operational capacity.

16. **Counterproductive Waivers and Exemptions**: The waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for our members and other providers. Providers must navigate separate, complex processes to demonstrate need, with the potential for penalties or exclusion from the exemption they are seeking. These processes are unlikely to provide meaningful relief and may, in fact, discourage providers (including our members) from seeking necessary exemptions, further increasing the risk of noncompliance, service reductions and closures.

17. **Conclusion**: The finalized minimum staffing rule, in its current form, is fundamentally flawed and will cause substantial harm to our nursing home providers, their residents, and their communities, particularly in rural and underserved areas. It is essential to the continued operation and provision of care by

our members that this rule is not enforced and be vacated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Topeka, Kansas, this 18th day of October 2024.

Rachel Monger

Rachel Monger

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF ALLISON CIBOROWSKI FOR LEADINGAGE MARYLAND

I, Allison Ciborowski, declare as follows:

1. I am Allison Ciborowski. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the President and CEO of LeadingAge Maryland.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LeadingAge Maryland is a memberships association representing not for profit aging services organizations in Maryland. We represent 28 not for profit nursing communities in Maryland. Among our members are Coffman Nursing Center, and Fahrney Keedy Home and Village. These and our other members are being harmed by, and will continue to be harmed by, the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

Financial Burden and Unfunded Mandates: Estimated Costs

5. The Final Rule will impose significant burdens. We estimate the staffing mandate will cost each nursing home in Maryland, on average, an additional $ 642,000 each year. Collectively, we anticipate the Final Rule will cost nursing homes in Maryland more than $142.5 million per year. The Rule contains no additional funding to support nursing homes in addressing these increased costs. The cost of implementing the proposed

staffing mandate will damage our member nursing homes and others in the State. The cost of delivering quality care already far exceeds Medicaid reimbursement, and this unfunded mandate will further jeopardize nonprofit and mission-driven nursing homes' ability to continue to serve older adults and families—forcing them to consider limiting admissions or even closing. Already today, Medicaid does not fully cover the cost of care. Not for profit skilled nursing providers are forced to make up the difference through reimbursement from residents who pay privately for care, and often through fundraising and donations. For example, Fahrney Keedy, and one of our members in Western Maryland, reports that their total expenses per patient day are $509.86, but Medicaid only reimburses them $295.40 per patient day. The organization is forced to find other ways to compensate for these un-reimbursed costs. Similarly, The Maryland Baptist Aged Home, a small, church owned nursing home in West Baltimore that has existed for nearly a century, notes that the proposed rule would have a "catastrophic effect on our ability to exist in a community that desperately needs our services." Approximately 82% of Maryland Baptist Aged Home's revenues come from Medicaid, and therefore most of their revenues are fixed. The proposed rule would more than double their nursing payroll and would put the nursing home out of business.

Harm to Licensed Practical Nurses

6. Licensed Practical Nurses (LPNs), who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards NA or RN ratio time, exacerbating staffing shortages and leaving facilities with even fewer options for care. Fahrney Keedy illustrates this challenge. They and other providers note that the current pool of nursing applicants is heavy with LPNs, and that on average, 1 of every 3 nurse applications received are RN vs. LPN. Unfortunately, our members have already begun

to plan for the elimination of LPN positions because of the Final Rule. For example, another of our members notes they will have to eliminate 10 full time and 8 part time LPNs.

Lack of Available Workforce

7. There are simply not enough registered nurses or nursing assistants in Maryland to meet the Final Rule's mandate. Based on recent Payroll Based Journalling data we estimate that collectively, nursing homes in Maryland would need to employ 206 more full-time registered nurses, and more than 1,897 additional full-time nursing assistants to be able to comply with the staffing mandate requirements. Unfortunately, these additional registered nurses and nursing assistants do not exist, and there is a documented shortage of nurses and nursing assistants in Maryland. In other words, our members and other nursing homes will be unable to meet the staffing mandate even if the increased costs were not an issue. According to the Maryland Nursing Workforce Study conducted in 2022, which detailed the shortage in Maryland's nursing workforce today and into the future, it is estimated that Maryland would need an additional 11,000 registered nurses by 2035 just to keep pace with the growing demand for care in our state. Specifically, it is estimated that by 2035, the state will need an additional 610 registered nurses working in nursing homes alone to keep pace with the growing demand for care. This was before the constraints of the staffing mandate were factored in.
8. Additionally, the staffing challenges facing Life Plan Communities have been further exacerbated by COVID. According to a new report from Fitch Ratings, employment at

Life Plan/Continuing Care Retirement Communities remains 5.90% below pre-pandemic levels. Skilled nursing facilities have seen a further decline in staffing of 7.27% since February of 2020.

9. Nursing homes in Maryland, particularly those in more rural areas, experience challenges hiring enough staff. For example, one of our members reports that it takes on average three months to hire a new nursing assistant or RN.

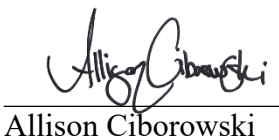
10. Fahrney Keedy Home and Village and their sister community, Coffman Nursing Center collectively have open positions for 12.5 full-time nurses and 24.5 full-time nursing assistants. Over the last year, the average outstanding open positions included 15-17 full-time nurse positions, and 16-18 full-time GNA positions. These numbers attest to the ongoing shortage and staffing challenges providers are facing.

11. The enhanced facility assessment required by the Final Rule imposes an additional and current burden on our members and other nursing homes. They are now required to consider outside views in assessing their staffing needs, but the Final Rule does not provide clear guidance as to how to do this. Similarly, the Final Rule requires the facility to "review and update that assessment, as necessary, and at least annually." Our members lack proper guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties. The enhanced facility assessment also requires facilities to create "contingency planning," even though the facilities already are required to have emergency plans for, among other things, staffing issues. With continual updates to the assessment required under the vague language of the rule, the costs associated with this overly burdensome piece of the Final Rule will increase rapidly. Already, our members are having to spend hours of additional

staff time and thousands of dollars on an additional assessment for which they lack clear guidance and for which they have not observed any measurable increase in resident wellbeing.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Sykesville, Maryland this 21day of October 2024.



Allison Ciborowski

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF DAVID HERBEL FOR LEADINGAGE MICHIGAN**

I, David Herbel, declare as follows:

1. I am David Herbel. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.

2. I currently serve as President & CEO of LeadingAge Michigan which is a state trade association that has operated for 56 years with over 200 not-for-profit and mission driven aging services providers, including 51 nursing homes.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule" or "the rule").

4. Among the members of LeadingAge Michigan are Oakview County Medical Care Facility and Chelsea Retirement Community. These and others we represent are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

5. **Increased Costs to Not-for-Profit and Government Providers.** In particular, the Final Rule will significantly increase the costs to not-for-profit and government providers, including those among our membership:

a. The first-year impact for County Medical Care Facilities, will be approximate $4 Million averaging over $100,000 per individual skilled nursing facility ("SNF").

b. The first-year impact for not-for-profit facilities will be nearly $15 million averaging about $200,000 per individual SNF. These costs will significantly burden on our members' operating abilities, with the expectation that many will be forced to limit their capacity or even close altogether. Under the current reimbursement model there are already 108 providers having approximately $63 Million in costs unreimbursed.

6. **Rural Impact.** The impact on our rural membership will be even more severe.

a. **Access to Care**: Smaller facilities in rural areas will be forced to close if they cannot meet staffing mandates, leaving older adults without local care options.

b. **Healthcare Shortages**: Mandated staffing levels will exacerbate existing healthcare staff shortages in rural areas, where finding qualified staff is already challenging.

c. **Unsustainable Financial Burden**: Many of our rural facilities operate on thin margins and will not survive the financial burden of mandated staffing, leading to reductions in programs or facility closures.

7. **Increased Costs to the Michigan Taxpayer.** Based on the current reimbursement methodology, the Final Rule will result in almost a $200 million cost increase to the Medicaid program annually.

8. **Community Impact.**

a. **Hospital Discharge Delays**: Facilities who cannot meet the mandated staffing levels will cause further delays in accepting hospital discharges or new admissions

b. **Loss of Local Jobs**: Facility closures or service reductions due to staffing mandates will result in job losses, negatively impacting the local economy.

c. **Displacement of Residents**: Older adults will be forced to move far from their communities and families to find care, causing emotional and social distress.

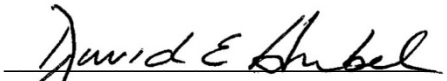
9. **College and University Impact:** There is a shortage of qualified nursing instructors across the state that limits the number of new nurses entering the profession.

10. The Final Rule's enhanced facility assessment already is imposing a significant burden on our member facilities and others in the state. These nursing homes are having to spend thousands of dollars in staff time and other resources on an additional administrative burden that is unnecessary to ensuring a high level of resident care. As part of the enhanced facility assessment, facilities must consider outside views, but its terms are vague as to the specific standards. The Final Rule

requires facilities to allow for the "active involvement" of the direct care staff and their representatives and they must "solicit and consider input received from residents, resident representatives, and family members." Similarly, the Final Rule requires the facility to "review and update that assessment, as necessary, and at least annually." Our members lack proper guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties. The enhanced facility assessment also requires facilities to create "contingency planning," even though the facilities already are required to have emergency plans for, among other things, staffing issues. With continual updates to the assessment required under the vague language of the rule, the costs associated with this overly burdensome piece of the Final Rule will increase rapidly.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in LANSING, MICHIGAN, this 18th day of October 2024.



David Herbel

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF KARI THURLOW FOR LEADINGAGE MINNESOTA**

I, Kari Thurlow, declare as follows:

1. I am Kari Thurlow. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President and CEO of LeadingAge Minnesota which is a state trade association that has operated for over 57 years with over 1,100 mission-driven aging services providers, including 239 nursing homes.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services's ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. Among the members of LeadingAge Minnesota are Halstad Living Center and Spring Valley Living. These and our other members are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.
5. The significant and irreparable harm that the Final Rule imposes on our members and other Minnesota nursing home providers as a group will be especially severe in rural and underserved areas of the state. The imposition of this rule is based on flawed and incomplete data, lacks evidence-based

justification, and will exacerbate existing workforce shortages, leading to devastating consequences for both providers and residents.

6. **Insufficient Evidence and Data**. The formulation of the Final Rule is grounded in data that fails to accurately reflect the realities of staffing in nursing homes. The use of nursing home Payroll Based Journaling ("PBJ") data does not account for the specific periods during which staff are working, leading to a misleading understanding of compliance with staffing requirements. For example, using the scenario of a nursing home that has three registered nurses ("RNs") working 8 hours of dayshift coverage each day, but no overnight coverage would be reflected in PBJ as meeting 24-hour RN coverage, when in reality they are not. Furthermore, the Abt Associates' *Nursing Home Staffing Study* explicitly states that no set number of staff can guarantee quality care, given the varying needs of residents and providers.

7. **Enhanced Facility Assessment**. The Final Rule's facility assessment requirement implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. These assessments also require "continuous" updates as well as including staff input either directly or via staff representation. However, there isn't adequate guidance within the Final Rule to state what how many types of representatives, or how many different staff representatives from different unions are required to meet the minimum requirements for the facility assessment facility, thereby creating

confusion with complying with the requirement and putting the nursing home at risk of noncompliance. The enhanced facility assessment imposes significant burden on our members' staff, diverting valuable time away from direct resident care to maintain continuous updates for compliance. Halstad Living Center is a prime example of this overly burdensome cost without benefit to residents. It has spent over $10,000 on administrative costs to date, over double the CMS estimated compliance cost for the requirement, in staff time alone in their attempt to comply with the new requirement but do not know if its attempt will be found compliant or not. These are for initial costs and do not include any costs associated with the issue of achieving compliance with "continuous" updates to the new facility assessment. We and our members are concerned about the lack of clear guidance on critical aspects of the assessment, such as what constitutes "continuous" updates or how to effectively "consider" feedback from residents, families, and staff. These vague and arbitrary definitions could result in providers, despite acting in good faith, being unfairly penalized through Civil Money Penalties during complaint investigations or annual surveys.

8. **Exacerbation of Workforce Shortages.**

The Final Rule imposes a 24/7 RN requirement and minimum staffing ratios for other direct care roles that are unattainable for our members given the current workforce crisis. The result of the Final Rule is clear, almost every nursing home will need to "hire more staff" at a time when those qualified

and licensed healthcare professionals do not exist and are not currently in the pipeline to exist. Per the LeadingAge New York data analysis Minnesota needs an additional 169 RNs and 806 nursing assistants ("NAs") to meet the minimum staffing ratios. However, these estimates are based on CMS's flawed data analysis on 24/7 RN coverage, and we know the number of RNs needed are significantly higher due to PBJ data not reflecting actual shifts worked. Our state is also facing an aging workforce and declining nursing program graduates, with 27% of the state's 133,000 RNs, or roughly 36,000 actively licensed RNs, planning to retire by 2027.[1] This is occurring at the same time as the state is only producing approximately 3,900 graduates yearly from Minnesota professional nursing programs who preparing for active registered nurse licensure.[2] Implementing the Final Rule without a sufficient workforce pipeline for the entire healthcare continuum will force our members and other providers in the state to make difficult choices, engaging in wage wars with other health care providers that are unsustainable and for many, impossible to win, or simply enacting closures or reductions in services in order to meet staffing ratios. To complicate matters, the ability to hire any licensed healthcare professional includes licensed

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[1] Minnesota Board of Nursing, *2023 Nursing Workforce Data Report* (Apr. 2024), available at https://mn.gov/boards/assets/2023_Workforce_Data_Rpt_tcm21-512309.pdf (last accessed Sept. 18, 2024).

[2] Minnesota Board of Nursing, *Annual Nursing Education Program Report: Calendar and Fiscal Year 2023* (Apr. 2024), available at https://mn.gov/boards/assets/2023_Annual_Educ_Rpt_tcm21-616787.pdf (last accessed Sept. 18, 2024).

practical nurses ("LPNs"), not just RNs, is a current crisis. In Minnesota, we know from our industry surveys nursing homes are actively searching for 1,474 RN job applicants.[3] There are an additional 3,000 RN job openings within the state.[4] The harm of the Final Rule extends beyond our nursing homes. The nursing workforce crisis cuts across the entire health care system, and this mandate will force further scarcity in the health labor market, robbing patients in hospitals and other clinical settings of nursing services when and where they are desperately needed just to provide 24-hour RN monitoring at a nursing home with no clinical need for it.

9. **One-Size-Fits-All Approach**. The Final Rule dangerously treats all nursing facilities as though they have identical needs, regardless of their size, location, or the complexity of care they provide. This blanket approach fails to recognize that in many smaller or rural settings, the demand for an RN presence around the clock is not only unnecessary but impractical. Licensed practical nurses, who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards NA or RN ratio time for the 3.0 hours per resident per day ("HPRD") requirements exacerbating staffing shortages and leaving facilities with even fewer options for care. While CMS finalized the total staffing hours to include LPNs to count

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[3] Long-Term Care Imperative, *LTC Imperative Survey* (Jan. 2024).

[4] Minnesota Department of Employment and Economic Development, *Job Vacancy Survey – Registered Nurses, Licensed Practical and Licensed Vocational Nurses, Nursing Assistants*, available at https://apps.deed.state.mn.us/lmi/jvs/Results.aspx (select SOC Code 291141) (last accessed Sept. 18, 2024).

towards 0.48 HPRD, this limited inclusion is inadequate, arbitrarily forcing providers to eliminate use of LPNs. Our members and other nursing home providers in the state employ roughly 3,000 LPNs who are particularly vital to the daily operations of nursing homes in rural parts of Minnesota who because of the Final Rule may find their situations and roles changed as CMS discounts their contributions to direct care.[5]

10. **Financial Burden and Unfunded Mandate**. A financial analysis conducted by LeadingAge New York and based on federally required cost reporting and PBJ data estimates this mandate will cost Minnesota nursing home providers $75 million in the first year, or an average of $216,968 per nursing home, to comply with the Final Rule. Each Minnesota nursing home provider, including our members, will be impacted by this unfunded mandate. This amount is based up on the current prevailing wage for nursing staff in Minnesota, and does not take into account the hyper wage inflation and temporary staffing agency price hikes that will inevitably occur if this staffing mandate is allowed to take effect in Minnesota. Minnesota nursing homes would be expected to find and fund the $75 million despite almost 60% of all nursing homes nationally struggling with a negative operating margin.[6] In Minnesota, we know from our recent survey addressing the topic that the

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[5] LeadingAge Minnesota, *Member Data Survey* (2024).

[6] CliftonLarsonAllen LLP, *CMS Proposed Staffing Mandate: In-Depth Analysis on Minimum Nurse Staffing Levels* (Sept. 2023), available at https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/CLA%20Staffing%20Mandate%20Analysis%20-%20September%202023.pdf (last accessed Sept. 18, 2024).

reality facing Minnesota nursing homes was alarming—the reported average negative operating margin was -5.6% in the second quarter of 2023.[7] The impacts to nursing home operations and reductions in resident access to cares because of the pandemic and the continued failure to provide adequate reimbursement for cares cannot be understated. Those two concepts' effects became apparent with the public health emergency starting in 2020 with nursing homes either reducing capacity to levels available staffing levels could safely support or closing altogether. To date, Minnesota has watched dozens of nursing homes close, and almost all of them in rural areas of our state. At current levels, and before or without any Final Rule minimum staffing standards, our state is likely to see more reductions in access to skilled nursing care soon. The Final Rule's minimum staffing requirements without adequate funding to achieve those requirements is unconscionable. LeadingAge Minnesota represents a significant amount of small, rural, and stand-alone nursing homes who will not be able to absorb this cost year after year as they continue to rely on historically underfunded Medicaid reimbursement and serving seniors in their communities who can already ill afford the escalating cost of the care they need. This estimated cost includes the costs for both employing new staff and using contracted nursing agency workers. Nursing homes will incur substantial costs, potentially requiring

[7] LeadingAge Minnesota, *Member Data Survey* (2024).

them to rely on contracted nursing agencies, which are significantly more expensive.

11. **Additional Unaccounted For State Financial Burdens.** Minnesota is unique in the area of nursing home staffing costs as a result of its Nursing Home Workforce Standards Board. This recent development from the 2023 legislative session impacts our members and all nursing homes within the state.[8] The enabling statutes require the board to establish minimum nursing home employment standards, which the board has interpreted to include minimum wages for specific nursing home worker roles including licensed practical nurses, trained medication aides, certified nursing assistants, as well as all other staff (i.e., dietary, housekeeping, maintenance, etc.).[9] These state-level wage increases for two of the three roles required by the Final Rule will occur twice, and potentially up to three times, before the Final Rule's implementation date for rural Minnesota nursing home providers. Again, as with the Final Rule, the board standards are not being directly funded ahead of their implementation. The wage costs for providers will be

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[8] Minnesota Department of Labor and Industry, *Nursing Home Workforce Standards Board*, available at https://www.dli.mn.gov/about-department/boards-and-councils/nursing-home-workforce-standards-board (last accessed Sept. 19, 2024).

[9] Minnesota Department of Labor and Industry, *Expedited rules to establish initial minimum nursing home wage standards, Expedited rules to establish minimum nursing home employment standards for pay during holidays; certification criteria for worker organizations; and notice requirements*, available at https://www.dli.mn.gov/about-department/rulemaking/nursing-home-workforce-standards-board-rulemaking (last accessed Sept. 19, 2024).

recouped via the state Medicaid reimbursement rate that in Minnesota comes between 15 to 21 months after the expenditures have occurred. This delay in the reimbursement rates results from Minnesota's value-based reimbursement statutes that require expenditures first that are later incorporated into reimbursement rates. The Final Rule minimum staffing standards not only add to this "deficit spending" by our members but have added to their uncertain fiscal and operational futures.

This financial strain, coupled with limited and inadequate Medicaid reimbursement rates, will push many providers to the brink of closure, and likely beyond, particularly in rural areas where operating margins are already razor thin.[10] The federal government has allocated only $75 million across all states for nursing program tuition reimbursement and scholarships, a fraction of what is needed. This cost burden of the Final Rule will not only fall on providers and private pay residents but will also fall on Minnesota taxpayers because the monthly average number of Medicaid recipients served in nursing homes during fiscal year 2023 was 11,335 with a state share cost of the Medicaid spending of $437.9 million.[11]

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[10] *See* Medicaid and CHIP Payment and Access Commission, *Estimates of Medicaid Nursing Facility Payments Relative to Costs* (Jan. 2023) available at https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-Payments-Relative-to-Costs-1-6-23.pdf (last accessed Sept. 18, 2024).

[11] MN House Research, *Nursing Facility Reimbursement and Regulation* (Dec. 2023) available at https://www.house.mn.gov/hrd/pubs/nfreimb.pdf (last accessed Sept. 18, 2024).

12. **State Prohibitions on Recapturing Expended Funds**. Minnesota, along with one other state in the nation, has since 1976 had a state statute known as rate equalization that applies to nursing homes. Under this law, our members and other Minnesota nursing homes must provide equal services to residents regardless of payor source and cannot charge private paying residents more (or less) than the rate paid by the State of Minnesota under its Medicaid program.[12] Third-party payors are exempt from rate equalization and have typically set their third-party rates at the average private pay rate, or because that rate is equalized with the State of Minnesota Medicaid set rate, their third-party rate is practically the same as the state Medicaid reimbursement rate. Nursing homes in Minnesota do not have the ability within their own rates to supplement their revenues, and those rates of third-party payors benefit only the third-party and not the nursing home. Therefore, any concepts such as the Final Rule's unfunded mandate that does not also provide State of Minnesota or federal funding is detrimental to our members and other nursing home providers' fiscal situation. It puts them further at risk of being forced to reduce expenditures in other operational areas (e.g., capital investments or resident programming that have beneficial effects on staff and residents alike) or consider other actions to reduce operational costs (including on staffing levels) thereby

[12] MN House Research, *Nursing Facility Reimbursement and Regulation* (Dec. 2023) available at https://www.house.mn.gov/hrd/pubs/nfreimb.pdf (last accessed Sept. 18, 2024).

impacting the ability or community members able to be served in the nursing home. While almost every other state can overcome such fiscal situations by supplementing their Medicaid reimbursement rates via private paying residents or other third-party payors, that is not the case for Minnesota. Any requirements that increase operational costs whether regulatory or otherwise, cannot be recovered by our members or other nursing homes in the state without the State of Minnesota setting higher Medicaid reimbursement rates. Despite all of this, CMS has pushed this unfunded mandate forward without evidence-based data to justify a sweeping rule that will have devastating consequences on availability and access to nursing home care that will cause nursing home providers to reduce the number of residents they accept and services they provide to be compliant with it.

13. **Increased Risk of Care Deserts, Closures and Lack of Access**. The number of seniors in our state is rapidly growing. Minnesota is now the home to over one million older adults.[13] 60,000 Minnesotans will turn 65 every year through 2030, when over 20% of our state population will be made up of older adults.[14] Seventy percent of adults aged 65+ will require long-term services and supports in their lifetime, with 28 percent of them receiving at least 90

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[13] *See* Minnesota State Demographic Center, *Minnesota's Aging Population and Disability Communities* (Jan. 8, 2022), available at https://mn4a.org/wp-content/uploads/2022/03/Minnesotas-Aging-Population-and-Disability-Communities-SBrower2022.pdf (last accessed Sept. 18, 2024).

[14] Minnesota State Demographic Center, *Aging - Key Findings* (Oct. 13, 2023), available at https://mn.gov/admin/demography/data-by-topic/aging/ (last accessed Sept. 18, 2024).

days of nursing home care.[15] In 2023, persons aged 65+ made up 32% of residents in counties outside of the seven-county metropolitan area where they comprised 19% of that urban population.[16] Those percentages will continue to increase as the inevitable occurs—our state's population is getting older, and that acceleration is happening more quickly in rural areas of the state. Nearly 18% of Minnesota counties have only one nursing home providing services for the county's residents.[17] Rural counties account for roughly 30% of all nursing homes but accounted for the majority of nursing homes closed between 2012 and 2021.[18] Looking at the more recent closures, twenty-six of Minnesota's nursing homes have closed since 2020, including eight in 2022 and six in 2023, with two closures currently in process and around 10% of nursing homes indicating that they are considering closure or

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[15] Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *What is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports* (April 3, 2019), available at https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0 (last accessed Sept. 18, 2024).

[16] Healthy Minnesota Partnership & Minnesota Department of Health, *2023 Statewide Health Assessment* (Oct. 2023) available at https://www.health.state.mn.us/communities/practice/healthymnpartnership/docs/2023statewidehealthassessment-publiccomment.pdf (last accessed Sept. 18, 2024)

[17] *See* Minnesota Department of Health, *Beds per 1000 for Populations over 65 and 85, by County and Contiguous County Groups* (July 2024), available at https://www.health.state.mn.us/facilities/regulation/nursinghomes/docs/beds.pdf (last accessed Sept. 18, 2024)

[18] Minnesota Department of Health, *Rural Health Care in Minnesota: Data Highlights* (Nov. 17, 2022), available at https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf (last accessed Sept. 18, 2024).

sale.[19,20] As more closures have occurred, access to care has greatly diminished for Minnesotans needing nursing home level of care. It has become a far too common story to hear that a senior needs to leave his or her home community to get the care they need, isolating them from friends and family. And the impact extends to access to acute care as well. There have been countless news stories of hospital patients that stay in inpatient care much longer than needed because there are not available nursing homes to accept those patients. That means that hospitals have also had extended waiting times in their emergency departments and have suffered financial losses. Unfortunately, at a time when demand for services is rising, nursing homes are still financially frail due to the COVID-19 pandemic and historic levels of inflation. A recent survey of long-term care providers shows that in Minnesota, almost 10% of nursing homes have completely exhausted reserves. Simply put, the workforce crisis in long-term care communities is the worst in a lifetime. In Minnesota, there are an estimated 16,821 open caregiver positions representing 20% of our entire workforce across assisted living facilities and nursing homes.[21] These open positions affect all areas of operation, including direct care staff, housekeeping, dietary, and management roles. A recent report by KFF shows that Minnesota is second

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[19] Minnesota Department of Health.

[20] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

[21] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

only to Alaska in reporting nursing home staffing shortages.[22] And we are losing more caregivers than we can recruit, despite every effort to recruit and retain quality caregivers. Without staff, nursing homes are required by regulation to limit the number of seniors they can serve. Currently 44% of Minnesota nursing homes are limiting admissions, and the primary reason cited is insufficient staffing.[23] This staffing shortage has contributed to an ongoing, steep drop in our occupancy rates which currently is hovering around 81.8%.[24] Without a full census, facilities have insufficient revenue to cover their costs, especially those that are fixed expenses; and importantly, with insufficient revenue, facilities are also unable to provide the competitive wages necessary to recruit and retain staff. The Final Rule is likely to exacerbate already critical access to care issues, where the State of Minnesota saw a reduction over 3,600 nursing home beds since the start of the pandemic in 2020. The result of these and other factors is that the financial health of the long-term care sector is fragile. A recent survey of long-term care providers shows in Minnesota that close to 10% of nursing homes have completely exhausted reserves.[25] Based on our survey,

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[22] N. Ochieng et al., *Nursing facility staffing shortages during the COVID-19 pandemic* (Apr. 4, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/ (last accessed Sept. 18, 2024).

[23] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

[24] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

[25] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

approximately 35 additional nursing homes representing 9.7% of our state's nursing homes have indicated they may close within the next year.[26] If those fears are realized, access to care for seniors in long-term settings will be lost and bottlenecks will worsen across hospitals and other acute care sites.

14. **Harm to Professionally Licensed Practical Nurses**. The Final Rule clearly emphasizes that RNs and NAs are the key to achieving quality care. However, the Abt Associates' *Nursing Home Staffing Study* noted there was minimal differences in safety and quality when analyzing the concept of permitting LPNs to be substituted into hourly staffing minimums for compliance purposes.[27] The Final Rule excludes LPNs from all but being counted toward achieving the "additional" 0.48 HPRD staffing standard. The constant, recurring themes with the Final Rule are two-fold. They do not account for the reality facing nursing homes with respect to the current workforce labor situation. At the same time, they remove active direct care contributing, licensed healthcare professional staff like LPNs from the nursing home's ability to achieve compliance with the Final Rule unless they are treated as equivalents to NAs to achieve the additional 0.48 HPRD staffing standard requirement. As a result, many of our state's 3,000 LPNs working in nursing homes may find their situations and roles changed as

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[26] Long-Term Care Imperative, *LTC Imperative Legislative Summary* (Jan. 2024).

[27] Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023), available at https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf (last accessed Sept. 18, 2024).

federal regulators discount their contributions to the direct care of nursing home residents.[28]

15. **Increased Risk of Noncompliance**. The enforcement mechanisms tied to the Final Rule, including Civil Money Penalties ("CMPs") and the potential for termination of provider agreements, are based on data and survey processes prone to human error and misinterpretation. Our members are gravely concerned by the risk of noncompliance, even when they are making good faith efforts to meet the standards. This risk is unacceptably high and further guarantees money needed to meet these regulations will be clawed back from providers attempting to provide quality care to residents. This presents another strain on our provider members' resources and burdens their operational capacity.

16. **Waivers and Exemptions**. CMS has set the minimum staffing standard to be comprised of specific employee classifications to achieve its desires for quality resident cares within nursing homes. However, the standard selected is an ineffective tool that CMS' own commissioned analysis shows does not guarantee a safe health care environment or quality level to achieve optimum patient outcomes.[29] Currently, ten Minnesota nursing homes cannot meet the current 8-hour/7-days per week RN standard as reflected by their federally

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[28] LeadingAge Minnesota, *Member Data Survey* (2024).

[29] Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023), available at https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf (last accessed Sept. 18, 2024).

approved waivers to the requirement. Compliance with the Final Rule that is triple the current one without any changes to improve the current labor situation via it is improbable. And yet, nursing homes would still have to find RNs to comply with the other RN/NA HPRD standard requirements to not be at risk of noncompliance or face termination from the Medicare or Medicaid programs for regulatory compliance failures. The Final Rule exemption process would determine workforce availability using data from the Census Bureau and Bureau of Labor Statistics. LeadingAge notes, however, that the Bureau of Labor Statistics data reports on the number of employed nurses in an area, not the number of nurses with appropriate qualifications who are available to be employed. A nursing home may be in an area with a high concentration of nurses but unless these nurses are looking for employment, they are little good to a nursing home seeking to hire staff. True availability of the workforce must be considered when determining eligibility for waivers and exemptions. Our analysis using the Final Rule's instructions to calculate eligibility for exemptions reflects that less than 14% of all nursing home providers in Minnesota will be eligible for the RN exemptions. Those that may be eligible are limited to the most northern and the most rural parts of the state. The Final Rule's waivers and exemptions have additional problems. According to CMS, a nursing home is required to be found deficient and receive a deficiency citation before being eligible to apply for a hardship waiver. This situation negatively impacts the nursing home, its Nursing

Home Care Compare ratings, and its reputation. Additionally, to be approved for either a waiver or exemption, the nursing home would have to demonstrate "good faith efforts" to "hire and retain" nursing staff. It is almost impossible to align new and developing worker desired workplace benefits like flexible scheduling, four-day work weeks, self-scheduling, etc. that are currently the distinguishing hiring factors between various industries' employment practices that meet CMS requirements. There would be difficulty with continually updating and maintaining these employee-desired hiring trends and incorporating any of them into a continually amended final rule or other regulatory guidance to nursing home providers. Additionally, CMS has yet to clearly address the issue of "how much" spending is enough to avoid regulatory noncompliance or provide clear guidance on what a "good faith effort" for hiring and retaining staff is. These examples of lack of clarity with the Final Rule, add to the detriment of it and presents more strain on our provider members' resources and burdens their operational capacity.

17. **Conclusion**. The effects of the Final Rule will impact the entire acute and post-acute care spectrum from hospitals to skilled care. In the worst scenario it will drive more development of post-acute rehabilitation entities that only exist for profit-driven rehabilitation purposes—driving such business out of nursing homes—and reducing revenue streams from our members and other nursing homes providers. While not guaranteed but extremely likely to occur because of the Final Rule, the ability of our member nursing homes to care

for current levels of residents will be reduced. Individuals will be forced to choose between the option to "stay at home" longer without receiving needed skilled cares or relocating to a nursing home farther away—if an opening is available. These individuals will likely be exacerbating their chronic and other conditions leading to increased resident medical complexity if or when the person is admitted to a nursing home or worse to the emergency department of their nearby hospital. When combined with the continued depopulation of rural locations and the lack of available and willing workforce the Final Rule will "deepen" the crisis we are in, not improve it. The Final Rule is fundamentally flawed and will cause substantial harm to our nursing home providers, their residents, and their communities, particularly in rural and underserved areas. It is essential to the continued operation and provision of care by our members that the Final Rule is not enforced and be vacated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Minneapolis, Minnesota, this 15th day of October 2024.

Kari Thurlow

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF WILLIAM B. BATES FOR LEADINGAGE MISSOURI

I, William B. Bates, declare as follows:

1. I am William B. Bates. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the Chief Executive Officer for LeadingAge Missouri, a membership association for 125 Missouri aging services providers, including nursing homes. In addition to managing the association, I assist members with state and federal regulatory compliance and advocate for public policy that improves the delivery of aging services.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. The members of LeadingAge Missouri ("LA MO") are mostly non-profit, mission-driven aging services provider organizations with religious affiliation. LA MO exists to advance the missions of its provider members through collective advocacy, education, and services. The association represents 44 nursing homes in urban and rural areas, which collectively offer 5,437 beds to Missourians throughout the State. LA MO member nursing homes range in size from 3 to 408 beds. More than 95% of total member beds are certified by CMS for service reimbursement by Medicare or Medicaid and, therefore, are subject to CMS rules.

5. Nursing Home Downsizings and Closures

a. In Missouri today, nursing homes face two significant challenges that threaten their survival: 1.) Maintaining sufficient workforce and 2.) Securing payments sufficient to cover the cost of nursing home care. Workforce shortages and insufficient reimbursement for nursing home services have caused LA MO member nursing homes, and other nursing homes in Missouri, to reduce the size of their nursing homes or to close facilities altogether. Thirty-four Missouri nursing facilities have closed in recent years; many more have downsized. LA MO members, and other nursing homes in Missouri, are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult, if not impossible, to meet.

b. The Final Rule requires certified nursing homes to have a registered nurse ("RN") on site 24 hours every day and to meet or exceed 3.48 Hours Per Resident Day ("HPRD"), including a minimum of .55 RN HPRD and 2.45 nurse aide HPRD. The Final Rule neither calls for nor is accompanied by funding to assist nursing homes in financing the cost of the Final Rule's required staff expansion. According to CMS collected data, the additional average cost of the Final Rule's implementation for each of Missouri's nursing homes is more than $500,000. From a staffing perspective, every certified Missouri nursing home, on average, will be required to hire 2-3 additional Registered Nurses ("RN") and more than five additional Certified Nursing Assistants ("CNA"). Few Missouri nursing homes can absorb these labor expense additions. Moreover, the Missouri healthcare labor pool does not have enough RNs and CNAs to fill vacancies at healthcare providers, which makes the cost of recruiting RNs and CNAs expensive.

c. Approximately 65% of Missouri nursing homes residents are covered by Medicaid. Missouri's Medicaid program has historically reimbursed nursing homes at rates below their cost of caring for Medicaid residents. Accordingly, Missouri nursing homes operate on razor thin margins. Insufficient reimbursement plus substantial expenses associated with maintaining a sufficient workforce in a challenging labor market – including the exorbitant expense of temporary staff to meet staffing requirements and the substantial cost of staff recruitment – have caused Missouri nursing homes, including LA MO members, to downsize or close and left many more in financial peril. The unfunded staffing requirements of the Final Rule, and the financial penalties associated with violating it even with a good faith attempt to comply, will force many Missouri nursing homes, including LA MO members, to downsize or close.

6. Fewer High Quality Nursing Home Beds

a. The Final Rule will have a negative effect on the availability of high-quality nursing home care in Missouri. Twenty-six LA MO provider members are Life Plan Communities (also known as Continuing Care Retirement Communities). Life Plan Communities ("LPC") provide multiple levels of residential and healthcare services - including skilled nursing facilities - on a campus or within a building. LA MO LPC members have consistently operated nursing facilities rated highly by CMS' 5-Star Quality Rating System - typically 4 or 5-Star facilities. In addition, Missouri LPCs traditionally make their high-quality nursing home beds available to residents of both their LPC and residents of the broader public community in which the LPC is located.

b. A LA MO member LPC, John Knox Village, in Lee's Summit, Missouri downsized its 5-Star rated, 430-bed nursing home to 121 beds due mostly to the inability to hire sufficient staff, but due also to below-cost-of-care reimbursement for Medicaid and Medicare services. While the smaller nursing home allows John Knox Village to meet the needs of its LPC campus residents, few of its high-quality beds are now available for the benefit of the broader public community. This result challenges John Knox Village's non-profit mission of service to older adults and it reduces access to high-quality nursing home care in the local community. This example represents an operational decision many LA MO LPC provider members are making. Across Missouri, LPCs are downsizing their nursing facilities due to staffing shortages and insufficient reimbursement. Moreover, even with Missouri Medicaid reimbursement rate improvement, because of the Final Rule's higher staffing requirements, LPC members are declining to add back certified nursing home beds (upsize previously downsized facilities). The Final Rule's costly requirements are thwarting the natural instincts of mission-driven nursing home providers.

7. Too Few Nurses For Final Rule Compliance

a. A financial analysis of CMS data indicates Missouri nursing homes will require an additional 1,377 RNs and 2,599 Certified Nursing Assistants (CNAs) to comply with the 3.48 minimum staffing ratio in the Final Rule. Further, in addition to the overall facility staffing requirement, Missouri nursing homes must employ an additional 227 RNs to meet the Final Rule's 24/7 RN requirement. There are not enough RNs or CNAs in Missouri today, or expected in the near future, to meet these mandates.

b. Missouri does not track or report nurse vacancies in nursing homes. However, the Missouri Hospital Association (MHA) regularly captures and reports nurse employment data. In its 2024 Workforce Report, MHA states there are 6,934 vacant nurse positions in Missouri hospitals, yielding a staff nurse vacancy rate of 15.6%. MHA characterizes this rate as a historically high statistic that highlights a structural challenge for Missouri's nursing workforce.

c. The Missouri State Board of Nursing ("BON") reports that Missouri nursing homes employ 10,683 of Missouri's licensed nurses (all categories) and that 81% of all licensed nurses are employed in nursing. The BON states that very few nurses report unemployment and that there is a limited supply of nurses in Missouri to meet current demand. Demand for nurses will rise over the next decade as the population of older adults increases in Missouri and in nursing homes. Today, nursing homes are unable to hire a sufficient number of RNs - especially in rural areas. The Final Rule will exacerbate the deficit.

d. In the absence of nursing home RN vacancy rate data, if one applies the comparable hospital nurse vacancy rate to nursing home nurse employment, there are approximately 1,667 open nurse positions. Today, nursing homes are expending considerable resources to fill these nurse vacancies but are largely unsuccessful due to challenging labor market conditions. There are currently too few Missouri nurses to fill healthcare provider needs. And in the intense competition for nurses, hospitals are advantaged by the ability to pay higher wages and to offer nursing work less taxing than in nursing homes. Most nursing homes cannot compete for nurses based on wages because most nursing homes are in dire financial straits due to below cost

Medicaid reimbursement for the majority of their residents. Nursing homes, currently unable to fill 1,667 open nurse positions (all licensed nurse categories), will not be able to hire 1,604 more RNs in current market conditions to meet the Final Rule RN staffing requirements.

e. If the nursing student pipeline were strong, there would be cause for optimism about filling current RN vacancies and meeting the requirements of the Final Rule. But Missouri nursing schools are reducing class sizes and turning away qualified students (1,221 in 2021) due to a lack of nurse educators and fewer nursing school applicants. MHA reports that applications to MO community college nursing/allied health programs are down 50% from prior years and MO high school graduation rates are declining. More critical, Missouri nursing programs need 64 full time faculty to accommodate qualified nursing student applicants. In addition, 98 nurse educators are expected to retire within 3-5 years. And the BON reports the average age of Missouri nurses is 45, with more than 30% of nurses over age 55. Consequently, even more nurses will be needed in the near future to fill positions open due to retirement. The nurse shortage is going to get worse before it improves. The nurse pipeline, already failing to deliver enough nurses to fill current nurse vacancies, is not going to improve in time for nursing homes to hire enough nurses to meet the requirements of the Final Rule.

f. Equally distressing, large numbers of nurses quit during the COVID pandemic and have not returned to nursing. Short staffing fuels burnout among those who remain. Nurses already average more than 40 hours per week. With increasing nurse retirements from an aging nurse workforce, increasing nurse departures due to short

staffing burnout, and increasing nurse transition driven by market competition, it's no wonder the rate of nurse turnover is historically high. Turnover fuels workplace stress, which furthers the vicious cycle that is producing a nursing shortage crisis. Nursing home operators cannot comply with the Final Rule in this labor market.

g. LA nursing home members in both urban and rural communities are experiencing Missouri's tight labor market for nurses. Bethesda Health Group, a multisite long term care provider organization in St. Louis, Missouri offers competitive RN wages and benefits plus a $25,000 signing bonus but is still unable to fill RN vacancies. At Pine View Manor in rural Stanberry, Missouri (population 1,146), the Administrator struggles to retain a RN for the required 8-hour day shift. RNs are unavailable locally for night and other shifts or for backup RN staffing. Pine View must resort to expensive staffing agencies when RNs are unavailable. The same is true at the Baptist Home Tri-County in rural Vandalia, Missouri (population 2,974). Competition for nurses with the area hospital and finding RNs willing to care for nursing home residents at acuity levels that don't require RN education and training have made staffing an 8-hour shift difficult and makes staffing additional shifts impossible.

8. One-Size-Fits-All Is A Costly Wrong Approach

a. Decades ago, Congress codified two staffing requirements for nursing homes that participate in the federal Medicare and Medicaid programs. Congress first directed nursing homes to use the services of a registered nurse for at least eight consecutive hours per day, seven days a week. Second, nursing homes must provide 24-hour

licensed nursing services sufficient to meet the nursing needs of residents. This simple, flexible approach allows nursing homes of different sizes and different locations with varying healthcare labor pools to meet the needs of residents with different levels of acuity.

b. The Final Rule dangerously treats all nursing homes as though they have identical needs and residents – regardless of nursing home size, location, or complexity of care provided. Even the Abt Associates 2022 Nursing Home Staffing Study – that CMS offers in support of its Final Rule – stated that no set number of staff can guarantee quality care, given the varying needs of residents and providers. The Final Rule essentially sets an arbitrary threshold for quality care.

c. This blanket approach in the Final Rule fails to recognize that, while nursing homes caring for residents with high acuity may need high levels of staffing, nursing homes caring for residents with low acuity – indeed, most nursing homes – do not need high staffing levels. The Final Rule ignores that in many smaller or rural settings in Missouri the demand for an RN's presence around the clock is not only unnecessary but impractical and unfeasible. And the cost of hiring and maintaining unnecessary RNs and more CNAs will cause many nursing homes to downsize or close. Both Pine View Manor and the Baptist Home Tri-County attest to this. Both nursing homes have RN and physician 24/7 on-call access to augment on-site Licensed Practical Nurses (LPN) and CNAs. However, neither rural nursing home admits residents needing 24/7 RN care and both represent they will close if 24/7 RNs are required and LPNs are not counted toward the licensed nurse requirement.

d. The Final Rule also wrongly diminishes the important contribution of Licensed Practical Nurses in long-term care. Licensed Practical Nurses ("LPNs") deliver vast amounts of caregiving across Missouri - more than a third of all Missouri LPNs are employed in long-term care. At nearly 60% of the long-term care workforce, LPNs are vital to Missouri nursing homes. The Final Rule's diminution of the LPN critical role in nursing homes is unconscionable and will contribute to nursing home downsizing and/or closure.

e. The Final Rule's rigid ratios do not count LPN care toward either RN or CNA ratio time. This will have the effect of forcing LPNs out of nursing homes and exacerbating staffing shortages and leaving facilities with fewer options for care. While the Final Rule counts LPN time toward the .48 HPRD, this limited inclusion is inadequate, arbitrarily forcing nursing facilities to eliminate the use of LPNs. LA MO nursing home members and others in Missouri rely heavily on LPN labor availability and skills to provide high quality and safe care to residents. Diminution of the LPN's role in Missouri nursing homes and the overall reduction of the available caregiver workforce appropriate for long-term care facilities like Pineview Manor and the Baptist Home Tri-County will hasten their downsizing and/or closure.

9. Enhanced Facility Assessment

a. The Final Rule's Enhanced Facility Assessment adds multiple new compliance requirements for certified nursing homes, which make the Final Rule overly burdensome and costly.

b. The facility assessment provision of the Final Rule requires a nursing home to

"conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually."

c. More specifically, the Final Rule requires annual or "as necessary" assessment of:

    1) Resident population - including overall required care based on all residents; staff competency & skill; physical environment; and resident personal factors that may affect care.

    2) Resources – including all buildings, equipment, services provided, personnel, third-party contracts for services, and technology; and

    3) Risk -utilizing an all-hazards approach.

d. If that were not enough, the Final Rule sets forth in detail how the facility assessment must be undertaken. It requires "active involvement" of specified people, including all care staff, leadership and management – including a member of the governing body - and third parties, like resident representatives and family members. The Final Rule then requires the facility assessment be used to inform or support specific decisions, actions, and plans set forth in the Rule. It is a micromanaging, comprehensive evaluation over and above care requirements and assessment tools already in place to ensure quality care.

e. LA MO nursing home members have characterized the time, effort, and expense associated with attempting to comply with the Final Rule's Enhanced Facility Assessment as excessive, redundant, and burdensome – even "ridiculous." Members are also concerned about the cost of compliance – both in financial terms

and in terms of the impact on care. The Final Rule is diverting already overworked care staff from caregiving in order to conduct and document the detailed facility-wide assessment. With tight budgets, the extra cost of compliance reduces funds available to enhance the overall residential quality of life – beyond critical, mandatory caregiving. The Final Rule's Facility Assessment requirements diminish the "home" in nursing homes, making the setting more institutional.

f. Moreover, the Final Rule requires the assessment to be reviewed and updated "as necessary." This is a vague, undefined requirement raising member concerns about being fined for failing to comply "as necessary" and about the cost of what is now necessarily constant review and updating to avoid such fines. Members also share compliance uncertainty about the burdensome requirement of "active involvement" of numerous enumerated participants. Members are concerned they will be unable to capture information from those not affiliated with the nursing home.

g. Overall, the Enhanced Facility Assessment is a redundant, time-consuming, costly, confusing, care diverting, regulatory overreach – the potential benefits of which pale in comparison to the burden and cost of compliance.

10. **Counterproductive Waivers and Exemptions**

The waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for LA MO members and other providers. Providers must navigate separate, complex processes to demonstrate need, with the potential for penalties or exclusion from the exemption they are seeking. These processes are unlikely to provide meaningful relief and may, in fact, discourage providers

(including LA MO members) from seeking necessary exemptions, further increasing the risk of noncompliance, service reductions and closures.

11. Conclusion

The Final Rule is causing substantial harm to LA MO nursing home providers, the residents of those providers, and the communities served by these providers – particularly in rural areas of Missouri. For legal, financial, and practical reasons the Final Rule should not be enforced and should be vacated to ensure the continued operation and delivery of care to Missouri citizens who need nursing home care.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Jefferson City, Missouri, this 17th day of October 2024.

William B. Bates

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF KIERSTIN REED FOR LEADINGAGE NEBRASKA**

I, Kierstin Reed, declare as follows:

1. I am Kierstin Reed. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of the Declaration if called upon to do so.

2. I currently serve as the President & Chief Executive Officer of LeadingAge Nebraska, a statewide trade association supporting nursing home and other providers of long term care services for over 50 years.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Instructional Payment Transparency Reporting,"89 Fed. Reg. 40,876 (the "Final Rule").

4. LeadingAge Nebraska represents 47 nursing home providers. Our membership largely consists of non-profit organizations or nursing homes operated by local governments. Among our members is Florence Home, a 126 bed nursing home located in Omaha, Nebraska, established in 1906. Our members are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

5. The final rule will impose significant and detrimental impacts to long-term care providers in Nebraska.

a. Nebraska is already facing a severe shortage of healthcare workers, particularly in long-term care settings. According to the 2022 Biennial Report from the Nebraska Center for Nursing, Nebraska has experienced a decrease of 9.5% in the nursing workforce when compared to 2019. The Nebraska RN workforce shortage will increase by 30% between 2020 and 2025. The workforce shortage for LPNs will also increase by 25% during this same period.

b. Long-term care settings experience a more severe healthcare workforce shortage in Nebraska. According to the 2022 Biennial Report from the Nebraska Center for Nursing, only 6.3% of RNs in Nebraska report working at a nursing home, furthering the shortage of nursing staff they are able to recruit or retain to work in this setting.

c. Rural nursing homes in Nebraska, which include many of our members, will be disproportionately affected by these staffing standards due to low workforce availability. There are already 19 out of 93 counties in Nebraska that have no nursing home due to an insufficient workforce availability. Nine of these counties (Arthur, Deuel, Grant, Hayes, Keya Paha, Logan, Loup, McPherson, and Sioux) have no RNs working in them and three counties (Banner, Blaine, and Wheeler) have only one RNs working in them. The remaining seven counties have limited nursing workforce availability.

d. Nebraska nursing homes are already relying on temporary staffing agencies to maintain their current census and meet their individualized staffing metrics. It is estimated that an average of twenty percent of staffing in nursing homes is provided by temporary staff in Nebraska. Temporary staff costs significantly more than retaining their own employees. Increasing the temporary workforce to meet the Final Rule would be cost-prohibitive for our members and others; and could lead to lower quality of care because the staff are not familiar with resident needs on a regular basis.

e. Since 2017, Nebraska has seen the closure of forty nursing home providers, many of these being in rural areas. Today, there are only 167 dual certified nursing homes remaining in Nebraska. The population over the age of 65 is proposed to reach 30% of the total population in Nebraska by 2030. The cumulative impact of increased staffing costs, workforce shortages, and reduced flexibility are likely to force additional nursing homes, including our members, to reduce the number of people served or close their doors all together. Facility closures would leave Nebraska families with fewer options for care, requiring many residents to be displaced to facilities further from their communities and loved ones.

f. The need for staff to meet the Final Rule staffing requirements will overburden existing staff at our members' facilities and others due to

the inability to recruit and retain additional staff. Nurses and aides will be stretched thin trying to meet the requirements, leading to burnout, turnover, and reduced quality of care as a result of the pressure to meet minimum standards. It is estimated that Nebraska will need an additional 217 RNs and 304 additional nurse aides to meet the minimum standards set in the Final Rule. The estimated cost for this will be $217,589 per facility, however if they are unable to find the staff and require the use of temporary staffing agencies, the estimate could be at least twice that amount.

g. Month over month, Nebraska hospitals report over one hundred patients awaiting post-acute placement across the state. As of August 2024, the Nebraska Hospital Association Throughput Survey Report indicates there are currently 109 patients awaiting post-acute placement. Forty-two of these patients have been waiting between 30 days and six months, while twelve have been waiting over six months for placement. The Final Rule is likely to increase this number as nursing homes reduce the number of admissions in order to meet the ongoing staffing required to meet the requirement. This will create a bottleneck in the system, increase wait times for care, and force hospitals to delay discharges even further, straining the healthcare continuum.

h. The CMS minimum staffing standards impose a one-size-fits-all model on nursing homes, disregarding the varying needs and complexities of residents. The current requirements provide flexibility in staffing, which allows facilities to allocate resources effectively, ensuring that each resident receives personalized care based on their condition, rather than adhering to rigid ratios. The Final Rule does not support our Nebraska nursing homes, which all have specific populations and needs that they are currently complying with.

i. CMS anticipates the cost over ten years for Nebraska nursing home providers will be $419 million, an average of $2.5 million per nursing home. There is no corresponding increase in federal or state funding to help our facilities comply with these staffing requirements. Nearly 60% of nursing home residents in Nebraska rely on Medicaid reimbursement for these services. The Nebraska Medicaid reimbursement cannot absorb the additional costs without risking financial insolvency. Without funding, this mandate is an unfunded burden on the entire state. In anticipation of the increased cost to the state, we have already consulted the Division of Medicaid and Long Term Care in Nebraska. They indicate they cannot act preemptively to address these increased costs and will need to rely on cost reporting and appropriations from the state legislature in order to increase funding. With the implementation of the Final Rule happening in May, nursing home providers will need

to wait nearly a full year to start receiving increased payments based on cost reports. The Nebraska legislature currently does not have any intention to allocate additional funds for Medicaid nursing home care.

j. Our Nebraska nursing home members are already facing increased burdens because of the Enhanced Facility Assessment component of the Final Rule, which was put into effect on August 8, 2024. This component requires nursing homes to expand upon their already existing Facility Assessment by conducting extensive evaluation on the acuity and needs of the residents to determine staffing levels, which may be above the minimum levels indicated in the Final Rule. The additional cost per facility, including at our members, is nearly $5000 just to complete the initial assessment, with an unclear definition as to how frequently it will need to be updated. The expectation for the Enhanced Facility Assessment also requires nursing homes to collect input from staff at all levels of the organization, including contracted agency personnel or union representatives, residents and family members on staffing levels and to create contingency plans to be utilized prior to emergency staffing plans. The guidance listed in the Final Rule has not provided nursing homes with significant instruction for the Enhanced Facility Assessment, although it has already mandated compliance. The Final Rule uses vague terms such as "continuous updates" and "consider" feedback from residents, families, and staff. The arbitrary definitions

in the rule leave providers acting in good faith concerned they may not live up to the Final Rule's requirements upon review and could face Civil Money Penalties for failing to comply. The Enhanced Facility Assessment also does not take into account providers that may have very low acuity residents that may not require what is now considered the minimum staffing levels as written in the Final Rule, such as the need for a nurse to be on site 24 hours per day. Providers with lower acuity will be forced to meet the minimum requirements, even if the data in their Enhanced Facility Assessment does not justify or necessitate that level of care.

k. Our Nebraska nursing home members are currently restructuring the availability of services based on the Final Rule. To comply with the staffing requirements, some nursing homes expect they will be forced to reduce the number of residents they serve to meet staffing ratios. Nearly all have reported they will reduce the Medicare Advantage and Medicaid funded beds due to low reimbursement rates.

l. Nursing homes caring for residents with complex medical conditions are also likely to face challenges in maintaining staffing ratios due to the higher intensity of care required. These nursing homes could be disincentivized to admit such residents, resulting in a lack of adequate care for some of the most vulnerable populations in Nebraska. This will

also impact our hospital system with continued housing of those waiting for long-term care.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Lincoln, Nebraska, this 15th day of October 2024.

Kierstin Reed

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF JAMES MCCRACKEN FOR LEADINGAGE NEW JERSEY AND DELAWARE

I, James McCracken, declare as follows:

1. I am James McCracken. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President & CEO of LeadingAge New Jersey, Inc. D/B/A LeadingAge New Jersey and Delaware (LANJDE) which is a state trade association founded in 1931 and incorporated in New Jersey in 1949. LANJDE has over 140 mission driven senior living and services providers as members, including several dozen who provide skilled nursing services.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LANJDE represents over 30 nursing communities. Among our members is United Methodist Communities. This and our other members are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.
5. The significant and irreparable harm that the Final Rule will impose on New Jersey and Delaware nursing home providers will be especially sever as there

is a shortage of qualified and available staff and Medicaid reimbursement rates are inadequate.

6. Residents who reside in long-term care communities, including our members, typically rely on Certified Nursing Aides (CNA's) for assistance with activities of daily living. Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) also provide care and dispense medications. Shortages of long-term care workers existed before nursing homes were closed to visitors in March of 2020 as a result of the COVID-19 pandemic, but New Jersey's approximately 54,361 workers, as well as Delaware's, many of whom were on the front lines, continued to report to work and provide care every day during the pandemic. CNA's, who provide approximately 90% of direct care, and earn relatively low wages, had additional pressures put on them due to chronic staffing shortages. The pandemic affected them mentally and physically.

7. The New Jersey Task Force on Long-Term Care Quality and Safety (Task Force) was established in 2020 as a result of the pandemic. The Task Force met for 20 months and a final report was issued in April 2024. The report identified three central themes, one of which is that "New Jersey's long-term services and supports (LTSS) workforce is shrinking, worsening the imbalance of supply relative to the growing elderly population" and concluded that "New Jersey's direct care workforce is shrinking and cannot meet the needs of the growing elderly population."[1] My experience is that Delaware's direct care

[1] *New Jersey Task Force on Long-Term Healthcare Quality and Safety, Final Report (Apr.*

workface faces the same challenges, making staffing increasingly difficult and more expensive for our nursing communities.

8. In the Spring of 2020, in response to the growing impact of COVID-19 on nursing home residents and staff, the New Jersey Department of Health (DOH) engaged Manatt Health (Manatt) to undertake a rapid assessment of the state's COVID-19 response targeted toward the long-term care (LTC) system. "Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19"[2] was published on June 2, 2020.

9. The Manatt Report states that there were already "long-standing staffing shortages or low staffing ratios" in Nursing Homes. (See Manatt Report page 12). The report also concluded that the staffing shortage is further compounded by low reimbursement rates. For 59% of New Jersey's nursing home residents, Medicaid is the primary payer. Nursing homes are paid a daily flat fee per patient, per day. Rates vary throughout the state, but the is one common theme, the Medicaid reimbursement rate does not equal what it costs to provide care. The per diem rates to not meet actual expenses.[3]

2024), available at https://www.nj.gov/health/ltc/documents/nj-task-force-ltcquality-and-safety-report.pdf.

[2] *Available at* https://tinyurl.com/bdef3u43.

[3] *See Manatt Health, Recommendations to Strengthen the Resilience of New Jersey's Nursing Homes in the Wake of COVID-19* (June 2, 2020), *available at* https://www.nj.gov/health/mgmt/documents/A%20Manatt%20Report.pdf ("Manatt Report").

10. So, with the number of people willing to work in nursing homes declining, and Medicaid reimbursement rates inadequate, how can New Jersey's 353 nursing homes provide care for approximately 41,000 residents, approximately 0.5% of the state population? Or how can Delaware's nursing communities provide care for their residents? The short answer, they can't. They are having a difficulty hiring staff, and even more problems meeting arbitrary ratios.

11. As the Task Force concluded, "New Jersey, as with many other states, faces an acute and growing workforce challenge that raises the possibility of decreased access to services for seniors and those with disabilities and threatens the long-term viability of some LTSS providers. There is a well-documented shortage of professional and paraprofessional personnel to manage, supervise, and provide LTSS in facility-based and home care settings. This includes a shortage of nurses, social workers, direct care workers, qualified drivers, as well as leadership positions such as nursing instructors and licensed nursing home administrators (LNHAs)." "We did not get here overnight. For many years, LTSS providers have struggled to attract and retain workers because of high turnover, competition from other better-funded provider types and other market-driven sectors of the economy, ageism by younger workers, and/or poor operating culture in which employees do not feel valued or have career ladders. Unnecessary logistical and financial barriers to training and entry into the LTSS workforce further

reduce the number of available direct care workers." "Compensation in LTSS is largely predicated on third-party reimbursement. To have the ability to recruit and retain workers, third-party payment rates must provide adequate resources to allow providers to be competitive with other health care entities, as well as with other sectors of the economy that employ persons with similar skill sets."

12. "Looking to the future in New Jersey, the imbalance between the working age population and seniors needing care will only worsen. Moreover, as LTSS is increasingly shifted to HCBS, it is reasonable to expect that the total demand for LTSS workers will increase significantly as well, since HCBS care can be one-on-one in many instances." "It will be imperative that New Jersey embrace all strategies to increase the supply of workers available to LTSS. This should include an all-of-government approach, as well as public-private partnerships." (See Task Force page 51).

13. Another burden imposed on our providers by the Final Rule is the enhanced facility assessment, which requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs, despite our nursing homes already having assessment tools to ensure quality care. The Final Rule's enhanced facility assessment imposes an additional administrative burden and produces an additional financial burden.

14. The waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for our members and other providers. Providers must navigate separate, complex processes to demonstrate need, with the potential for penalties or exclusion from the exemption they are seeking. These processes are unlikely to provide meaningful relief and may, in fact, discourage providers (including our members) from seeking necessary exemptions, further increasing the risk of noncompliance, service reductions and closures.

15. **Conclusion:** There are simply not enough CNA's and other staff available to meet a federal staffing mandate in nursing communities in New Jersey and Delaware. Nursing Homes are competing with each other, home health care companies, and staffing agencies for a limited pool of people. Reimbursement rates are not adequate to meet the increasing costs of compensation and Medicaid revenue remains static. As a result, I expect to see many of our nursing communities forced to reduce the number of our senior citizens they care for or even close their doors altogether.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Hamilton, New Jersey, this 14 day of October 2024.

James McCracken

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF GARRY PEZZANO FOR LEADINGAGE PA**

I, Garry Pezzano, declare as follows:

1. I am Garry Pezzano. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President and CEO of LeadingAge PA. LeadingAge PA is an association representing more than 400 non-profit and mission-driven providers of senior services in Pennsylvania, and its membership encompasses 182 of the more than 600 skilled nursing facilities (SNFs) in Pennsylvania. Among our members operating nursing homes throughout Pennsylvania, for example, are Passavant Community (operating in Zelienople), Vincentian Home (operating in Pittsburgh), and St. Paul Homes (operating in Greenville). As President and CEO of the state association that represents these and several other mission-driven providers across the state, I am responsible for ensuring that the association's work on behalf of its members promotes a healthy vision of aging services and influences positive change for quality, affordable, and ethical care for Pennsylvania's seniors.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").

4. The Final Rule will not only harm long-term care providers financially and threaten their sustainability, but it will further reduce access and quality for older Pennsylvanians in need of care, particularly because of pre-existing workforce and underfunding challenges. It will impose an unreasonable administrative burden and contribute to severe burnout of staff for our members and other providers in the state. Because there is not a sufficient number of workers available to comply with the federal rule, providers will face additional financial impacts, which will ultimately cause our members and others to reduce services or close, further reducing access to care for older adults.

5. There is a known workforce shortage in healthcare which predated the pandemic and was further exacerbated by it. Due to the inability to hire needed workers, many providers will be unable to comply with the rule or will face a great deal of hardship to make compliance possible (often in ways that are not sustainable). As a result, providers, including our members, will face financial harm either in the form of increased costs associated with attempting to hire and retain staff or paying increased rates to temporary staffing agencies, paying penalties for deficiencies related to noncompliance with the rule for circumstances beyond their control, or facing decreased revenue as a result of having to reduce census. Citations related to staffing will also have an impact on providers' star ratings on CMS Care Compare,

which will negatively impact public perception of their nursing home and could lead to reduced revenue.

6. LeadingAge PA members, many of whom staff at higher-than-average levels to begin with, have been struggling to find the staff they need for years. The workforce crisis, particularly for aging services, existed prior to and was worsened by the COVID-19 pandemic, and has been further strained by strict application of recent state staffing standards (implemented on July 1, 2023 and increased again on July 1, 2024), which include an overall per patient day (PPD) minimum, as well as per-shift ratios for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides (NAs). As one of our members stated, "We have taken our occupancy to 75% over 2.5 years ago as staffing is our biggest challenge. Being in a rural area we have limitations for staffing and agency staffing are below par in quality and they are very expensive. I pay my people 1.2 or 2 times more when we are short but this is not sustainable. Being in a rural area our hospital has limited places to send people. We need better for our seniors, this is terrible!"

7. Since the state standards went into effect, Pennsylvania providers have been grappling with the challenges associated with prescriptive staffing standards in the midst of a workforce crisis. The experiences reflected throughout this Declaration demonstrate many of the unintended consequences these types of mandates have, and these outcomes will only be exacerbated further by

layering on the federal mandate in the Final Rule in addition to the existing state requirements.

8. Many nursing homes have had to resort to paying costly temporary healthcare staffing agencies (THCSAs) to fill open shifts when they have not been able to hire the staff they need to meet increased standards. THCSAs have continued to charge exorbitant amounts and are taking advantage of providers' inability to find the staff they need in their communities. Relying on costly THCSAs to fill these positions may create an illusion of compliance in some cases that will not be sustainable in the long-term.

9. Even THCSAs often do not have the staff necessary to fill all open positions. One LeadingAge PA member commented in our 2023 survey that (even prior to recent state staffing increases) they have not been able to secure agency staff to fill open positions for more than three years. Many of our members frequently report that even with using THCSAs and offering bonuses to in-house staff, they are still not able to adequately fill open positions. Another provider member stated that since the higher state staffing requirements went into effect, "We lost more RNs to the hospital that paid [a] sign-on bonus. We have reached out to multiple staffing agencies, but they are unable to fill our professional open positions. Our RNAC has had to fill in multiple times on the floor to cover. Staff are tired and burnt out with no relief in [sight]."

10. One Pennsylvania provider, a small 50-bed nursing home within LeadingAge PA's membership, reported a temporary staffing agency bill for the month of September 2023 alone of $114,000, a dramatic and unsustainable amount directly tied to the recently increased Pennsylvania state staffing requirements. Another of our members explained, "We have always had high staffing ratios to provide the level of care we feel the residents need and deserve however this has come at a high cost since we have been very dependent on agency. The cost of agency is very high and at times we have had to halt admissions because of staffing, and it is becoming more and more difficult to afford the high cost of agency. Also, agency staff are unreliable and many are not invested so they do not provide the high quality care that we expect from our employees."

11. The federal mandate does not include any funding to help providers meet these increased requirements. And while funding to support any staffing mandate is needed, money alone will not solve the workforce crisis, as there are many other factors at play that make this a gravely inopportune time to impose additional standards that providers will be penalized financially for being unable to comply with due to factors beyond their control.

12. Pennsylvania nursing homes, despite serving one of the oldest populations in the nation, are chronically underfunded. According to an independent report commissioned by LeadingAge PA in 2022, Pennsylvania's nursing homes were underfunded by nearly $1.2 billion in Medicaid reimbursement in 2019-

2020. https://www.leadingagepa.org/docs/default-source/advocacy-policy/rkl%27s-pa-medicaid-funding-gap-analysis-report-for-leadingage-pa.pdf?Status=Master&sfvrsn=4c52ca09_5/RKL%27s-PA-Medicaid-Funding-Gap-Analysis-Report-for-LeadingAge-PA

13. Current Medicaid reimbursement rates are nowhere near what providers need to continue operating and ensure access to care is available for those who need it, and an unfunded federal mandate will only further exacerbate the consequences we are seeing as a result of this chronic underfunding and an imperfect reimbursement system.

14. The federal mandate does not offer any support or effort to improve the workforce available to meet the demand in aging services aside from a meager $75 million investment to incentivize RNs nationwide to enter the field (only $1.5 million per state). Because there are no federal funds available to support implementation of the federal mandate, the heavy price tag to comply will fall to state Medicaid budgets and providers who are already operating at an impossible deficit.

15. LeadingAge's national office estimates that the additional yearly cost for PA providers to meet the federal mandate, as calculated in September 2024, would be $462.8 million (which averages to over $689,000 in additional annual costs per provider). The data used in that calculation was based on Payroll Based Journal (PBJ) staffing data for the first quarter (Q1) of 2024. One LeadingAge PA member, St. Paul Homes, has estimated that if

implemented, the federal staffing standards would increase their annual direct care staffing costs by approximately $725,000 including benefits. This represents about $6,000 on an annual basis per resident. St. Paul Homes also estimates an additional $50,000 annually to add administrative staff hours simply to support the management of these regulatory requirements beyond the direct care staff needed.

16. In order to comply with the federal mandate, using Q1 2024 as a baseline, Pennsylvania nursing homes would need to hire 798 additional full-time equivalent (FTE) RNs and 5,543 additional FTE nurse aides. This is problematic given that providers already cannot find the staff they need, and healthcare workforce trends are getting worse, not better.

17. According to data provided by the Pennsylvania Department of Education, Pennsylvania has seen a net loss of active nurse aides on the nurse aide registry for the past four consecutive years. In 2019, the total number of active records on the nurse aide registry at year-end was 96,020. That number has steadily declined each year thereafter and reached a low of 81,512 at the end of 2023. From December 2019 to December 2023, there was a net loss of 14,508 nurse aides in Pennsylvania, which represents a reduction of 15%. Successful implementation of the federal rule, as stated above, would require an increase of over 5,500 nurse aides. Even if the registry numbers level off in 2024, it will take a significant effort to grow the registry sufficiently to add a net increase of at least 5,500 before 2026 when

the first phase of the federal rule goes into effect.

18. Various studies have, for years now, predicted an increasing deficit in the number of healthcare workers needed to meet demand in each state. Even before the federal (or Pennsylvania) staffing standards were finalized, a shortage of nurses and nurse aides was predicted, which will be exacerbated further by the Final Rule's staffing mandates. A 2022 Bureau of Labor Statistics report[1] found that the number of RN openings is expected to outpace supply by 15,660 from 2022 to 2032, with 193,100 RN openings anticipated for each year through 2032. A 2023 analysis from NCSBN, titled "Examining the Impact of the COVID-19 Pandemic on Burnout & Stress Among U.S. Nurses"[2] revealed that 100,000 nurses left the workforce during the pandemic, and by 2027 almost 900,000, or roughly one-fifth, of the 4.5 million total RNs in the United States, intend to leave the workforce. According to the U.S. Bureau of Labor Statistics, Monthly Jobs Reports continue to show growth in healthcare jobs. The latest report[3] showed that the number of healthcare jobs increased by 71,000 in August 2024, up from 63,000 added in July 2024. Nursing and residential care facilities alone saw 16,500 of that increase. Nationwide, demand for labor continues to notably exceed supply.

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[1] *Available at* https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-6.

[2] *Available at* https://www.ncsbn.org/news/ncsbn-research-projects-significant-nursing-workforce-shortages-and-crisis.

[3] *Available at* https://www.bls.gov/news.release/pdf/empsit.pdf.

19. Even before the state or federal staffing mandates were finalized, independent reports showed concern for projected trends related to healthcare workforce in the coming years. A 2021 US healthcare labor market report[4] from Mercer listed Pennsylvania as having the largest gap in demand for RNs, predicting a need for 20,345 additional RNs by the year 2026. Pennsylvania was also in the bottom five for worst gaps anticipated for "Lower Wage Healthcare Workers," which includes nurse aides, indicating Pennsylvania will need an additional 277,711 lower wage healthcare workers by the year 2026 to account for increased demand and those leaving these jobs. The report found that while more than 6.5 million individuals will leave lower wage healthcare jobs within five years across the United States, only 1.9 million new workers will step in to fill those vacancies.

20. In more recent reports, such as the 2024 Mercer Report, Future of the U.S. Healthcare Industry: Labor Market Projections by 2028,[5] Pennsylvania fares better than many states in overall healthcare staffing outlook, however there is still a severe concern for the shortage of nursing assistants in particular, including in Pennsylvania. Even where Pennsylvania scores slightly higher than neighboring states in meeting demand for RNs and nurse aides, it will face intense competition from neighboring states who are in a worse position

[4] *Available at* https://www.mercer.com/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf.

[5] *Available at* https://www.mercer.com/en-us/insights/talent-and-transformation/attracting-and-retaining-talent/future-of-the-us-healthcare-industry/#download.

and will likely recruit aggressively across state lines to secure the staff they need as well.

21. Due to many factors, including a decreased working age population and the exacerbating effects of the pandemic, nursing facilities in Pennsylvania are already struggling to find the staff they need just to comply with the new state standards. The Final Rule's higher mandated staffing requirement at the federal level will only put additional strain on our nursing facilities to find and hire people who do not exist in the labor market. Administrative hurdles and limited access to training programs have also limited our ability to build a robust workforce, despite the willingness and desire of providers to host these career development programs.

22. Because of the recently implemented state staffing standards that are misaligned with the federal mandate, providers in Pennsylvania will have to operate at a higher standard in order to comply with both. For example, a 59-bed nursing home in PA would have to staff at a *minimum* 3.93 overall hours per resident day (HPRD) to satisfy both the state and federal requirements. This includes using two RNs to count as LPNs toward the state ratios and adding five additional nurse aides per day, and does not account for scheduling logistics and staff preferences that likely would result in an even higher overall HPRD. For most census levels, providers in Pennsylvania will need to operate at a minimum 3.79 to comply with both state and federal requirements, and in reality most will need to be much higher because

staffing at the exact ratio using partial shifts is often not realistic (e.g., the state ratio may only require 3.44 LPN FTEs on the day shift, but in reality staff are not willing to come in for a partial shift and the provider will have to pay for a full shift by rounding up to 4 FTEs).

23. Despite working to increase training opportunities and employ other strategies to meet new state staffing standards implemented on July 1, 2023, our member providers and others in the state have been unable to recruit and train needed staff despite their best efforts, and these challenges will not go away when the Federal Rule is implemented beginning in 2026.

24. In addition to the above cost considerations and lack of available workers, older adults and those requiring long-term care services will ultimately be harmed by the Final Rule as well, because access to care will be further threatened as a result of high quality providers having to downsize, close, or sell to owners who are less quality-driven. One member explained, "We have the space to provide care to many more people who need it. Unfortunately, we do not have the funds to support opening the beds at this time. We are no longer competing for staff with just other healthcare organizations. Retail and food service are paying more than we are able to and they aren't taking care of the most vulnerable people in our population."

25. In order to comply with state-level ratios that went into effect in July 2023 (and increased again in July 2024), our member providers and others in the

state are having to even further reduce their census to stay in compliance with per-shift ratios because the required staff simply do not exist.

26. In Pennsylvania, there have been at least 27 nursing home closures since the pandemic started (i.e., over the last four and a half years), including among our members. There was also a statewide reduction of 2,963 certified nursing beds. Both of these decreases have continued on this dramatic downward trend over the past year at a remarkably higher rate than pre-pandemic shifts. This data also does not account for the additional loss of beds that many of our provider members and others still have licensed but are currently not filling due to ongoing funding and workforce challenges. For context, since February 2014 (i.e., over the last ten and a half years), there have been at least 34 nursing home closures in PA, and a loss of 3,457 certified nursing beds. This means that 79% percent of the reduction in available nursing homes over the last decade has happened within the last 4.5 years, and 86% of the certified beds that have come offline since 2014 have been delicensed within the last 4.5 years.

27. The alarming pace of closures and sales we are seeing already in Pennsylvania as a result of the pandemic and the recent state staffing mandate serves as a cautionary tale for what is to come if additional standards are imposed by the federal Final Rule. In many cases, our providers' only option to remain in compliance is to pay unsustainably high rates to THCSAs and/or overtime and bonuses to in-house staff (which also

contributes to burnout), reduce the nursing home's census (thereby limiting the number of beds available for older adults who need them), sell their facility to a larger, often out-of-state for-profit company, or cease operations altogether.

28. Providers in PA, including our members, have already been forced to limit census due to workforce and funding challenges, contributing to hospital backlogs and limiting access to care. When census is reduced, wings are shut down, or entire facilities close, the community and broader healthcare network ultimately suffer because hospitals can no longer find available beds to discharge their patients to for short-stay rehabilitation or long-term care.

29. According to PHC4 publicly reported hospital data, patients in the top 15 largest hospitals in Pennsylvania who were awaiting discharge to a nursing home experienced an increased average length of stay (ALOS) from 9.7 in 2020 to 11.3 in 2023. This increase of nearly 2 days spent in the hospital (compared to those discharging to their home whose ALOS remained steady) supports the anecdotal reports we've been hearing that hospital social workers are having a harder time finding available nursing beds, and nursing homes are having to refuse admissions from hospitals.

30. With multiple healthcare settings (e.g., hospitals, home care, hospice, physicians' offices, etc.) all competing for similar types of staff, an additional increase in requirements for nursing homes will also result in staffing challenges for these other settings as providers compete more heavily for the

limited labor pool available. In most cases, nursing homes are at a disadvantage in this competitive labor market as insufficient reimbursement rates often leave them unable to compete aggressively with salaries and benefits offered by other settings, or even entry level non-healthcare jobs.

31. As a result, it will be difficult or impossible for providers to qualify for a waiver and exemptions for the Final Rule if they are not able to demonstrate they've offered "prevailing wages" in their geographic region in an attempt to recruit needed staff. The option for obtaining a hardship waiver, as described in the Final Rule, appears to be very limited in scope and requires providers to jump through several hoops in order to qualify. Many of our members, and others, who are genuinely struggling likely will still not be eligible for a waiver and will waste valuable staff time and resources submitting an application only to have it ultimately denied.

32. There does not appear to be any stated exemptions available for reasons other than workforce-related hardships. There are many valid reasons a nursing home may be better-served by a staffing pattern that is not fully aligned with the federal mandate (let alone a federal mandate coupled with a prescriptive state mandate), and obtaining a waiver or exception through the current process is often ineffective and overly cumbersome. Providers are supposed to staff according to resident needs and preferences as identified through the Facility Wide Assessment. Notably, recently updated state regulations now require Pennsylvania providers to conduct a Facility Wide

Assessment at least quarterly. This frequent review of an assessment meant to direct staffing needs should be enough to justify whether a nursing home is staffing appropriately or not, yet there is no provided recourse for facilities to receive an exception to the Final Rule if their Facility Wide Assessment indicates the need for a staffing pattern that does not align with the requirements in the Final Rule.

33. The Final Rule's enhanced facility assessment, implemented on August 8, 2024, is in itself also imposing an additional burden on our member providers. The rule fails to clarify expectations regarding the requirement to include input from residents, resident representatives, and family members, particularly if these parties are not interested in participating despite the nursing home's efforts to involve them. Furthermore, the cost and workforce challenges associated with pulling direct care staff from the floor to participate in this process can be unnecessarily burdensome for many providers, as are the contingency planning requirements which are largely duplicative of existing requirements for emergency planning.

34. For one LeadingAge PA member, a small (less than 50-bed) nursing home located in Bucks County, Pennsylvania, the Nursing Home Administrator (NHA) felt tremendous stress and the burden of the time required to implement the enhanced Facility Assessment requirements in her community. This time and stress took away from her ability to spend time with her residents and focus on other quality-drivers for the community. This

NHA shared several of the challenges she faced in implementing these requirements: "Since CMS is offering no template, the templates available vary. And what information is entered into the template varies as well. A colleague shared her completed version of The Compliance Store template and she completed some of the sections very differently than I did. Gathering the data for the document was painful. I used many different resources but that was also extremely time consuming. Especially for me since 2/3 of our population is short term rehab. For example, the section on ADL level of assistance over a period of time was challenging because our population changes so frequently." Additionally, the requirements for involving different levels of staff are confusing and impractical. As this NHA explained, "I shared a draft of the document with a few nurses and CNAs. They were overwhelmed with the document. I got very little feedback. And I sent out a text msg to my families asking for input- nothing in return. And I asked for input from resident council- no feedback from residents. There is a tremendous amount of vagueness to the facility assessment. And I can't imagine the surveyor reading through the entire document. And how will the surveyor be judging the content since each facility assessment may be very different?"

35. Another LeadingAge PA member, Vincentian Home, shared the added costs they have faced in implementing the enhanced Facility Assessment requirements: "We have looked at the effort to comply with the revised

Facilities Assessment report, which included 15 different persons within our organization cutting across various disciplines and aggregating to more than 120 hours. Even if we back down and attribute some of that effort to existing PBJ requirements, we can still defensibly identify 90 hours. At a modest rate of $35/hour, it's a material investment of limited resources already stretched thin." Similarly, another LeadingAge PA member, Passavant Community, estimated at least 65 hours of staff time were required to come into compliance with the enhanced Facility Assessment requirements.

36. As another LeadingAge PA member located in Allegheny County stated: "Updating our assessment to meet the 8/8/24 requirements [the enhanced Facility Assessment requirements in the Final Rule which went into effect on August 8, 2024] required several weeks of intense work by multiple leaders to ensure our policies complied with the results of our assessment. We also faced barriers with the vagueness of new Facility Assessment requirements. It was problematic to determine what level of resident and staff involvement was necessary to meet the regulations and what questions should be asked on our questionnaires."

37. The Final Rule's staffing mandate would lead to more closures and would force many providers to take additional beds offline. If providers are unable to meet the established staffing minimum, even if it is only slightly higher than their current staffing levels, they will be forced to close beds or face paying a penalty. While an increased staffing minimum may benefit a few

residents at select poor-performing facilities operating below that threshold, many more residents at our members' facilities and elsewhere will face disruption as their current home reduces services, is sold, or wings are shuttered. This mandate would further limit the ability of high-quality providers to serve the growing aging population and force closures or sales to entities with poor track records.

38. Pennsylvania's demographic trends show a rapidly growing senior population who will be in need of the care and services that skilled nursing facilities provide. But instead of increasing capacity, providers are *decreasing capacity* in response to a lack of funding and a lack of workforce. In a February 2024 survey of LeadingAge PA members assessing the state of access to care and staffing since the increased state staffing requirements went into effect in 2023, 48% reported they have had to decline potential hospital admissions within the last 2-3 months (despite having licensed beds available). 77% had to use temporary agency staff to fill open positions, and as a result of reducing census to help comply, nearly one in four licensed beds were not in use. The use of temporary agency staff is not a sustainable solution for many reasons in addition to the exorbitant costs. As one of our members described, "Agencies don't even always have staff to send, or they just no show to their shift. This directly impacts our residents. Some agency staff are good, but most of the ones we get have no loyalty to our company and are just here to punch a timeclock. They have no investment in our residents and reputation

and cut corners because what can you do about it? Would love to see more funding and support for caregivers. Where do they think the elderly will go when places have to close?"

39. In a similar survey in October 2023, respondents shared that on average, 1 in 4 care staff in a nursing home (including nurse aides, LPNs, and RNs) were from a temporary staffing agency.

40. As of October 2023, 51.9% of survey respondents had to self-limit their census (despite having licensed beds available) to comply with new state staffing ratios. On average, respondents had 23.6% of their beds offline, with some as high as 60.0%.

41. October 2023 survey respondents also reported that 25.5% had experienced increased turnover among nurse management positions (e.g., Director of Nursing, RNAC, Nurse Scheduler, etc.) since the new state staffing requirements went into effect. 41.2% reported an increase in turnover of direct care staff compared to turnover rates before the state staffing increase.

42. In October 2023, 62.8% of survey respondents reported that they would have to further reduce their census if a federal staffing mandate is added in addition to existing state ratios in PA. 15.7% reported they would have to cease operations or sell their facility.

43. Beyond the inability to hire needed staff and additional costs imposed by the Final Rule, our providers will be negatively impacted by the toll it takes on existing staff and facility leadership. In Pennsylvania, many high-quality

providers had to resort to a substantial amount of overtime hours from existing staff, including nurse management (e.g., Registered Nurse Assessment Coordinators, Directors and Assistant Directors of Nursing, Nurse Schedulers, etc.), in order to comply with the state requirements in the absence of available workers. While this may help achieve compliance in the short-term, it has resulted in extreme burnout and causes many dedicated healthcare workers to leave the field altogether.

44. Our members experience a significant administrative burden for facility leadership and scheduling teams in managing schedules that adhere to very prescriptive staffing standards. Those in charge of scheduling nursing services personnel at each nursing home are overly stressed and burnt out from working to ensure 100% compliance with a prescriptive staffing mandate. In addition to direct care staff burning out and leaving the field, administrative and scheduling managers are experiencing burnout and leaving the industry as well. We're already seeing this happen in Pennsylvania as a result of the state staffing mandate, and it will only get worse if a federal mandate is implemented as well.

45. When staff are burnt out, or forced to schedule in ways that are not necessarily best-aligned with resident need but instead are compliant with arbitrary standards, residents ultimately suffer because quality levels actually are reduced, which is counterintuitive to the stated intention of the

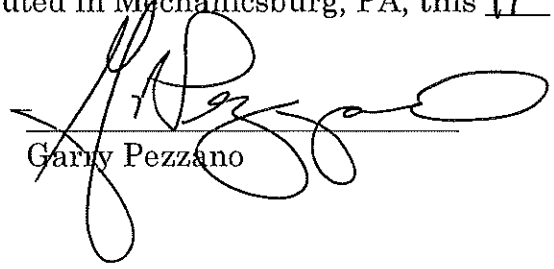
Final Rule (which was stated to be to improve safety and expand access to affordable, high-quality care).

46. As an association, the Final Rule will directly harm LeadingAge PA by infringing on the ability of our members to advance aging services and quality of care for seniors in Pennsylvania, which is central to our mission as an advocacy-driven non-profit association. When our members are overburdened with administrative efforts and expenses to comply with requirements that are misaligned with the needs of their residents, and in many ways impossible to comply with, they are unnecessarily penalized and limited from being able to advance the evolving continuum of aging services in Pennsylvania. The incoming influx of older adults needing care and services, coupled with the workforce crisis that was exacerbated by the COVID-19 pandemic and has not yet recovered, will require innovation and creative solutions from mission-driven experts in the field, such as those leaders of our member organizations and our association's in-house staff. Instead of focusing on those innovations and advancements in care models and technology that will improve services and access for older adults, we are all instead wrestling with unfunded and impossible mandates. Furthermore, when our members struggle financially, especially to the point of reducing their census or closing altogether, our association's revenue is reduced by way of decreased membership dues, and we are further limited in our ability to positively impact the field of aging services per our mission. Decreased

revenue will put at risk the many programs and opportunities we provide to support aging services in Pennsylvania, including education, leadership development, scholarship and grant opportunities, and initiatives like our Careers to Love campaign which serves to recruit and attract workers to the aging services workforce. A reduction in our membership would further harm members and their ability to operate by impacting our ability to secure lower rates through group purchasing and insurance programs. Additionally, a decrease in member dues could also jeopardize LeadingAge PA's ability to hire and retain qualified internal staff at a time when our team would also need to focus on increased costs and staff time in helping our members navigate and understand the vague requirements of this rule, as referenced above, and in helping them appeal or fight unwarranted citations for things out of their control or when surveyors inappropriately apply the vague or subjective elements of the rule.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Mechanicsburg, PA, this 17th day of October 2024.



Garry Pezzano

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF STEPHEN D. BAHMER FOR LEADINGAGE SOUTHEAST

I, Stephen D. Bahmer, declare as follows:

1. I am Stephen D. Bahmer. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President & CEO of LeadingAge Southeast, an association of senior living providers in Florida, Alabama, Louisiana, and Mississippi. I am responsible for the leadership and management of the association, including advocacy on behalf of our nursing home members. That advocacy has and continues to include a focus on reimbursement and workforce challenges faced by our nursing home members and efforts to resolve those challenges.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LeadingAge Southeast represents 115 nursing communities across four states: Florida, Alabama, Louisiana, and Mississippi. In that capacity, LeadingAge Southeast provides legislative and regulatory advocacy, professional development and education, managed care and nursing home quality consulting, group purchasing, networking, and many other services.

LeadingAge Southeast has been the premier association for senior living providers in Florida since 1963, and across the Gulf Coast region since 2022, after affiliating with the former LeadingAge Gulf States and LeadingAge Alabama. Our nursing home members are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

5. The Final Rule will have a severely negative effect by limiting access to high quality nursing home care. With the current shortfall of nurses and the outlook worsening in the future, this proposal is not realistic. The education system cannot meet the current demands. The added demand that this rule creates will dramatically increase scarcity, with ripple effects throughout the entire healthcare system.

6. Nursing homes that are unable to meet minimum staffing standards will be forced to deny admissions, take beds offline, or close the nursing home altogether. This will mean that individuals who are no longer safe at home will have nowhere to go and individuals in need of post-acute care after hospitalization will either be stranded in the hospital, occupying valuable acute care beds needed for other individuals, or they will be forced to be discharged back home without the skilled nursing care that they need. Hospitals often encounter challenges when attempting to discharge residents in the current environment.

7. The rule imposes an unfunded mandate. In the case of Medicaid rates in particular, those rates have long been insufficient to cover the cost of providing care. The current work force shortages, COVID, and other inflationary pressures on wages are only exacerbating and exposing an already problematic reimbursement shortfall. Because of low Medicaid reimbursement rates, nursing homes were never able to compete on wages with the hospitals, and that calculus has only gotten worse. The annual cost of the rule's implementation is estimated to be $225.7 million in Florida, $61.1 million for Alabama, $184.4 million in Louisiana, and $55.5 million in Mississippi. The average cost per provider across the states is over $385,000 annually. The rule did not allocate any funding to cover those additional costs.

8. With Medicaid accounting for over 60% of the residents in member states' nursing homes, additional Medicaid funding will be necessary for nursing homes to comply with higher staffing requirements. This may have impacts on other components of the state budget and could lead to cuts to other Medicaid services. The minimum staffing requirements have a disproportionately negative impact on high Medicaid nursing homes. Like many other states, Florida, Louisiana, and Mississippi law already require minimum staffing standards in nursing homes. Adding an additional Federal measure on top of the state-specific requirements adds additional

unnecessary complexity. States should have the authority to institute regulations that are most appropriate for their unique demographics. Finally, this rule will increase costs for all nursing home patients, not only for Medicaid recipients. Increased costs may make needed nursing services unattainable to those who do not have an insurance benefit that covers the services.

9. The Final Rule is already imposing costs and burdening our nursing home members through its enhanced facility assessment. They are having to divert hours of staff time to administrative work that has vague requirements as to how they are to consider the views of staff and residents and their families and how often updates to the assessment are necessary. Because of the level of detail required, the time and staff needed to create and maintain the enhanced facility assessment is extensive and expensive. The enhanced facility assessment results in professionals diverting their attention away from direct resident care and focusing on paperwork compliance.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Tallahassee, Florida, this 18th day of October 2024.

Stephen D. Bahmer

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF KASSIE SOUTH FOR LEADINGAGE SOUTH CAROLINA**

I, Kassie South, declare as follows:

1. I am Kassie South. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President & CEO of LeadingAge South Carolina. LeadingAge South Carolina is an Association that represents 30 non-profit mission driven skilled nursing communities in South Carolina. These communities include Presbyterian Communities of South Carolina, Lutheran Homes of South Carolina, The Woodlands at Furman, Wesley Commons, Westminster Towers, Bishop Gadsden Episcopal Community, Saluda Nursing & Rehabilitation, The Cypress of Hilton Head, Park Pointe Village, The Seabrook of Hilton Head, Rolling Green Village, South Carolina Baptist Ministries of Aging, and Still Hopes Episcopal Retirement Community.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Service's ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule"). I have communicated with many of LeadingAge South Carolina's members about the Final Rule and the burdens that it will or already has imposed on them.

4. The Final Rule will significantly increase the costs, make staffing incredibly difficult if not impossible, and compromise the care provided by LeadingAge South Carolina's members. Each nursing home is estimated to have to pay $550,818 to implement this mandate which will close most nursing homes. The nursing communities that LeadingAge South Carolina represents are among those that will experience these increased costs and likely be forced to close or severely limit the population they serve. For example, The Foothills Presbyterian Community located in Easley, South Carolina has had an overall star rating of 5/5 for over 4 years, indicating Much Above Average in each measure of Health Inspections, Staffing, and Quality Measures. Yet, Foothills does not have the 24/7 RN Coverage. Currently they operate with no RN's 7pm-7am, seven days a week. Despite their great efforts to recruit an RN, they have had a part-time nurse position open at night for over a year. Currently, their costs from January to July 2024 have exceeded $240,000 for agency staff to compensate for not having the staff they require. Foothills is an exceptional community providing Above Average Care indicated by their Overall Star Rating and Staffing Rating, yet they will not be able to continue to operate with the 24/7 RN requirement. These residents who are receiving exceptional care will be forced to move out of the home they love and receive care somewhere else. The Final Rule will impact South Carolina residents more generally. The cost of the rule's implementation in South Carolina alone is estimated to be over $104-104-684 per year, with no funding allocated from

the federal government aside from $75 million across all states for nursing program tuition reimbursement and scholarships.

5. Our members will be unable to obtain the workforce necessary to meet the standards in the rule. There is an insufficient nursing workforce pipeline to achieve the standards outlined in the Final Rule.
    a. According to our national affiliate South Carolina needs an additional 411.29 RNs and 1,170.75 Nursing Assistants to meet the minimum staffing ratio provision in the Final Rule. That's in addition to the current **8,148** RN job openings and **4,984** LPN job openings in South Carolina in June 2024, per the South Carolina's Nursing Association.
    b. In December 2022, the US Health Resources and Services Administration (HRSA) updated their healthcare workforce supply and demand projections. The model predicts a national shortage of 78,610 full-time equivalent (FTE) registered nurses (RNs) by 2025 and a shortage of 63,720 FTE RNs by 2030.
    c. South Carolina is projected to have the 10th largest shortage in the US by 2035, behind Washington, Georgia, California, Oregon, Michigan, Idaho, Louisiana, North Carolina, and New Jersey.
    d. Previous HRSA projections predicted that South Carolina would have the 4th worst shortage in the US by 2030

e. According to the South Carolina Workforce Publication on Nursing, 53% of RN's work in hospital settings, whereas only 4.4% of RN's work in long-term care. Nursing home providers are already at a disadvantage in this labor market and this rule will have a cascading effect on the whole health care system including state agencies and state hospitals.

f. In the Final Rule, CMS increased the total staffing hours from 3 to 3.48 to include LPNs, who now count for 0.48 hours. However, limited funding is prompting providers to reconsider the effectiveness of using LPNs versus RNs, given LPNs contribute to only a fraction of the required hours.

6. The Enhanced Facility Assessment is currently causing harm to our members to implement and sustain. The Final Rule's enhanced facility assessment, implemented on August 8, 2024, imposes a significant burden on member facilities and others in the state. The nursing homes were already in compliance with an existing facility assessment, and the enhanced facility assessment requires the facilities to undertake additional financial and administrative burdens that are unnecessary to achieve quality of care. For example, Wesley Commons staff have spent hours weekly updating the Facility Risk Assessment, creating a new Facility Risk Assessment policy and going back through policies to ensure compliance with the requirements effective August 8, 2024. Executives, direct care staff, family members, board

members, and the facility assessment team have had to spend an additional 48 hours to review documents and ensure compliance. Wesley Commons had to change two Licensed Practical Nurse positions to Registered Nurse positions to meet the requirements which have increased cost by $14,560 not including weekend and night shift differential pay. The previous facility assessment showed that their acuity level did not justify these positions needing to be filled by Registered Nurses and that Licensed Practical Nurses are fully capable of caring for their residents. They had to reinstate two full-time certified nursing assistants positions effective October 1, 2024 to meet the hours per resident day requirements. Wesley Commons had put a hold on these positions because they were meeting state and federal requirements previously without them, but they had to reinstate them due to the Final Rule costing them an additional $66, 560 per year. Due to the Final Rule and the need for additional staff, that are not needed yet being required, they have had to increase pay to retain and recruit staff. This increase is costing an additional $164, 428 per year starting October 1, 2024. The enhanced facility assessment imposes hours upon hours of additional administrative work which takes away valuable time the staff can be serving residents. The enhanced facility assessment requires continuous updates and the administrative cost continues to build rapidly and produce an additional financial burden.

7. The waiver and exemptions for the Final Rule are unachievable and therefore cannot be relied upon by LeadingAge South Carolina's nursing communities.

    a. The waivers and exemptions require a survey process to demonstrate that the facility cannot meet the requirements. Our current annual survey by the South Carolina Department of Public Health is behind by 19-24 months currently. Facilities would be monetarily penalized if they don't meet requirements for exemptions. For example, the Florence Presbyterian Community did not receive their annual survey for 23 months. If they submitted a waiver under the Final Rule and had to wait almost 2 years to get a survey to determine they meet the waiver requirements, they would have to cease providing care for almost 2 years or risk financial penalties. The patients will have to receive care elsewhere during the lag of time for state surveyors due to the workforce shortage of South Carolina surveyors.

    b. The provider would have to demonstrate they've offered prevailing wages in their geographic region – comparative to other facilities such as private hospitals. This will lead to increased price gauging to try and attract staff away from hospitals, who are also struggling with workforce burdens. For example, South Carolina Baptist Ministries of Aging paid over 1.25 million dollars in 2022 to staffing agencies and has paid $500,000 this year to staffing agencies thus far in 2024 ahead of the Final Rule. They have not been able to staff in their community

for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants despite continuous recruiting efforts, working with educational systems, and utilizing every resource available to try and find staffing. Wesley Commons, a community in Greenwood, SC, has had to pay double their rates to a staffing agency to get staff to work. The Final Rule will force these communities to close their skilled nursing offerings because it is financially unsustainable to pay staffing agencies these high rates to meet the mandate. The table below shows the staffing agency hourly rate for South Carolina:

Service	4+ Week Assignment Rate	Per Diem / Travel Rate
RN	$65	$75
LPN	$50	$55
CNA	$33	$40

The Woodlands at Furman has had to raise their pay rates by over 20% in the past 12 months and they are still competing with private hospital systems who are continuously raising their rates to compete. These staffing mandates will create a market where our skilled nursing facilities will have to limit their offerings and shut their doors to elderly people who need care.

8. This Final Rule will lead to more closures and have unintended consequences of reducing access to care for South Carolina – especially in rural areas of the state.

a. Since the start of the pandemic, South Carolina has seen facilities close or reduce their offerings because of workforce shortages. Rolling Green Village in Greenville, South Carolina had to make the difficult decision of decertifying 48 of their skilled nursing beds for residents who needed short term rehabilitation care. These residents came to Rolling Green Village from the hospital systems, assisting the continuum in meeting older adults needs while allowing hospitals to utilize their beds for residents who need acute care. With the increased burdens of Medicare regulations and increased staffing requirements they had to decertify 48 short term rehabilitation beds. The cost burden of recruiting, retaining, and adding additional staff, especially during a workforce shortage, has now resulted in less beds available in Greenville and the surrounding area for elders who need subacute rehabilitation services post hospitalization.

b. By 2036, the 65+ population in South Carolina will grow by over 250,000 people, and more, if people continue to move to South Carolina for retirement living. Who will be around to care for them if more facilities close?

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Mount Pleasant, South Carolina, this 18 day of September 2024.

Kassie South, CEO

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF GWYN EARL FOR LEADINGAGE TENNESSEE**

I, Gwyn Earl, declare as follows:

1. I am Gwyn Earl. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the executive director of LeadingAge Tennessee. We are a nonprofit association representing all areas of long-term care in the state, and are part of the national association, LeadingAge. We have been serving long-term care providers and the seniors they serve, for the past 35 years. We have approximately 50 members with over 40% being nursing homes.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. LeadingAge Tennessee represents 22 nursing communities. Our members are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet. Additionally, the waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for our members and other providers.

5. The Final Rule will impose significant burdens on the providers in this state, many being in rural areas. A financial analysis conducted by LeadingAge New York and based on cost reporting and Payroll Based Journaling data estimates this mandate will cost each Tennessee provider, including our members, an average of $528,763.62 per year. This amount is based on the current prevailing wage for nursing home staff in Tennessee, and does not take not account the wage inflation and huge temporary staffing agency price hikes that will continue to occur. There are 306 licensed nursing homes in the state and because of the mandate, these nursing homes will have to hire an additional 541 FTE nurses and 2,123 FTE nursing aides. One of our members, the Ocoee Foundation, manages 13 nursing homes in the state, mainly in rural areas, giving care to some of our frailest seniors. They anticipate not being able to keep all their facilities open if this final ruling takes place. Who will care for their seniors then? This rule dangerously treats all nursing facilities the same, regardless of their size, location, or complexity of care they provide. This blanket approach fails to recognize that in many smaller or rural settings, such as with many of the Ocoee Foundation facilities, the demand for an RN's presence around the clock is not only unnecessary but impractical. Licensed Practical Nurses, who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards the RN ratio time. This will exacerbate the staffing

shortage we currently have and is simply a very poor, unwise, unfunded, mandate.

6. The Enhanced Facility Assessment imposes a huge burden on our member facilities and others in this state. The assessment in the Final Rule requires our providers to take on additional administrative burden that is completely unnecessary to ensure a high level of resident care. It has other requirements that will cause our facilities to do extra work without clear and defined explanations. The requirement to create a contingency plan is asking facilities to duplicate work, again causing a great unnecessary administrative burden. This truly imposes many hours of additional work on the facilities and subjects them to vague requirements that could result in steep civil penalties. The enhanced facility assessment imposes a significant burden on our members' staff, diverting valuable time away from direct resident care to maintain continuous updates for compliance. We also feel the CMS estimated cost for the assessment of $4,955 per facility is far below what it will actually cost. Additionally, we are greatly concerned about the lack of clear guidance on critical aspects of the assessment.
7. The finalized minimum staffing rule, in its current form, is fundamentally flawed and will cause substantial harm to our nursing home providers, their residents, and their communities, particularly in rural and underserved areas. It is essential to the continued operation and provision of care by our members that this rule is not enforced and be vacated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Knoxville, TN this 30th day of September 2024.

Gwyn E. Earl
Executive Director, LeadingAge Tennessee

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF MELISSA ANDREWS FOR LEADINGAGE VIRGINIA**

I, Melissa Andrews, declare as follows:

1. I am Melissa Andrews. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.

2. I currently serve as President/CEO of LeadingAge Virginia which is a state trade association that has operated for over 50 years with over 90 not-for-profit and mission-driven aging services providers, including 46 nursing homes.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule" or "the rule").

4. Among the members of LeadingAge Virginia are Our Lady of the Valley and Summit Square. These and others we represent are being harmed by and will continue to be harmed by the Final Rule because of the significant costs and onerous staffing requirements that are difficult if not impossible to meet.

5. The significant and irreparable harm that the Final Rule imposes on Virginia nursing home providers will be especially severe in rural and underserved areas. The imposition of this rule is based on flawed and incomplete data, lacks evidence-based justification, and will exacerbate existing workforce shortages, leading to devastating consequences for both providers and residents.

6. **Insufficient Evidence and Data**: The formulation of the rule is grounded in data that fails to accurately reflect the realities of staffing in nursing homes. The use of Payroll Based Journaling (PBJ) data does not account for the specific periods during which staff are working, leading to a misleading understanding of compliance with staffing requirements. An example would be a nursing home that has three Registered Nurses (RNs) working 8 hours of dayshift coverage each day, but no overnight coverage. On paper it would reflect they are meeting 24-hour RN coverage, when in reality they are not. Furthermore, the Abt Associates 2022 Nursing Home Staffing Study explicitly states that no set number of staff can guarantee quality care, given the varying needs of residents and providers. A financial analysis conducted by LeadingAge New York, based on cost reporting and Payroll Based Journaling data, estimates this mandate will result in an exceptional total cost to all Virginia nursing homes of $234,601,068 which translates to an average cost of $811,768 per year for each Virginia provider, including our members. This amount is based on the current prevailing wage for nursing staff in Virginia and does not take into account the hyper wage inflation and temporary staffing agency price hikes that will inevitably occur if this staffing mandate is allowed to take effect in Virginia. Despite this, CMS has pushed this unfunded mandate forward without evidence-based data to justify a sweeping rule that will have devastating consequences on availability and access to nursing home care as increased costs without any corresponding financial support or access to adequate pools of nursing staff will cause providers to reduce the number of residents they accept and services

they provide.

7. **Enhanced Facility Assessment**: The Final Rule's enhanced facility assessment, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their nursing home, residents, staff, and resident families to determine staffing and other needs. This assessment imposes a significant burden on our member facilities and others in the state. The nursing homes already were subject to an existing facility assessment to consider their staffing needs. The Final Rule's enhanced facility assessment requires nursing homes to undertake an additional administrative burden that is unnecessary to ensure a high level of resident care. As part of the enhanced facility assessment, nursing homes must consider outside views, but its terms are vague as to the specific standards. In particular, the Final Rule requires nursing homes to allow for the "active involvement" of the direct care staff and their representatives and they must "solicit and consider input received from residents, resident representatives, and family members." CMS guidance as to how to incorporate or "consider" these outside parties is not available. Similarly, the Final Rule requires the nursing home to "review and update that assessment, as necessary, and at least annually." The nursing homes lack further guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties. The enhanced facility assessment also requires nursing homes to create "contingency planning," even though the nursing homes already are required to have emergency plans for, among other things, staffing issues. In total, the enhanced facility

assessment imposes hours upon hours of additional work and significant administrative burdens on the nursing homes and subjects them to vague requirements that could result in steep civil penalties. The staff hours and costs associated with the enhanced facility assessment may vary widely by each nursing home.

Our Lady of the Valley and Summit Square represent typical members of LeadingAge Virginia. Both currently have a CMS 5-Star Rating. CMS created the 5-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which you may want to ask questions. The CMS Nursing Home Care Compare website features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-Star rating for each nursing home, and separate ratings for health inspections, staffing and quality measures. The staff hours required for the initial establishment of the enhanced facility assessment ranged from 32 hours to 120 hours. The estimated cost for each time they must update the assessment ranges from $1,800 to $9,000.

With continual updates to the assessment required under the vague language of the rule, the costs associated with this overly burdensome piece of the staffing mandate rule quickly spiral. We will also note that the significant staff hours required to maintain this assessment are hours taken away from administration and direct

resident care that are actually necessary for quality and safety.

8. The minimum staffing ratios also outlined in the Final Rule require nursing homes to ignore the same variability inherently recognized in the enhanced facility assessment in resident acuity and needs across different settings by establishing arbitrary thresholds for quality care. Some nursing homes with higher acuity residents may need increased staffing, while others with lower acuity residents may not require a 24/7 RN presence. Requiring nursing homes with such lower acuity residents to maintain higher staffing than needed substantially increases the nursing homes' costs without a corresponding increase in quality of care or life for residents. Our Lady of the Valley and Summit Square are examples of overly burdensome costs without benefit to residents. The Final Rule will require these nursing homes to incur additional administrative burdens and to divert resources to unnecessary staff rather than toward necessary operating expenses or actual enhancements to resident experience. The harm extends beyond our nursing homes. The nursing workforce crisis cuts across the entire health care system, and this mandate will force further scarcity in the health labor market, robbing patients in hospitals and other clinical settings of nursing services when and where they are desperately needed just to provide 24-hour RN monitoring at a nursing home with no clinical need for it.

9. The enhanced facility assessment imposes significant burden on our members' staff, diverting valuable time away from direct resident care to maintain continuous updates for compliance. CMS estimates the cost of the enhanced facility assessment to be around $4,955 per nursing home, which is likely to be much lower

than the actual cost. In the Final Rule, an enhanced facility assessment is required of all nursing home facilities and the expectations of the assessment include evaluating the acuity and needs of the residents to determine staffing levels, collecting input from staff including but not limited to contracted agency personnel or union representatives, collecting input from residents and their families, and creating a contingency plan to be utilized before an emergency staffing plan is needed. We and our members are concerned about the lack of clear guidance on critical aspects of the assessment, such as what constitutes "continuous" updates or how to effectively "consider" feedback from residents, families, and staff. These vague and arbitrary definitions could result in providers, despite acting in good faith, being unfairly penalized through Civil Money Penalties during complaint investigations or annual surveys.

10. **Increased Risk of Care Access**: Demographic projections indicate that Virginia's population is both aging and becoming more diverse. According to the Virginia Department for Aging and Rehabilitative Services, nearly 1.9 million of Virginia's 8.6 million residents are currently aged 60 or older. By 2030, this figure is projected to rise to 2.2 million. If nursing homes close or reduce their capacity, the state's ability to provide necessary care will be severely strained. Our Lady of the Valley, one of our member nursing homes located in Roanoke, Virginia with a bed capacity of 70, has demonstrated exceptional quality of care and services, as evidenced by its 5-Star rating awarded by CMS. This rating signifies that Our Lady of the Valley consistently provides much above-average care in terms of staffing,

quality measures, and health inspections, placing it among the highest-quality nursing homes available to older adults. Despite this recognized excellence, the newly proposed CMS Staffing Rule significantly threatens their ability to maintain their current level of quality. Under these new standards, they would, on average be unable to meet the RN minimum staffing requirements 79% of the time and would fall short of the Nursing Aide (NA) minimum standard 92% of the time. The financial burden imposed by compliance with the new staffing requirements would be substantial, amounting to $379,269 in additional costs during the first year alone. As a not-for-profit organization, this is a significant hardship that would likely lead to layoffs and a reduction in the array of services that can be provided to residents. Moreover, this rule would result in a decrease in their star rating, negatively impacting their reputation and ability to serve the people in their care and the community. Compliance challenges could also force the closure of their Medicaid beds, further reducing access to care at a time when the population of older adults in Virginia is rapidly increasing. Our Lady of the Valley's inability to offer adequate services would be detrimental to both its residents and the broader community that relies on it for high-quality, compassionate care.

11. **Exacerbation of Workforce Shortages**: The rule imposes a 24/7 RN requirement and minimum staffing ratios that are unattainable for our members given the current workforce crisis. Virginia needs an additional 694 RNs and 2,891 NAs to meet the minimum staffing ratios. However, these estimates are based on CMS's flawed data analysis on 24/7 RN coverage, and we know the number of RNs

needed are significantly higher due to PBJ data not reflecting actual shifts worked. The state is also facing declining nursing program admissions and an aging workforce, with roughly 27% of RNs aged 55 or older and nearing retirement. Nursing homes are already at a disadvantage in the labor market, where hospitals employ 49% of RNs compared to 3% in long-term care settings. Implementing these staffing mandates without a sufficient workforce pipeline for the entire healthcare continuum will force our members and other providers in the state to make difficult choices, engaging in wage wars with other health care providers that are unsustainable and for many, impossible to win, or simply enacting closures or reductions in services in order to meet staffing ratios. At least several of our nursing homes are already making staffing changes, attempting to hire additional RNs rather than LPNs, and increasing hiring efforts in preparation for the Final Rule's staffing mandates going into effect. Because of their ongoing struggles to fill open positions, they cannot wait until the mandate goes into effect to have any hope of achieving compliance.

12. **One-Size-Fits-All Approach**: The rule dangerously treats all nursing homes as though they have identical needs, regardless of their size, location, or the complexity of care they provide. This blanket approach fails to recognize that in many smaller or rural settings, the demand for an RN's presence around the clock is not only unnecessary but impractical. Licensed Practical Nurses (LPNs), who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards NA or RN ratio time, exacerbating staffing shortages and leaving nursing homes with even fewer options for care. While CMS finalized the total staffing hours

to include LPNs to count towards 0.48 hours per resident per day, this limited inclusion is inadequate, arbitrarily forcing providers to eliminate use of LPNs. Our nursing home members and others in the state employ a large number of LPNs in Virginia, relying heavily on their labor availability and skills to provide high quality and safe care to residents. LPNs are particularly vital to the daily operations of nursing homes in rural parts of Virginia.

13. **Financial Burden and Unfunded Mandates**: Estimated Costs: The total estimated costs for Virginia nursing homes to comply with the Final Rule on minimum staffing standards is $234 million in the first year, at an average cost of $811,768 per Virginia nursing home per year. LeadingAge Virginia represents rural and urban nursing homes that will not be able to absorb this cost year after year as they continue to rely on historically underfunded Medicaid and Medicare reimbursement and serving seniors in their communities who can already ill-afford the escalating cost of the care they need. This estimated cost includes the costs for both employing new staff and using contracted nursing agency workers. Nursing homes will incur substantial costs, potentially requiring them to rely on contracted nursing agencies, which are significantly more expensive. This financial strain, coupled with limited and inadequate Medicaid reimbursement rates, will push many providers to the brink of closure, and likely beyond, particularly in rural areas where operating margins are already razor thin. The federal government has allocated only $75 million across all states for nursing program tuition reimbursement and scholarships, a fraction of what is needed. The cost burden of this rule will not only

fall on providers and private pay residents but will also fall on Virginia taxpayers, as more than 60% of nursing home residents in the state rely on Medicaid.

14. **Harm to Licenses Practical Nurses (LPNs)**: The rule's exclusion of LPN care from the minimum staffing calculations will have severe consequences for the long-term care workforce. LPNs play a critical role in bridging the gap between CNAs and RNs, yet the rule effectively sidelines them, forcing many to either leave the profession or seek employment in other settings. This will further deplete the already limited workforce pool for aging services and reduce the quality of care available to residents.

15. **Increased Risk of Noncompliance and Closure**: The enforcement mechanisms tied to the rule, including Civil Money Penalties (CMPs) and the potential for termination of provider agreements, are based on data and survey processes prone to human error and misinterpretation. Our members are gravely concerned by the risk of noncompliance, even when they are making good faith efforts to meet the standards. This risk is unacceptably high and further guarantees money needed to meet these regulations will be clawed back from providers attempting to provide quality care to residents. This presents another strain on our provider members' resources and burdens their operational capacity. Summit Square, a rural member nursing home located in Waynesboro, Virginia, has also achieved a 5-Star rating from CMS. Situated in a rural community and operating with a bed capacity of only 18, Summit Square is one of the few high-quality care options available for older adults in the area. The new CMS Staffing Rule places Summit Square's future

in jeopardy. If implemented, they would be out of compliance with the RN minimum staffing standard 26% of the time, and they would not meet the Nursing Aide minimum staffing requirement 72% of the time. Complying with these new regulations would result in an increased financial burden of $179,161 in the first year alone—an overwhelming cost for a not-for-profit of this scale. Such an expense would necessitate layoffs and the reduction of vital services, thereby severely impacting the quality of care available to residents. In addition, these staffing constraints would likely cause a decline in Summit Square's CMS star rating, removing its status as one of the area's leading care providers. With the older adult population in Virginia continuing to grow, the loss or reduction of Summit Square's services would be a significant detriment to the community, leaving older adults with fewer choices and diminished care quality in an already underserved rural area.

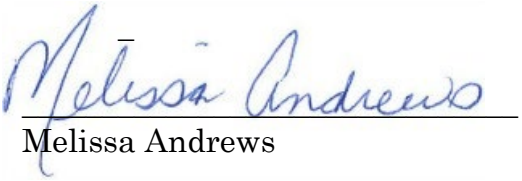
16. **Counterproductive Waivers and Exemptions**: The waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for our members and other providers. Providers must navigate separate, complex processes to demonstrate need, with the potential for penalties or exclusion from the exemption they are seeking. These processes are unlikely to provide meaningful relief and may, in fact, discourage providers (including our members) from seeking necessary exemptions, further increasing the risk of noncompliance, service reductions and closures.

17. **Conclusion**: The finalized minimum staffing rule, in its current form, is fundamentally flawed and will cause substantial harm to our nursing home

providers, their residents, and their communities, particularly in rural and underserved areas. It is essential to the continued operation and provision of care by our members that this rule is not enforced and be vacated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Glen Allen, Virginia, this 7th day of October 2024.



Melissa Andrews

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS,

Plaintiffs,

v.

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

Defendants.

Civil Action No. 1:24-cv-00110

DECLARATION OF SUSAN WALLACE FOR LEADINGAGE OHIO

I, Susan Wallace, declare as follows:

1. I am Susan Wallace. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.

2. I currently serve as President & CEO of LeadingAge Ohio. LeadingAge Ohio is an Association that represents 112 non-profit, mission-driven skilled nursing communities in Ohio. These communities include Shepherd of the Valley communities in Poland, Boardman, Girard and Howland; Community First Solutions, which operates three facilities in Hamilton, Ohio; Heritage Manor of the Jewish Federation of Youngstown; and Fairlawn Retirement Community in Archbold.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule" or the "rule"). I have communicated with many of LeadingAge Ohio's members pertaining to the Final Rule and the burdens that it will impose on them.

4. The Final Rule will significantly increase Ohio nursing homes' costs of doing business, increase staffing difficulties and reduce provider flexibility in staffing choices. In some cases, the staffing rule will compromise the care provided by LeadingAge Ohio's members. Ohio nursing homes will be expected to absorb $419.72 million in additional labor costs in order to implement this mandate, or an average of $451,307 per facility, which will drive closures and service reductions across the state.

5. Not-for-profit (NFP) operators do staff at higher levels than their for-profit counterparts, with an estimated 20 percent of NFP staffing below the all-nursing threshold compared to 50 percent of their for-profit counterparts.

Reported Total Nurse Staffing Hours per Resident per Day

	Statewide	Non-Profit	For-Profit
10%	3.016	3.228	2.955
20%	3.141	3.476	3.086
30%	3.250	3.669	3.193
40%	3.356	3.905	3.286
50%	3.483	4.135	3.397
60%	3.599	4.323	3.509
70%	3.768	4.533	3.618
80%	3.997	4.841	3.783
90%	4.507	5.146	4.092

6. Despite this, most if not all LeadingAge Ohio members will still experience increased costs, diminished flexibility to meet staffing needs, and some will be forced to close and / or reduce the amount of service they provide to aging Ohioans. For example:
    a) Shepherd of the Valley community in Poland, Ohio was recently recognized as one of only six (6) nursing homes across the state to have five-star rating for quality, health inspection and staffing. Their all-nursing level (4.48 HPRD) far exceeds the threshold outlined in the rule (3.45 HPRD) as does their RN staffing level (.98 HPRD compared to .55 HPRD required by the rule). However, their nurse aide staffing is at just 2.26 HPRD, falling below the 2.45 HPRD required by the rule.
    b) Jamestowne is a community operated by Community First Solutions in Hamilton, Ohio; its population is entirely those in need of high-acuity short-term medical or rehabilitation services. Jamestowne uses few nurse aides, instead opting for most personal care being delivered by licensed practical nurses. Their total nurse staffing hours are 4.756 HPRD. Compliance with the rule for Jamestowne would require them

to hire less-skilled nurse aides instead of licensed practical nurses, effectively downgrading care for individuals with high-acuity care needs.

c) Heritage Manor is a mission of the Jewish Federation of Youngstown and operates a nursing-rich program focused on restorative care. They are a five-star community for health inspection, long and short-stay quality measures and have a four-star rating for staffing. Their acuity is lower than others (0.97. Nursing case-mix ratio). They budget first for registered nurses and LPNs, with the remainder of their budget for nurse aides. Despite being nursing-rich, their weekend nursing is below the CMS threshold because the needs of their residents do not necessitate additional hours. Were the mandate to take effect, they would be forced to move LPN hours to nurse aides and shuffle the schedule of nurses to meet a 24/7 RN requirement. Neither of these changes are necessary for the quality of care delivered to their resident population.

7. The CMS rule, should it take effect, will also have an impact on Ohio residents. The cost of the rule's implementation in Ohio alone is estimated to be over $420 million per year, with no funding allocated from the federal government aside from $75 million across all states for nursing program tuition reimbursement and scholarships.
    a) 930 nursing homes participate in the Ohio Medicaid program, which in 2023 funded over 60 percent of nursing home care in Ohio.
    b) Currently, Ohio Medicaid funding fails to compensate $70.14 of costs per resident day or $1.23 million per year for an average 100-bed nursing home, or $1.58 billion per year for the entire state of Ohio. Adding the staffing costs necessitated by the rule would bring the deficit to $2 billion per year.
    c) In order to address this deficit, Ohio's Medicaid budget would need to increase by between 1-2 percent just to pay for the additional nursing home staffing costs. Ohio Medicaid already accounts for 43 percent of the state's spending (all funds).

8. Our members will be unable to obtain the workforce necessary to meet the standards in the rule. There is an insufficient nursing workforce pipeline to achieve the standards outlined in the Final Rule.

a) According to data analysis by our national affiliate, Ohio needs an additional 1,336 RNs and 5,519 nurse aides to meet the minimum staffing ratio provision.
b) That's in addition to the current 7,993 RN job openings and 7,768 nurse aide job openings in Ohio in August 2024, according to the Ohio Means Jobs database.
c) In December 2022, the US Health Resources and Services Administration (HRSA) updated their healthcare workforce supply and demand projections. The model predicts a national shortage of 78,610 full-time equivalent (FTE) registered nurses (RNs) by 2025 and a shortage of 63,720 FTE RNs by 2030.
d) According to HRSA projections, Ohio is projected to have the sixth-largest demand for long-term care staff, particularly RNs, across US states.
e) According to the 2023 Ohio Board of Nursing RN Ohio Workforce Data Report, only 5.5% of RNs work in nursing homes or other extended care facilities compared to 56% of RNs who work in hospital settings. Our nursing home members and other providers in the state are already at a disadvantage in this labor market and this rule will have a cascading effect on the whole health care system including state agencies and state hospitals.
f) Ohio is reliant on licensed practical nurses (LPNs), with 49 percent of Ohio LPNs working in nursing homes/long-term care according to the 2022 Ohio Board of Nursing Ohio LPN Workforce Report. This is the result of over a decade of slow-to-catch-up Medicaid reimbursement which forced Ohio operators to identify staffing efficiencies. LPNs have no required staffing threshold in the Final Rule, though presumably the .48 HPRD added to the final rule may be made up of LPNs.

9. While the Final Rule includes processes for waivers and exemptions, these are unpredictable for our Ohio nursing home members and cannot be relied upon.
    a) To be exempted from aspects of the staffing rule, noncompliance needs to first be demonstrated at the time of survey and a provider must meet four narrow prongs for the exemption to be granted. That is, there is no opportunity for a nursing home to raise their hand to alert surveyors at the time of the workforce shortage; they must first fail to

meet the standards before they can be considered for temporary leniency.

Furthermore, this burdens an already-taxed state survey system. The Ohio Department of Health is already unable to comply with its current workload: over half (54.9 percent / 510 total) of Ohio nursing homes are overdue for their annual survey with no end in sight to these delays, as workforce shortages impact providers also impact state agencies.

b) In order to receive an exemption, the provider would have to demonstrate they've offered prevailing wages in their geographic region – comparative to other facilities such as private hospitals, whose scale and financing often enable them to offer higher wages than long-term care settings. This will lead to rapid inflation in local wages, as hospitals and long-term care compete for the same, finite pool of workers. While much of Ohio considers itself rural, because of the distribution of cities across the state, these "rural" areas compete with major health systems in nearby cities for workforce.

   For example, Fairlawn Retirement Community is a stand-alone, faith-based life plan community in rural Archbold, Ohio that houses roughly 10 percent of the small community's population and draws significantly from its local employment pool, with a quarter of staff residing in Archbold proper. However, there are 7 hospitals within a 30-minute drive of Archbold and an additional 8 hospitals (15 total) within 60 minutes which draw employees out of this already limited employment pool.

10. This Final Rule will lead to more closures and result in reducing access to care for Ohioans. Since the beginning of the pandemic, over 400 nursing homes have closed nationwide and between 40 and 50 have closed in Ohio, with 17 closing in calendar year 2023 alone. Among these are significant numbers of not-for-profit or historic programs, including nursing homes that supported specific populations / cultures, county homes, and programs with over-100 years of service to their communities.

11. Furthermore, Ohio has seen reductions in the number of beds as communities, including many of our members, opt to limit their exposure to

rapidly inflating labor costs, including staffing agency utilization, by shrinking their nursing facility's footprint. Over the COVID-19 pandemic, Ohio saw a 12 percent reduction in beds from 88,793 in 2019 to 78,386 in 2023.

12. This contraction in nursing home care is coming at a time when need is growing: Ohio currently has the 6th largest older adult population in the United States. While Ohio's population is projected to decline by nearly 6% over the next 30 years, its population composition will shift along the way. By 2030, one in four Ohioans will be age 60 or older.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Columbus, Ohio, this 21 day of October 2024.

Susan Wallace, CEO

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF MARK MAINS FOR WESLEY TOWERS**

I, Mark Mains, declare as follows:

1. I am Mark Mains. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as President/CEO of Wesley Towers, a continuing care retirement community located in Hutchinson, Kansas, which has served the community for over 55 years. With 185 employees and 300 residents, 50 of whom are cared for in its nursing home, Wesley Towers is committed to helping residents achieve the highest quality of life, valuing respect, dignity, independence, balance, and family.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. The minimum staffing requirements in the Final Rule will cause significant harm to Wesley Towers, its residents, their families, its staff, and the surrounding community, warranting relief from this court. Wesley Towers primarily cares for residents with a lower acuity threshold, as evidenced by an average case-mix index (CMI) of 1.1827. The facility consciously evaluates each referral to ensure it can provide appropriate care, focusing on service to its

close-knit community rather than financial gain. After completing the required Enhanced Facility Assessment, Wesley Towers determined that 24/7 RN coverage was not necessary due to the acuity and needs of its residents.

5. In preparing the enhanced facility assessment at Wesley Towers, our staff invested significant time and resources in researching, editing, and reviewing several new policies, including the Staffing to Acuity Determination Policy, Sufficient Staff Policy, and Contingency Staffing Plan, as well as revising the Facility Assessment Policy and integrating the Infection Prevention and Control Plan. These tasks required approximately 30 hours, involving 4 hours of research and editing, plus 2 hours for leaders to review and provide feedback at an average salary rate of $65 per hour. Additionally, we completed the Facility Behavioral Health Needs Assessment (Center of Excellence for Behavioral Health in Nursing Facilities) over 16 hours to ensure compliance with new Enhanced Facility Assessment requirements. Participation in webinars and review of Enhanced Facility Assessment-related materials took another 4 hours, followed by 4 hours spent preparing Enhanced Facility Assessment summary reports for QAPI meetings. Collecting and compiling various reports, such as MDS quality measures, Case Mix Reports, and resident profiles, required 17 hours. Further, meetings with key staff, including the Director of Nursing (DON), MDS, Care Coordinator, and Food Service Director, accounted for an additional 6 hours. Time spent sending emails, organizing data, and creating summaries for the Enhanced Facility Assessment A notebook totaled 12 hours. In total, 89 hours were spent on these

efforts. Looking forward, ongoing costs are difficult to estimate, but gathering data and preparing reports for discussions will require 6 hours of staff time each Enhanced Facility Assessment update. While it is understood that CMS aims to standardize facility operations, it is redundant for well-managed facilities such as Wesley Towers to gather evidence-based data for the Enhanced Facility Assessment, as we already monitor trends and plan accordingly. Staff involved in reviewing or answering questions included the CEO, Administrator, DON, Care Coordinator, MDS Nurse, Food Service Manager, and Assistant, with the Medical Director and Pharmacist reviewing FA reports in QAPI meetings. The arbitrary nature of the Enhanced Facility Assessment and its use in complaint surveys increases the risk of deficiencies and civil penalties, despite Wesley Towers' attempts at compliance in good faith. The administrative burden combined with the likelihood of penalties for failure to achieve unclear requirements despite our best good faith efforts make the Enhanced Facility Assessment extremely burdensome for Wesley Towers.

6. Wesley Towers does not currently have 24/7 RN coverage, as its assessment determined it is not necessary, particularly during evening and night shifts. Our organization employs 17 licensed practical nurses (LPNs), 10 of those who primarily work in the nursing home and provide continuous licensed nursing care, especially during overnight shifts. The Final Rule would force Wesley Towers to hire additional registered nurses (RNs), despite the Kansas Labor Information Center indicating that there are 59 RN job openings in Reno

County alone. This requirement places Wesley Towers in direct competition with other healthcare providers for a limited pool of qualified RNs, further burdening the facility and indicating that it would be difficult if not impossible for Wesley Towers to meet the requirement.

7. Wesley Towers typically meets the current staffing requirements of .55 RN and 2.45 NA hours per resident per day without the use of staffing agencies. However, the new staffing mandate, coupled with unavoidable staff absences due to illness or vacation, would likely force Wesley Towers to rely on staffing agencies, which are known for inconsistent care and high costs. LeadingAge New York's financial analysis estimates that compliance with the federal staffing rule would cost Wesley Towers an additional $185,259 per year. These estimates do not account for increased costs due to shift differentials, staffing agencies, or wage inflation resulting from competition in the healthcare labor market, which continues to be strained.

8. Wesley Towers operates at 98-99% capacity, meaning almost all its beds are occupied by residents. Compliance with the federal staffing mandate would force the facility to turn away new residents or discharge current residents to meet the new staffing ratio requirements. Failure to comply would result in fines and penalties that would likely render continued operation unsustainable. The Final Rule poses a direct threat to the well-being of Wesley Towers itself, its residents, their families, staff, and the broader community.

9. For these reasons, Wesley Towers requests that the court grant preliminary injunctive relief and vacate the Final Rule to prevent irreparable harm to Wesley Towers and the community it serves.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Hutchinson, Kansas, this 24th day of September 2024.

Mark Mains

EXHIBIT 25

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF RENEE PORTER FOR DOOLEY CENTER**

I, Renee Porter, declare as follows:

1. I am Renee Porter. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.
2. I currently serve as the licensed nursing home administrator for Dooley Center in Atchison, KS. Dooley Center is a 44 person licensed nursing facility, that accepts Medicaid and private pay only. We care for the retired Benedictine Sisters of Mount St. Scholastica. Our mission is "the care of the sick rank above and before all else, so they may truly be served as Christ." I have been at Dooley Center for 10 years as their administrator, and I am responsible for the overall operational oversight, regulatory compliance, financial operations and employment for Dooley Center.
3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule").
4. The Final Rule will lead to irreparable harm for nursing home residents and other healthcare patients in the Atchison, Kansas area.
5. Within a 25-mile radius of Atchison, Kansas, there are currently 196 RN positions available, as verified and referenced by the Kansas Department of Labor.
6. Data from June 1, 2024, to August 31, 2024, reveals that Dooley Center's staffing included 3.16 hours per patient day from Nurse Aides (NAs), 0.84 hours per patient day from Licensed Practical Nurses (LPNs), and 0.64 hours per patient day from RNs (including management roles). The Final Rule mandates 2.45 NA hours, 0.48 LPN hours, and 0.55

RN hours per patient day out of a total 3.48 hours per patient day. Internal analysis shows that Dooley Center would have failed to meet the required 0.55 RN hours per patient day 39.1% of the time if these regulations were currently implemented, resulting in 36 days of non-compliance over the reviewed period. The center achieved continuous 24-hour RN coverage only 1.08% of the time. On certain days, nurse managers had to cover RN shifts, which impacted compliance. Despite meeting the minimum staffing levels on some days, we found no significant correlation between RN staffing levels and reduction in falls or infection rates.

7. For NAs, the soon-to-be required 2.45 hours per patient day was unmet 8.6% of the time, primarily in August due to a COVID-19 outbreak. Our analysis of falls did not show a correlation between NA hours and fall prevention. LPN hours exceeded the allowable 0.48 hours per patient day but could not substitute for deficiencies in NA and RN hours under the Final Rule. On certain days, the total direct care staff hours met the required 3.48 hours per patient day, yet due to regulatory constraints, these days were still deemed non-compliant.

8. The current deficit at Dooley Center to meet the minimum staffing in the Final Rule is a total of 2.5 registered nurses, and 1 nursing aide. This impacts the overall health care continuum for Atchison, Kansas for registered nurses and nursing aides, causing the number of openings to increase dramatically from the current 196 openings, within 25 miles of Atchison. This means the labor market will continue to expand past financial means available through Medicaid, the primary payor source at Dooley Center, and past Dooley Center's ability to pay.

9. The Final Rule also requires that all licensed nursing homes, which includes Dooley

Center, must complete an enhanced facility assessment. According to the Centers for Medicare and Medicaid Services QSO-24-13-NH, 483.71 (c), the facility must use this facility assessment to: 483.71 (c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in 483.35(a)(3). 483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. 483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. Dooley Center completed the enhanced facility assessment, which took approximately 16 hours of staff time to complete which comes out to approximately $579.36 per month to stay in compliance. This is an additional $6,592 per year on an already under reimbursed healthcare continuum. A summary of the facility assessment for Dooley Center is 54.5% of residents require 1 or 2 person assist, 0% of residents require assistance with all activities of daily living (ADLs), 6% of residents require a mechanical lift at least some of the time, 0% on hospice, 0% on dialysis, 27% on injections, 0% on internal feedings, 3% being treated for infections, 30% with an Alzheimer's or Dementia diagnosis, 54.5% mental illness/psychiatric mood disorder, 36.3% bowel incontinent, and 100% bladder incontinent. The primary diagnosis for Dooley Center is hypertension. According to the facility assessment, there is no supported need for 24 hours per day, 7 day per week RN coverage, as Dooley Center's acuity is relatively low with no major diagnosis or skill needs requiring registered nursing care 24/7. Dooley Center's Case Mix Index is 0.8717, as reported on the Kansas Medicaid Rate Calculation prepared by Myers and Stauffer on

06/10/2024. In conclusion, if the facility assessment is utilized to determine sufficient staffing, the assessment does not support the Final Rule's requirement of .55 RN hours per patient or 24/7 RN coverage.

10. The financial impact of the Final Rule is significant. To meet the RN requirements, Dooley Center would incur an estimated annual cost of $246,341.02, which includes wages, benefits, and retirement contributions. If internal hiring is not feasible, reliance on agency nurses would cost approximately $421,668 annually. This would mean, Dooley Center would be relying on nurse agencies which have no regulatory oversight or wage caps. The RN workforce crisis, with 196 RN positions open within a 25-mile radius of Atchison, KS and anticipated national shortages, exacerbates these challenges. Projections from the Health Resources and Services Administration (HRSA) indicate a substantial shortfall in the RN workforce in the coming years, further complicating recruitment efforts. In the Health Workforces Analysis published by the Health Resources and Services Administration (HRSA) in November 2022, federal authorities project a shortage of 78,610 full-time RNs in 2025 and a shortage of 63,720 full-time RNs in 2030. According to the Bureau of Labor Statistics, they project 193,100 openings for RNs each year through 2032 when nurse retirement and workforce exits are factored into the number of nurses needed in the U.S.; this is without the added demand for RNs as stated in the regulations.

11. As the shortfall of RNs is projected to continue to remain high, the demand for geriatric care, including care for individuals with chronic diseases and comorbidities is also indicated to grow by 23% of the population by 2050. According to the U.S. Census of Bureau, Americans aged 65 and older are projected to increase from 58 million in 2022 to 82 million in 2050. Couple those statistics with the fact that 47 nursing homes in Kansas

either closed or de-licensed beds in 2023, primarily due to staffing shortfalls, which in turn, creates a crisis for the continued aging population of the U.S.

12. If the Final Rule is enforced, Dooley Center will have an increase incurred expense for advertising for registered nurses and nurse aides, along with the increased cost of labor. The additional registered nurses will cost a minimum of $246,301, if we are able to fill the positions despite the national shortage of nurses. When we do not meet the 24/7 RN coverage, we will be forced into deficient practice and receive citations from the government, with no remediation possible due to the workforce crisis. This will force Dooley Center to not just de-license our beds, which will lead to a loss of funding of millions of dollars per year to care for our elders, but this could ultimately lead to the closure of Dooley Center, forcing our Sisters and elders to move away from the home they have always known. This Final Rule is larger than the financial impact with no additional funding, it is forcing elders to move away from their family and friends and potentially displacing them out of their home, as this regulation is unattainable with the registered nursing national shortage.

13. In conclusion, the Final Rule will cause considerable operational and financial difficulties for Dooley Center. The inability to meet mandated staffing levels, combined with increased costs and ongoing workforce shortages, underscores the substantial harm inflicted by the Final Rule. Based on this data and analysis, it is respectfully requested that the court consider the demonstrated harm and provide appropriate relief to mitigate the impact on Dooley Center and similar healthcare facilities.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Atchison, Kansas, this 15th day of October 2024.

Renee Porter

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTAASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF CLAIRE DOWERS FOR LEADINGAGE OKLAHOME**

I, Claire Dowers, declare as follows:

1. I am Claire Dowers. I am over the age of 18 and a U.S. citizen. I have personal knowledge of the facts contained in this declaration unless otherwise stated. I could competently testify as to the contents of this Declaration if called upon to do so.

2. I currently serve as President/CEO of LeadingAge Oklahoma which is a state trade association that has operated for 30 years with over 100 not-for-profit and mission driven aging services providers, including 58 nursing homes.

3. I am familiar with and have reviewed the Center for Medicare & Medicaid Services' ("CMS") regulation titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40,876 (the "Final Rule" or "the rule").

4. The significant and irreparable harm that the Final Rule imposes on Oklahoma nursing home providers will be especially severe in rural and underserved areas. The imposition of this rule is based on flawed and incomplete data, lacks evidence-based justification, and will exacerbate existing workforce shortages, leading to devastating consequences for both providers and residents.

~~5.~~ **Insufficient Evidence and Data**: The formulation of the rule is grounded in data that fails to accurately reflect the realities of staffing in nursing homes. The use of Payroll Based Journaling (PBJ) data does not account for the specific periods during which staff are working, leading to a misleading

understanding of compliance with staffing requirements. An example would be a nursing facility that has three RNs working 8 hours of dayshift coverage each day, but no overnight coverage. On paper it would reflect they are meeting 24-hour RN coverage, when in reality they are not. Furthermore, the Abt Associates 2022 Nursing Home Staffing Study explicitly states that no set number of staff can guarantee quality care, given the varying needs of residents and providers.

6. **Enhanced Facility Assessment**: The enhanced facility assessment, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. The minimum staffing ratios also outlined in the Final Rule require facilities to ignore that same variability in resident acuity and needs across different settings by establishing arbitrary thresholds for quality care. Some facilities with higher acuity residents may need increased staffing, while others with lower acuity residents may not require a 24/7 RN presence. Requiring facilities with such lower acuity residents to maintain higher staffing than needed substantially increases the facilities' costs without a corresponding increase in quality of care or life for residents. The harm extends beyond our nursing homes. The nursing workforce crisis cuts across the entire health care system, and this mandate will force further scarcity in the health labor market.

7. The enhanced facility assessment imposes significant burden on our members' staff, diverting valuable time away from direct resident care to maintain continuous updates for compliance. CMS estimates the cost of the enhanced facility

assessment to be around $4,955 per facility, but we know based on our own modeling their estimates tend to fall woefully low. In the Final Rule, an enhanced facility assessment is required of all nursing home facilities and the expectations of the assessment include evaluating the acuity and needs of the residents to determine staffing levels, collecting input from staff including but not limited to contracted agency personnel or union representatives, collecting input from residents and their families, and creating a contingency plan to be utilized before an emergency staffing plan is needed. We and our members are concerned about the lack of clear guidance on critical aspects of the assessment, such as what constitutes "continuous" updates or how to effectively "consider" feedback from residents, families, and staff. These vague and arbitrary definitions could result in providers, despite acting in good faith, being unfairly penalized through Civil Money Penalties during complaint investigations or annual surveys.

8. **Exacerbation of Workforce Shortages**: The rule imposes a 24/7 RN requirement and minimum staffing ratios that are unattainable for our members given the current workforce crisis. Oklahoma is also facing declining nursing program admissions and an aging workforce. Implementing these staffing mandates without a sufficient workforce pipeline for the entire healthcare continuum will force our members and other providers in the state to make difficult choices, engaging in wage wars with other health care providers that are unsustainable and for many, impossible to win, or enacting closures or reductions in services in order to meet staffing ratios.

9. **One-Size-Fits-All Approach**: The rule treats all nursing facilities as though they have identical needs, regardless of their size, location, or the complexity of care they provide. This approach fails to recognize that in many smaller or rural settings, including our own rural members, the demand for an RN's presence around the clock is not only unnecessary but impractical. Licensed Practical Nurses (LPNs), who are vital to the long-term care workforce, could be forced out of their roles due to not counting towards NA or RN ratio time, exacerbating staffing shortages and leaving facilities with even fewer options for care. While CMS finalized the total staffing hours to include LPNs to count towards 0.48 hours per resident per day, this limited inclusion is inadequate, arbitrarily forcing providers to eliminate use of LPNs. Our nursing home members and others in the state employ a large number of LPNs, relying heavily on their labor availability and skills to provide high quality and safe care to residents. LPNs are particularly vital to the daily operations of nursing homes in rural parts of Oklahoma.

10. **Financial Burden and Unfunded Mandates**: LeadingAge Oklahoma represents a significant amount of small, rural, and stand-alone nursing homes who will not be able to absorb the costs of the Final Rule year after year as they continue to rely on historically underfunded Medicaid and Medicare reimbursement and serving seniors in their communities who can already ill afford the escalating cost of the care they need. Nursing homes will incur substantial costs, and they may be required to rely on contracted nursing agencies, which are significantly more expensive. These increased costs will likely lead to reduced services and even closures

for many Oklahoma nursing homes, including among our membership.

11. **Increased Risk of Care Deserts**: Many Oklahomans live in areas with only one nursing and residential care provider within a thirty-minute drive. The closure of a local provider would double the average drive time required to access care, pushing more residents into care deserts, and significantly limiting their access to essential services, friends, family, and loved ones. By 2030, Oklahoma will have more people over the age of 60 than under the age of 18. With this rapid growth of the older population, the capacity to provide care will be severely strained if more facilities close or reduce needed capacity.

12. **Harm to Licensed Practical Nurses (LPNs)**: The rule's exclusion of LPN care from the minimum staffing calculations will have severe consequences for the long-term care workforce. LPNs play a critical role in bridging the gap between CNAs and RNs, yet the rule effectively sidelines them, forcing many to either leave the profession or seek employment in other settings. This will further deplete the already limited workforce pool for aging services and reduce the quality of care available to residents.

13. **Increased Risk of Noncompliance and Closure**: The enforcement mechanisms tied to the rule, including Civil Money Penalties (CMPs) and the potential for termination of provider agreements, are based on data and survey processes prone to human error and misinterpretation. Our members are gravely concerned by the risk of noncompliance, even when they are making good faith efforts to meet the standards. This risk is unacceptably high and further guarantees money

needed to meet these regulations will be clawed back from providers attempting to provide quality care to residents. This presents another strain on our provider members' resources and burdens their operational capacity.

14. **Counterproductive Waivers and Exemptions**: The waiver and exemption processes for the 24/7 RN requirement and minimum staffing ratios are unachievable, arbitrary, and burdensome for our members and other providers. Providers must navigate separate, complex processes to demonstrate need, with the potential for penalties or exclusion from the exemption they are seeking. These processes are unlikely to provide meaningful relief and may, in fact, discourage providers (including our members) from seeking necessary exemptions, further increasing the risk of noncompliance, service reductions and closures.

15. **Conclusion**: The finalized minimum staffing rule, in its current form, is fundamentally flawed and will cause substantial harm to our nursing home providers, their residents, and their communities, particularly in rural and underserved areas. It is essential to the continued operation and provision of care by our members that this rule is not enforced and be vacated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in ~~Oklahoma~~ City, Oklahoma, this 21 day of October 2024.

Claire Dowers

EXHIBIT 27

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

KANSAS, et al., Plaintiffs, v. XAVIER BECERRA; et al., *Defendants*.	Civil Action No. 1:24-cv-00110 **DECLARATION OF TRAYLOR RAINS** **STATE MEDICAID DIRECTOR** **STATE OF OKLAHOMA**

I, Traylor Rains, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by Oklahoma Health Care Authority personnel:

1. My name is Traylor Rains, and my business address is 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the State Medicaid Director since April 1, 2022. I have a Bachelor of Arts degree from Texas A&M University and a Juris Doctorate from Baylor University School of Law. I have enjoyed a nineteen-year career in public service including leadership roles within Oklahoma's Department of Human Services and Oklahoma Department of Mental Health and Substance Abuse Services. My job responsibilities at the Oklahoma Health Care Authority currently include: Contracting and completing oversight of the state's Medicaid managed care system comprised of 5 MCOs; Oversight of the Medicaid fee-for-service program and the MMIS system that supports it; Overall planning, implementation, coordination, and evaluation of programs and policies to promote effective program administration and service delivery; Management of functional areas including Pharmacy Operations, Customer Experience Operations, Health Policy, Quality Assurance/Quality Improvement, Long Term Services and Supports, Behavioral Health, Care Management and Medical Services.

Purpose of Declaration

3. I am submitting this declaration in reference to Plaintiffs' Motion for Preliminary Injunction as to a final rule published by Centers for Medicare and Medicaid Services ("CMS") on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-

Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," 89 Fed. Reg. 40876 (the "Final Rule").

4. I am familiar with the Final Rule and its impact on Oklahoma.

Impact on Oklahoma

5. Oklahoma has two hundred and eighty-seven (287) privately-run long-term care (LTC) facilities that receive Medicare and Medicaid, and therefore the Final Rule governs conduct of Oklahoma.

6. The Final Rule has caused and is causing immediate harm to Oklahoma in the form of compliance costs.

7. First, the Final Rule requires Oklahoma, through its Medicaid agency, to provide "institutional payment transparency reporting," which means it must provide to the United States government a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40990.

8. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Oklahoma well before that. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. *Id.* at 40991.

9. For Oklahoma, the up-front implementation costs would be up to $200,000.00.

10. Second, the Final Rule requires Oklahoma LTC facilities to conduct enhanced facility assessments (EFA) within 90 days of publication of the final rule. 89 Fed. Reg. at 40913. An EFA is a comprehensive evaluation of an LTC facility, residents, staff, and resident families to determine staffing and other needs. 89 Fed. Reg. at 40999-41000.

11. Specifically, the Final Rule requires LTC facilities to ensure the "active involvement" of direct care staff and their representatives, and to "solicit and consider input" from residents, their representatives, and family members. *Id*. at 41000.

12. The Final Rule requires facilities to "review and update" the EFA at least annually. *Id*. at 40999.

13. LTC facilities must also create "contingency planning." *Id*. at 41000.

14. CMS estimates that EFAs will cost $4,955 per LTC facility, but that number is understated. The actual cost for the initial EFA per LTC facility operated in Oklahoma ranges between $5,000.00 and $6,000.00 depending on the size of the facility. And subsequent annual EFAs are expected to increase.

15. Additionally, for LTC facilities operated in Oklahoma, the amount of staff time spent performing the initial EFA ranges between sixteen (16) hours and ninety (90) hours depending on the size of the facility.

16. The significant amount of time needed for the EFA detracts from the essential administration and direct resident care necessary for quality and safety. The EFA is a significant burden on staff because it diverts time away from direct resident care to maintain overburdensome compliance updates.

17. Third, the Final Rule imposes a costly minimum staffing requirement on Oklahoma LTC facilities that receive Medicare and Medicaid funding.

18. The Final Rule requires (1) total nurse staffing of at least 3.48 hours per resident day ("HPRD"); (2) a mandate for RN staffing of at least 0.55 HPRD; and (3) nurse aid ("NA") staffing of at least 2.45 HPRD. 89 Fed. Reg. at 40877. HPRD is defined as the "total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS." *Id*.

19. The total cost for Oklahoma LTC facilities to comply with the Final Rule's minimum staffing requirement—in the first year alone—will be up to $76,000,000.00, excluding the additional costs of employee benefits.

20. The estimated financial burden caused by the Final Rule will also include costs for both employing new staff and the use of contracted nursing agency workers—which is significantly more expensive.

21. Fourth, even if Oklahoma can allocate the money to pay for the Final Rule's minimum staffing requirements, Oklahoma will struggle to comply with those requirements due to LTC staffing shortages.

22. To comply with the Final Rule's minimum staffing requirements, Oklahoma LTC facilities will have to hire an additional seven hundred fifteen (715) RNs to comply with both the 24/7 Requirement and 0.55 RN HPRD requirements, as well as five hundred thirty-eight (538) additional NAs to comply with the Final Rule's HPRD ratios. *Id*. at 40058-40059, 40077-79.

Impact of a Preliminary Injunction

23. While a preliminary injunction would not restore any costs already incurred by Oklahoma because of the Final Rule, it would prevent Oklahoma from incurring further costs.

24. This the 22nd day of October, 2024.

Traylor Rains
State Medicaid Director
Oklahoma Health Care Authority

EXHIBIT 28

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA

KANSAS, et al.,

Plaintiffs,

v.

XAVIER BECERRA; et al.,

Defendants.

Civil Action No. _____

DECLARATION OF CYNTHIA BEANE

I, Cynthia Beane, hereby declare and state under penalty of perjury that the following is true and correct to the best of my knowledge, based on my personal knowledge and information provided by West Virginia Bureau for Medical Services personnel:

1. My name is Cynthia Beane, and my business address is West Virginia Department of Human Services, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301. I am over the age of eighteen, have personal knowledge of the subject matter, and am competent to testify concerning the matters in this declaration.
2. I have served as the Commissioner within West Virginia's Bureau for Medical Services (WVBMS) since July 2014. I have a Masters in Social Work from the West Virginia University. Under the West Virginia Department of Human Services' Cabinet Secretary's direction, I perform highly complex administrative work in formulating plans, programs, systems, and procedures for a variety of highly complex programs; I direct the work of a large staff of expert level professional and administrative employees; I oversee the preparation and execution of large and complex budgets; I represent the state and department to national, state and local agencies and advocacy groups on important issues affecting large client populations; and I serve as a key congressional and legislative liaison for departmental programs. My job responsibilities include administering the oversight and compliance of the state Medicaid program for West Virginia, including but not limited to planning, organizing and directing activities in policy, program, operational, and financial areas to provide the most appropriate and cost-conscious strategies to strengthen health care services for eligible members.
3. The WVBMS is responsible for administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate,

medically necessary, and quality health care services for all members; provide these services in a user-friendly manner to providers and members alike; and focus on the future by providing preventive care programs. Medicaid is a public benefit program that provides health insurance that enables eligible individuals to obtain health care services and is co-financed by state and federal governments. The Bureau for Medical Services is the single state agency responsible for administering the program.

4. I am submitting this declaration in support of Plaintiffs' Motion for Preliminary Injunction as to the Final Rule published by Centers for Medicare and Medicaid Services on May 10, 2024, titled "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting." 89 Fed. Reg. 40,876.
5. I am familiar with the Final Rule and its impact on West Virginia.
6. There are 124 long term care facilities in West Virginia that receive Medicare and/or Medicaid, and therefore the Final Rule governs conduct of West Virginia.
7. The Final Rule has caused and is causing immediate harm to West Virginia in the form of compliance costs.
8. For instance, the Final Rule requires West Virginia's Medicaid agency to provide "institutional payment transparency reporting." 89 Fed. Reg. at 40,990. This means West Virginia must provide the federal government with a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs.
9. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. at 40,990.

10. Although this reporting requirement does not go into full effect until four years after the Final Rule is published, it will impose immediate costs on West Virginia. The Final Rule acknowledges as much by estimating the cost to the States in year one to be $183,851. 89 Fed. Reg. at 40,991.
11. For nursing homes in West Virginia, the estimated implementation costs to the facilities would be approximately $31,163,430.72. This amount is likely on the lower end for the actual impact due to items that cannot be accurately predicted, such as changes in wages due to increased demand, as well as the impact to other provider types should they move from providers such as hospitals. Additionally, the administrative cost to WV Medicaid is estimated to be at least $538,904.
12. These costs are irreversible. New positions may have to be created to comply with the Final Rule which cannot simply be eliminated. Further, the expended time or costs to prepare for the reporting requirements cannot be refunded.
13. The Final Rule's new requirements would immediately distract the WVBMS from serving its full mission in other regards, as directed by the West Virginia Legislature. This in turn would constrain the WVBMS's ability to serve the citizens of West Virginia.
14. While a preliminary injunction would not restore the costs already incurred by West Virginia because of the Final Rule, it would prevent the State from suffering further harm.

Executed in Charleston, WV, on October 22, 2024.

Cynthia Beane, MSW, LCSW
Commissioner,
West Virginia Department of Human Services,
Bureau for Medical Services

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, STATE OF SOUTH CAROLINA, STATE OF IOWA, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARKANSAS, STATE FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, COMMONWEALTH OF KENTUCKY, STATE OF MISSOURI, STATE OF MONTANA, STATE OF NEBRASKA, STATE OF OKLAHOMA, STATE OF NORTH DAKOTA, STATE OF SOUTH DAKOTA, STATE OF UTAH, COMMONWEALTH OF VIRGINIA, STATE OF WEST VIRGINIA, LEADINGAGE KANSAS, LEADINGAGE SOUTH CAROLINA, LEADINGAGE IOWA, LEADINGAGE COLORADO, LEADINGAGE MARYLAND, LEADINGAGE MICHIGAN, LEADINGAGE MINNESOTA, LEADINGAGE MISSOURI, LEADINGAGE NEBRASKA, LEADINGAGE NEW JERSEY/DELAWARE, LEADINGAGE OHIO, LEADINGAGE OKLAHOMA, LEADINGAGE PA, SOUTH DAKOTA ASSOCIATION OF HEALTHCARE ORGANIZATIONS, LEADINGAGE SOUTHEAST, LEADINGAGE TENNESSEE, LEADINGAGE VIRGINIA, DOOLEY CENTER, WESLEY TOWERS, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; and CHIQUITA BROOKS-LASURE, in her official capacity of Administrator of the Centers for Medicare and Medicaid Services, *Defendants*.	Civil Action No. 1:24-cv-00110 **FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

INTRODUCTION

Senior citizens and other vulnerable members of society rely on nursing homes and similar facilities to meet their needs when family members cannot. Although the nursing home industry certainly has had its share of challenges, it fills a vital need in our communities that cannot be replaced. Instead of addressing the legitimate challenges nursing homes face, the Defendants put forward a heavy-handed mandate through its Final Rule entitled, "*Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*" ("the Final Rule"). *See* 89 Fed. Reg. 40876 (May 10, 2024). This Final Rule poses undue hardship and potentially fatal inflexibility to the nursing home industry. Many nursing homes that are already struggling will have no choice but to go out of business under the Final Rule. And the main victims will be the patients who will have nowhere else to go. The increased costs under the Final Rule will also punish struggling good actors in the nursing home space while creating an advantage for bad actors who keep costs low by providing substandard and dangerous levels of care. Plaintiffs represent a diverse group of States and industry organizations who aim to prevent this from happening.

This Final Rule represents not only another attempt from the Biden-Harris administration to impose its policy preferences on the rest of the country but is also monumentally costly and nearly impossible to comply with. During the public comment period, an outside study found that: (1) nursing homes will need to hire more than 100,000 additional full-time employees; (2) the Final Rule will cost nursing homes approximately $6.8 billion per year (higher than CMS's own estimate of $4 billion per year); (3) 94 percent of current skilled nursing facilities will be out of compliance with at least one of the three

staffing requirements; and (4) more than 285,000 nursing home beneficiaries (or one-fourth of total nursing home residents) will be at risk of losing necessary care if nursing homes are unable to increase their workforce to meet these new standards. *See* CliftonLarson Allen LLP, CMS Proposed Staffing Mandate, 6 ("CLA Study"), *available at* https://tinyurl.com/yc2v4t3h (July 8, 2024).

Beyond the costs, the latest Rule from the Biden-Harris Centers for Medicare & Medicaid Services (CMS) is not even close to lawful. Over forty years ago, Congress established two basic staffing requirements for nursing homes participating in both Medicare and Medicaid. *First*, nursing homes participating in these programs "must use the services of a registered professional nurse [("RN")] for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord id*. § 1395i-3(b)(4)(C)(i). *Second*, Congress established the flexible staffing standard that requires a nursing home "[to] provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents." *Id*. § 1396r(b)(4)(C)(i); *accord id*. § 1395i-3(b)(4)(C)(i). For decades, Congress, CMS, and its predecessors have considered—and rejected—proposals to replace the flexible staffing standards with a one-size-fits-all requirement. *See e.g.*, 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974); 45 Fed. Reg. 47368, 47371 (July 14, 1980); 52 Fed. Reg. 38583, 38586 (Oct. 16, 1987); 80 Fed. Reg. 42168, 42201 (July 16, 2015); 81 Fed. Reg. 68688, 68755 (Oct. 4, 2016).

Nevertheless, CMS proposed and promulgated the Final Rule that is unlawful and threatens the health, safety, and well-being of millions of nursing home patients across the country. The Final Rule departs from the longstanding staffing requirement in two ways. *First*, the Final Rule conspicuously *triples* the statutory nursing home staff requirement. It replaces Congress's directive for an RN to be present for 8 hours per day, 7 days a week, with

a new mandate to have an RN "onsite [for] 24 hours per day, for 7 days a week" ("24/7 requirement"). 89 Fed. Reg. 40876, 40898. *Second*, the Final Rule abandons the flexible statutory staffing standard that is "Sufficient to meet the nursing needs" of each facility's residents, 42 U.S.C. 1396r(b)(4)(C)(i); *accord id*. § 1395i-3(b)(4)(C)(i), in favor of a three-part national requirement—irrespective of facility needs, current staffing capacity, or State law minimum staffing standards. The Final Rule requires (1) total nurse staffing of at least 3.48 hours per resident day ("HPRD"); (2) a mandate for RN staffing of at least 0.55 HPRD; and (3) nurse aid ("NA") staffing of at least 2.45 HPRD. 89 Fed. Reg. at 40877. HPRD is defined as the "total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS." *Id*. Essentially, the Final Rule abandons Congress's *qualitative* and flexible staffing standard for CMS's *quantitative r*equirement that does not account for resident acuity nor individual nursing home staff capacity.

Instead of pointing out where in the applicable Congressional statute they have the authority to promulgate this Final Rule, CMS takes the audacious approach of ignoring the statute altogether. CMS points to broadly worded provisions and a "miscellaneous" rulemaking provision that allows the Secretary of Health and Human Services to impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary." 42 U.S.C. § 1395i-3(d)(4)(B); *accord id*. 42 U.S.C. § 1396r(d)(4)(B) as justification for the Final Rule.

The wafer-thin reliance on a vague statutory provision does not allow CMS to promulgate a Final Rule that conflicts with a separate Congressional statute. But CMS's illegality is more apparent because this is a Major Questions Doctrine case. Implementing such a broad mandate that would result in *at least* $43 billion of compliance costs for nursing

homes nationwide over the next ten years, without Congress "speak[ing] clearly" to the issue, is a flagrant violation of the Major Questions Doctrine. *See Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin*., 595 U.S. 109, 117 (2022). And surely Congress did not intend CMS to pull such an "elephant" of a mandate out of the "mouseholes" of either the Medicare or Medicaid Acts. *See Whitman v. Am. Trucking Associations*, 531 U.S. 457, 468 (2001). This is especially true given both Congress's and CMS's longstanding policy positions for maintaining a flexible staffing standard for nursing homes.

Beyond the statutory problems with the Final Rule, it is also the very definition of arbitrary and capricious rulemaking because (1) it represents a sharp departure from past CMS policy without reasoned explanation, (2) CMS did not consider reliance interests when promulgating the Final Rule and (3) CMS did not consider important aspects of the problem such as the cost of the Final Rule. In short, there is no universe in which this Final Rule is lawful.

The Final Rule also causes harm to both organizational and State plaintiffs in this case, and much of that harm is irreparable. As noted above, the costs are impossible for many nursing homes to comply with while also bearing the current costs of delivering adequate care to residents. And although the Final Rule claims to have an extended implementation period, many nursing homes bear those costs *now*. This is because CMS requires nursing homes to conduct unreasonable enhanced facility assessments (EFA) within 60 days of publication of the Final Rule. These assessments are costing each nursing significant amounts of money and labor in order to comply. And even though the staffing requirements have a 2-3-year implementation period depending on the region, the reality of a tight labor market requires

nursing homes to hire *immediately* because the available supply of nurses will dwindle as the implementation date approaches. Some nursing homes have had to immediately increasing their staffing and incurred significant costs. Similarly, states have their own enhanced reporting requirements for their Medicaid programs. Although CMS claims to have a delayed implementation period for this portion of the Final Rule, states have also had to start immediately implementing these requirements. The Final Rule acknowledges as much by pointing to costs states will incur in year one.

Plaintiffs have no option but to seek relief through this Court and request this Court to vacate, set aside, and permanently enjoin the Final Rule. In the interim, the Plaintiffs will seek to preliminary enjoin the Final Rule to spare them the irreparable harm they are already facing and will continue to face in the future.

THE PARTIES

1. Plaintiff Alabama is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Alabama brings this suit through its attorney general, Steve Marshall, who is the chief legal officer for the State and is "authorized to institute and prosecute, in the name of the state, all civil actions and other proceedings necessary to protect the rights and interests of the state." Ala. Code § 36-15-12.

2. Plaintiff Alaska is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Alaska brings this suit through its Attorney General, Treg R. Taylor. He is authorized by Alaska law to sue on the State's behalf.

3. Plaintiff Arkansas is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Arkansas brings this suit

through its attorney general, Tim Griffin. General Griffin is authorized to "maintain and defend the interests of the state in matters before the United States Supreme Court and all other federal courts." Ark. Code Ann. § 25-16-703.

4. Plaintiff the State of Florida is a sovereign State and has the authority and responsibility to protect its sovereign interests and the health, safety, and welfare of its citizens. As the State's Chief Legal Officer, Attorney General Ashley Moody is authorized to represent the interests of the State in civil suits. § 16.01(4), (5), Fla. Stat.

5. Plaintiff State of Georgia is a sovereign state of the United States of America. Georgia sues to vindicate its sovereign, quasi-sovereign, and proprietary interests, including its interests in protecting its citizens, businesses and employees. Georgia brings this suit through its Attorney General, Christopher Carr. He is the chief legal officer of the State of Georgia and has the authority to represent the State in federal court.

6. Plaintiff State of Idaho is a sovereign State of the United States of America. Idaho sues to vindicate its sovereign, quasi-sovereign, and proprietary interests, including its interests in protecting its citizens. The Final Rule will harm Idaho and its citizens. Idaho brings this suit through its attorney general, Raúl Labrador, the State's chief legal officer. He is authorized by Idaho law to sue on the State's behalf under Idaho Code § 67-1401. His address is 700 W. Jefferson Street, P.O. Box 83720, Boise, Idaho 83720.

7. Plaintiff Indiana is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Indiana brings this suit through its attorney general, Theodore E. Rokita. He is authorized to "represent the state in any matter involving the rights or interests of the state." Ind. Code § 4-6-1-6.

8. Plaintiff Iowa is a sovereign state of the United States of America. Iowa sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Iowa brings this suit through its attorney general, Brenna Bird. She is authorized by Iowa law to sue on the State's behalf under Iowa Code § 13.2.

9. Plaintiff Kansas is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Kansas brings this suit through its attorney general, Kris W. Kobach. He is the chief legal officer of the State of Kansas and has the authority to represent Kansas in federal court. Kan. Stat. Ann. 75-702(a).

10. Plaintiff Commonwealth of Kentucky is a sovereign state of the United States of America. Russell Coleman is the duly elected Attorney General of the Commonwealth of Kentucky with the constitutional, statutory, and common-law authority to bring a suit on behalf of the Commonwealth and its citizens. *See* Ky. Rev. Stat §§ 15.020, 15.255(a), 15.260; *see also Commonwealth ex rel. Beshear v. Commonwealth ex rel. Bevin*, 498 S.W.3d 355, 362 (Ky. 2016).

11. Plaintiff Missouri is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Missouri brings this suit through its attorney general, Andrew Bailey. He is the chief legal officer of the State of Missouri and has the authority to represent Missouri in federal court. Mo. Rev. Stat. § 27.060.

12. Plaintiff Montana is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Montana brings this suit through its attorney general, Austin Knudsen. He is the chief legal officer of the State of Montana and has the authority to represent Montana in federal court. Mont. Rev. Code § 2-15-501.

13. Plaintiff Nebraska is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Nebraska brings this suit through its attorney general, Mike Hilgers. He is the chief legal officer of the State of Nebraska and has the authority to represent Nebraska in federal court. Neb. Rev. Stat. § 84-203.

14. Plaintiff Oklahoma is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Gentner Drummond is the duly elected Attorney General for the State of Oklahoma. Being "the chief law officer of the state," OKLA. STAT. tit. 74, § 18, General Drummond is empowered "[to] appear for the state and prosecute and defend all actions and proceedings in any of the federal courts in which the state is interested as a party." *Id.* at § 18b(A)(2).

15. Plaintiff North Dakota is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Drew Wrigley is the Attorney General of North Dakota and is authorized to "[i]nstitute and prosecute all actions and proceedings in favor or for the use of the state." N.D.C.C. § 54-12-01(2).

16. Plaintiff South Carolina is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. South Carolina brings this suit through its attorney general, Alan Wilson. He is the chief legal officer of the state of South Carolina and has the authority to represent South Carolina in federal court. *State ex rel. Condon v. Hodges*, 349 S.C. 232, 239-40, 562 S.E.2d 623, 627 (2002) (the South Carolina Attorney General "may institute, conduct and maintain all such suits and *proceedings as he deems* necessary for *the enforcement of the laws of the State*, the *preservation of order*, and the *protection of public rights*.") (emphasis in original) (quoting

State ex rel. Daniel v. Broad River Power Co., 157 S.C. 1, 68, 153 S.E. 537, 569 (1929), *aff'd* 282 U.S. 187 (1930)).

17. Plaintiff South Dakota is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. South Dakota brings this suit through its Attorney General, Marty J. Jackley. He is the duly elected Attorney General of South Dakota with the authority, per SDCL 1-11-1(1), to prosecute and defend all actions, civil or criminal, in which the state is an interested party.

18. Plaintiff Utah is a sovereign State of the United States of America. It sues to vindicate its sovereign, quasi-sovereign, and proprietary interests. Utah brings this suit through its attorney general, Sean D. Reyes. He is the chief legal officer of the State of Utah and has the authority to represent Utah in federal court. Utah Const. art. VII, § 16; Utah Code § 67-5-1(1)(b).

19. Plaintiff Commonwealth of Virginia is a sovereign State of the United States of America. Jason Miyares, the Attorney General of Virginia, is authorized by statute to "represent the interests of the Commonwealth … in matters before or controversies with the officers and several departments of the government of the United States." Va. Code § 2-2.513.

20. Plaintiff State of West Virginia is a sovereign State of the United States of America. Patrick Morrisey is the Attorney General of the State of West Virginia. The Attorney General "is the State's chief legal officer," *State ex rel. McGraw v. Burton*, 569 S.E.2d 99, 107 (W. Va. 2002), and his express statutory duties include "appear[ing] as counsel for the state in all causes pending . . . in any federal court[] in which the state is interested," W. Va. Code § 5-3-2.

21. Plaintiff LeadingAge Kansas is a state trade association that has operated for 70 years with over 150 not-for-profit and mission driven aging services providers, including 116 nursing homes. LeadingAge Kansas represents a significant number of small, rural, and stand-alone nursing homes who will not be able to absorb the cost of the Final Rule year-after-year as they continue to rely on historically underfunded Medicaid and Medicare reimbursement.

22. Among the nursing homes that are members of Plaintiff LeadingAge Kansas are Plaintiffs Dooley Center and Wesley Towers. These and others are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

23. Plaintiff Dooley Center is a 44-person licensed nursing facility located in Atchison, Kansas, that accepts Medicaid and private pay only. It cares for the retired Benedictine Sisters of Mount St. Scholastica. Its mission is "the care of the sick rank above and before all else, so they may truly be served as Christ." It is harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

24. Plaintiff Wesley Towers is a continuing care retirement community located in Hutchinson, Kansas. It currently has 185 employees and 300 residents, 50 of whom are cared for in its nursing home. It is harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

25. Plaintiff LeadingAge South Carolina is an association that represents 30 non-profit mission driven skilled nursing communities in South Carolina. These communities, which include Presbyterian Communities of South Carolina, Lutheran Homes of South

Carolina, The Woodlands at Furman, Wesley Commons, Westminster Towers, Bishop Gadsden Episcopal Community, Saluda Nursing & Rehabilitation, The Cypress of Hilton Head, Park Pointe Village, The Seabrook of Hilton Head, Rolling Green Village, South Carolina Baptist Ministries of Aging, and Still Hopes Episcopal Retirement Community, are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

26. Plaintiff LeadingAge Colorado is a statewide trade association that represents the continuum of senior living and aging services providers including not-for-profit nursing homes. It represents 12 nursing communities, including Eben Ezer Lutheran Care Center, which are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

27. Plaintiff LeadingAge Iowa is a trade association that represents not-for-profit aging services providers in Iowa, including 60 nursing homes, nearly half of which are located in this District. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

28. Plaintiff LeadingAge Maryland is a membership association representing not-for-profit aging services organizations in Maryland. It represents 30 nursing communities, with its members including Coffman Nursing Center, Fahrney Keedy Home and Village. These and other members are harmed by the Final Rule because of significant costs and mandatory

staffing requirements that are impossible to meet without reducing services or further limiting access to care.

29. Plaintiff LeadingAge Michigan is a state trade association with over 200 not-for-profit and mission-driven aging services providers, including 51 nursing homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

30. Plaintiff LeadingAge Minnesota is a state trade association that has over 1100 mission-driven aging services providers, including 239 nursing homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

31. Plaintiff LeadingAge Missouri is a membership association for 125 Missouri aging services providers, including 44 nursing homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

32. Plaintiff LeadingAge Nebraska is a statewide trade association supporting nursing home and other providers of long-term care services in Nebraska. It represents 47 nursing home providers, including Florence Home, which are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

33. Plaintiff LeadingAge New Jersey/Delaware is a state trade association with over 140 mission driven senior living and services provider members, including over 30 nursing

communities. These members, including United Methodist Communities, are harmed by the Final Rule because of significant costs and mandatory staffing requirements are impossible to meet without reducing services or further limiting access to care.

34. Plaintiff LeadingAge Ohio is an association that represents 112 nonprofit, mission-driven skilled nursing communities in Ohio, with its member including Shepherd of the Valley communities in Poland, Boardman, Girard and Howland; Community First Solutions, which operates three facilities in Hamilton, Ohio. These and other members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

35. Plaintiff LeadingAge Oklahoma is a state trade association with over 100 not-for-profit and mission driven aging services providers, including 58 nursing homes. These and other members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

36. Plaintiff LeadingAge PA is an association representing more than 400 non-profit and mission-driven providers of senior services in Pennsylvania, with its membership encompassing 182 of the more than 600 skilled nursing facilities in Pennsylvania. These and others members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are impossible to meet without reducing services or further limiting access to care.

37. Plaintiff LeadingAge South Dakota Association of Healthcare Organizations ("SDAHO") is a state trade association serving South Dakota's hospitals, nursing homes,

home health, hospice and assisted living providers through advocacy, education and quality integration. Its membership includes 57 hospitals, 47 nursing homes, 77 assisted living facilities, and approximately 18 home health and hospice providers. Many of its members, including The Neighborhoods at Brookview in Brookings, SD, Bethesda Home of Aberdeen, South Dakota, and Winner Regional Healthcare Center in Winner, SD, are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

38. Plaintiff LeadingAge Southeast is a state trade association with over 250 mission driven communities. Their members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

39. Plaintiff LeadingAge Tennessee is a state trade association with 20 not-for-profit nursing home members serving the State of Tennessee. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are difficult if not impossible to meet without reducing services or further limiting access to care.

40. Plaintiff LeadingAge Virginia is a state trade association with over 90 mission driven provider members, including over 46 homes. These members are harmed by the Final Rule because of significant costs and mandatory staffing requirements that are impossible to meet without reducing services or further limiting access to care.

41. Defendant Xavier Becerra is the Secretary of Health & Human Services. Defendant Becerra oversees the Medicare and Medicaid programs and approved the Final Rule at issue in this litigation. *See* 89 Fed. Reg. at 41000. Defendant Becerra is sued in his official capacity.

42. Defendant United States Department of Health and Human Services ("HHS") is a federal agency organized under the laws of the United States. It is responsible for administering federal healthcare policy and is the cabinet-level department of which the Centers for Medicare & Medicaid Services ("CMS") is a part.

43. Defendant CMS is a federal agency within HHS responsible for the federal government's administration of Medicare and Medicaid.

44. Defendant Chiquita Brooks-Lasure is the Administrator of CMS and is sued in her official capacity.

JURISDICTION AND VENUE

45. This Court has jurisdiction over this action under 28 U.S.C. § 1331 and has authority to grant the relief requested under the Administrative Procedure Act, 5 U.S.C. §§ 701-706, and the Declaratory Judgment Act, 28 U.S.C. §§ 2201-2202.

46. The Court is authorized to set aside the challenged agency actions, postpone their effective date pending judicial review, hold them unlawful, grant preliminary and permanent injunctive relief, and award the declaratory and injunctive relief requested below. 5 U.S.C. §§ 705-06 (2018); 28 U.S.C. §§ 1361, 2201-02 (2018).

47. Venue is proper under 5 U.S.C. § 703 and 28 U.S.C. § 1391(e) because (1) Plaintiff State of Iowa and members of LeadingAge Iowa reside in this judicial district and no real property is involved in this action.

48. Plaintiffs are challenging a final agency action pursuant to 5 U.S.C. §§ 551(13) and 704 (2018).

BACKGROUND

A. Medicare and Medicaid Statutes

49. In 1965, Congress established the Medicare and Medicaid programs by amending the Social Security Act. *See* Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965).

50. Medicare is a federal program that provides healthcare coverage to individuals 65 or older, as well as those with certain disabilities or conditions. *See* 42 U.S.C. § 1395c.

51. Medicaid, on the other hand, is a joint federal-state program offering healthcare coverage to low-income individuals. *See* 42 U.S.C. §§ 1396-1, 1396a.

52. Nursing homes that wish to participate in Medicare must comply with the statutory requirements for "skilled nursing facilities" ("SNFs") provided for at 42 U.S.C. § 1395i-3.

53. Those participating in Medicaid must meet similar requirements for "nursing facilities" ("NFs") set forth at 42 U.S.C. § 1396r.

54. Together, "skilled nursing facilities" covered under Medicare, and "nursing facilities" covered under Medicaid are often collectively referred to as "long-term care" ("LTC") facilities. *See, e.g.* 87 Fed. Reg. 22720, 22790 (Apr. 15, 2022). Referring to both types of facilities as LTCs is convenient because the statutory language for both Medicare and Medicaid requirements are largely parallel.

55. CMS has issued consolidated regulations applicable to all LTC facilities participating in either or both Medicare and Medicaid. *See e.g.* 42 C.F.R. § 483.1.

56. Under the Medicaid statute, a state may waive the staffing requirements for an LTC facility if it cannot meet them, provided certain conditions are met: (1) the LTC facility must demonstrate to the state that, despite diligent efforts, it was unable to recruit suitable

personnel; (2) granting a waiver will not compromise the health or safety of the LTC facility's residents; (3) during times when an RN is unavailable, an RN must be able to respond to calls from the LTC facility; (4) the state agency must notify the state long term care ombudsman about the waiver; and (5) the LTC facility must inform its residents and family about the waiver. *See generally* 42 U.S.C. § 1396r(b)(4)(C)(ii)(I)-(V).

57. Similarly, under the Medicaid statute, LTC facilities are addressed in 42 U.S.C. § 1396r(b)(4)(C), also entitled "Required nursing care." This section mandates that LTC facilities provide necessary services and activities to achieve or maintain the highest practical well-being of each resident. Both the Medicare and the Medicaid emphasize the importance of quality care.

58. LTC facilities participating in either Medicare or Medicaid are required to utilize the services of a registered professional nurse for "at least 8 consecutive hours a day, 7 days a week." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *accord id*. § 1396r(b)(4)(C)(i)(II) (Medicaid).

59. They are required to provide 24-hour licensed nursing services that are "sufficient to meet the nursing needs of their residents." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *accord id*. § 1396r(b)(4)(C)(i)(I) (Medicaid).

60. Under the Medicare statute, the Secretary of HHS is authorized to waive the requirement for LTC facilities to employ an RN for more than 40 hours per week if: (1) the facility is "located in a rural area where the supply of skilled nursing services is insufficient to meet the needs" of local residents; (2) "the facility has one full-time RN who is regularly on duty at the [LTC] for 40 hours [per] week"; (3) the LTC facility has patients whose physicians have indicated that they do not require an RN or physician for 48 hours, or it has arranged for

an RN or physician to provide necessary services when the full-time nurse is unavailable; (4) "the Secretary provides notice of the waiver to the State long-term care ombudsman …"; and (5) the facility that is granted the waiver notifies residents of the LTC facility and their families of the waiver. *See generally* 42 U.S.C. § 1395i-3(b)(4)(C)(ii)(I)-(V).

61. Waivers of staffing requirements under the Medicaid statute are subject to annual review by the State and Secretary of HHS. *Id*. If a state is found to regularly grant waivers without facilities making diligent efforts to meet staffing requirements, the Secretary "shall assume and exercise the authority of the State to grant waivers." *Id*.

62. Neither the Medicare nor Medicaid statutes grant the Secretary the authority to establish a uniform HPRD requirement across all LTC facilities, irrespective of the actual needs of their residents or the idiosyncrasies of each facility. Rather, these statutes require nursing services that "are sufficient to meet the nursing needs" of each facility's residents. *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id*. 42 U.S.C. § 1396r(b)(4)(C)(i)(I).

63. Neither statute authorizes the Secretary to impose standardized HPRD requirements for RN staffing at every LTC facility across the country, regardless of their residents' specific needs or the idiosyncrasies of each LTC facility. *Id*.

64. Neither statute authorizes the Secretary to impose standardized HPRD requirements for NA staffing at every LTC facility across the country, regardless of their residents' specific needs or the idiosyncrasies of each LTC facility. *Id*.

65. Neither statute authorizes the Secretary to alter or increase the hour requirement for LTC facilities to employ the services of a registered professional nurse beyond "at least 8 consecutive hours a day, 7 days a week." *Id*.

B. Statutory and Regulatory History of Nursing Staff Requirements

66. For over fifty years, Congress has been at the helm of deciding the requisite staffing requirements for nursing homes participating in Medicare and Medicaid. In 1972, Congress amended the Social Security Act to declare that all LTC facilities participating in Medicare or Medicaid provide "24-hour nurse service[s] which is sufficient" to meet patient needs, including employing at least one registered professional nurse full-time. Pub. L. No. 92-603, § 278, 86 Stat. 1329, 1424-27 (1972).

67. The amendments also introduced nurse-staffing waiver provisions for rural facilities under specific conditions. *See id*. § 267, 86 Stat. at 1450.

68. The Department of Health, Education and Welfare (predecessor of HHS), through its Social Security Administration ("SSA"), proposed regulations in 1973 that aligned with these statutory requirements. *See* 38 Fed. Reg. 18620 (July 12, 1973).

69. At the same time, during the notice-and-comment period, the SSA received public input urging it to deviate from Congress's flexible (qualitative) approach for a staffing requirement that all nursing homes implement a rigid (quantitative) nurse-to-patient ratio. *See* 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974).

70. Despite calls for these specific nurse-to-patient ratios, the SSA rejected such a uniform approach, citing the variability in facility needs and the potential negative impacts of arbitrary staffing quotas. *Id*.

71. SSA reasoned that "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs and the services necessary to meet those needs precludes setting [a specific ratio]." *Id*. Moreover, "[a] minimum ratio could result in all facilities striving only to reach that minimum and could result in other facilities hiring unneeded staff to satisfy an arbitrary ratio figure." *Id*.

72. Later, in 1980, HHS took over the administration of Medicare and Medicaid services. It proposed a "general revision" of the regulation governing the participation of LTC facilities in the Medicare and Medicaid programs. *See* 45 Fed. Reg. 47368 (July 14, 1980).

73. However, HHS declined to implement any specific staffing ratios, but rather "retain[ed] the language in the existing regulations" that mirrored those statutes which called for "adequate staff to meet patient needs" *Id*. at 47371; *see also id*. at 47387 (requiring "24-hour nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of the patient," and a registered nurse working full time for 7 days a week).

74. In 1987, Congress—and not HHS—redefined nursing home categories and imposed uniform staffing requirements on LTC facilities under Medicare and Medicaid by requiring a registered nurse on duty for at least eight hours per day, seven days a week. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4201(a), 101 Stat. 1330-161; *accord id*. § 4211(a), 101 Stat. 1330-186 (Dec. 22, 1987).

75. Congress further refined nursing home legislation by introducing waiver provisions and commissioning studies to analyze staffing requirements. These studies aimed to "determine the appropriateness of establishing minimum caregiver to resident ratios" for LTC facilities. *See* Pub. L. No. 101-508, §§ 4008(h), 4801(a), 104 Stat. 1338 (1990)).

76. Yet no mandatory ratios or staffing requirements were implemented, and CMS continuously administered the staffing standards established by Congress without incident. *See* 42 C.F.R. § 483.35(a)-(b) (2016).

77. In 2016, CMS once again dismissed the push for mandatory staffing ratios in LTC facilities and for the 24/7 RN requirement. *See* 81 Fed. Reg. 68688, 68754-56 (Oct. 4, 2016).

78. It concluded that a "one-size-fits-all approach" to staffing was not only "inappropriate[,]" but also that "mandatory ratios" and a "24/7 RN presence" were concerning. *Id*. at 68754-56, 68758; *see also* 80 Fed. Reg. 42168, 42201 (July 16, 2015) (emphasizing the importance of taking resident acuity levels into account").

79. Specifically, CMS expressed concerns about mandatory ratios and the 24/7 requirement because "LTC facilities [vary] in their structure and in their resident populations." *Id*.

80. CMS determined that the "focus" of its regulations "should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care." 80 Fed. Reg. at 42201. And "establishing a specific number of staff or hours of nursing care could result in staffing to that number rather than to the needs of the resident population." *Id*.

81. CMS also found that having a 24/7 RN requirement "could negatively impact the development of innovative care options, particular[ly] in smaller, more home-like settings," and that "geographic disparity in supply could make such a mandate particularly challenging in some rural and underserved areas." 81 Fed. Reg. at 68755.

82. Indeed, LTC facilities differ and vary across the country. CMS found that obvious when it succinctly explained its rejection of the one-size-fits-all staffing requirement: "The care needs of each of these populations are different. Facilities range in size from the very small to the very large. The capabilities of these facilities are [] different." *Id*. at 68755.

83. Because of the variation in LTC facility needs across the country, LTC facility minimum staffing requirements are handled differently across states. As CMS acknowledged,

there is "widespread variability in existing minimum staffing standards" adopted by 38 States and the District of Columbia. *See* 89 Fed. Reg. at 40880.

THE FINAL RULE

84. In February 2022, the Biden-Harris Administration departed from these decades of practice to establish a "reform" that would "establish a minimum nursing home staffing requirement." White House, FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes (Feb. 28, 2022) ("White House Fact Sheet").[1]

85. In doing so, the administration directed CMS to conduct a research study to determine the level and type of staffing needed to ensure safe and quality care. *Id*.

A. The Abt Study

86. In response to this directive, CMS contracted with a private firm, Abt Associates, to perform a "mixed-methods Nursing Home Staffing Study" as a party of CMS's goal of identifying a minimum staffing requirement.[2] The goal was to issue proposed rules by February 2023 and establish minimum standards for staffing adequacy. *See Supra*, White House Fact Sheet.

87. However, the truncated Abt Study was "conducted on a compressed timeframe" with data collected between June of 2022 through December of 2022. Abt Study at xix. Strikingly, "the short duration reflect[ed] the time-sensitive nature of the study and CMS's timeline for proposing a minimum staffing requirement in support of the Presidential initiative." *Id*.

[1] The White House, *FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes* (Feb. 28, 2022), available at https://tinyurl.com/3626wt8k
[2] Abt Associates, *Nursing Home Staffing Study: Comprehensive Report* (June 2023) ("Abt Study") at viii, available https://tinyurl.com/b2ehy528

88. The study was completed and published in June of 2023. Consistent with the decades of prior practice and contrary to the directive of the Biden-Harris Administration, the Abt Study did "not identif[y] a minimum staffing level to ensure safe and quality care." Abt Study at 115.

89. According to the study, if a minimum staffing level was to be implemented, "[n]ursing homes [would] face barriers to hiring, primarily [with] workforce shortages and competition from staffing agencies." *Id*. at xi; *see also*, *e.g*., *id*. at xii, xiv, 19, 31-32, 115.

90. Furthermore, it concluded that between 43 and 90 percent of nursing homes would have to add more staff to comply with a federal minimum staffing requirement. *Id*. at 113. It also predicted that a federal minimum staffing requirement could cost the nursing home industry up to $6.8 billion in compliance costs each year. *Id*. And that annual total salaries per nursing home would have to increase from as low as $316,000 to $693,000 in order to comply. *Id*. at 113-14.

91. Nowhere in the study did Abt Associates conclude that a minimum staffing requirement would result in *definitive* benefits. The Abt Study provides data for only "*potential* minimum staffing requirement benefits" and for "potential barriers to and unintended consequences of [an] implementation." Abt Study at 121 (emphasis added).

92. Nowhere in the study did Abt Associates conclude that a federally mandated minimum staffing requirement would *actually* provide better healthcare outcomes for nursing home residents. Rather, the reviewed literature "underscored" that there was no "clear eviden[tiary] basis for setting a minimum staffing level." Abt Study at xi.

93. Moreover, the staffing study did not find the implementation of a federally mandated minimum staffing requirement to be feasible without considering factors such as

variations in resident acuity, ongoing staffing shortages, compliance costs, and the diverse circumstances affecting quality patient care. *Id*. at 32.

94. That is not surprising given CMS's past positions that rejected calls to impose a one-size-fits-all approach. *See e.g.* 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974) (explaining that the variation in patients' needs is a valid basis to reject setting a specific staff-to-patient ratio); 45 Fed. Reg. 47368, 47371 (July 14, 1980) (rejecting nursing staff ratios or minimum number of nursing hours per patient day because of the lack of conclusive evidence supporting the implementation of a minimum staffing requirement); 52 Fed. Reg. 38583, 38586 (Oct. 16, 1987) (explaining that a 24-hour nursing requirement would be impractical and that a nurse staffing requirement should be sensitive to the "patient mix") ; 80 Fed. Reg. 42168, 42201 (July 16, 2015) ("We believe that the focus should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care that does not consider resident characteristics such as stability, intensity and acuity and staffing abilities including professional characteristics, skill sets and staff mix."); 81 Fed. Reg. 68688, 68755 (Oct. 4, 2016) ("[w]e do not agree that we should establish minimum staffing ratios at this time . . . [t]his is a complex issue and we do not agree that a 'one-size-fits-all' approach is best . . . [o]ur approach would require that facilities take into account the number of residents in the facility, those residents' acuity and diagnosis.").

95. As a result, the Abt Study never came to a definitive conclusion that supported a national, one-size-fits-all approach to minimum staffing requirements that the Biden-Harris Administration was hoping to achieve.

96. Rather, there was no "specific evidence" that a minimum nursing staff level could be feasibly implemented. *Id*. at 111. Troublingly, the study disregarded the ongoing "national health care staff shortages" and "current hiring challenges" that present barriers to nursing homes—which would make compliance with a new federal staffing requirement impractical. *Id*. at xxi.

97. The study acknowledged but ultimately ignored several potential unintended consequences of implementing a national minimum staffing requirement. These include: (1) the possibility that nursing homes might be unable to achieve the one-size-fits-all staffing levels; (2) LTC facilities could be limited in resident admissions because of staff-to-patient ratios; or (3) nursing homes might even close down entirely, thereby potentially reducing access to care. *Id*.

B. Promulgation of the Final Rule

98. In lockstep with marching orders from the Biden-Harris Administration, CMS issued a proposed rule in September of 2023 that introduced new minimum staffing standards for LTC facilities. *See* 88 Fed. Reg. 61352 (Sept. 6, 2023).

99. Despite the 46,000 public comments—some of which informing CMS that the proposed rule exceeded CMS's statutory authority, contravened Congress's considered decision to keep flexible staffing standards, and failed to consider the barriers nursing homes would face with compliance—CMS published the Final Rule in May of 2024. *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).

100. CMS claims that the minimum staffing standard is supported by "literature evidence, analysis of staffing data and health outcomes, discussions with residents, staff, and industry." *See* 89 Fed. Reg. at 40877.

101. Citing the inconclusive and truncated six-month Abt Study, CMS claims that this was enough to conclude that an overly-broad and onerous staffing requirement was necessary. *See* 89 Fed. Reg. at 40881, 40877.

102. Yet, CMS acknowledges that "[t]here is no clear, consistent, and universal methodology for setting specific minimum staffing standards" as evidenced by the 38 states and the District of Columbia that have adopted their own nurse-to-patient ratios. *Id*. at 40881.

103. Notwithstanding the variability across the minimum staffing requirements different states employ, the inconclusive determination of the Abt Study, or the consistent rejection of a one-size-fits-all staffing requirement for over fifty years, CMS published the Final Rule.

104. CMS asserts that "various provisions" across 42 U.S.C. §§ 1395i-3 and 1396r contain "separate authority" to impose the Final Rule. *See* 89 Fed. Reg. at 40879, 40890-9.

1. The Secretary may impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary." 42 U.S.C. § 1395i-3(d)(4)(B); *accord id*. § 1396r(d)(4)(B).

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

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

C. The Final Rule's Provisions

105. The Final Rule imposes two mandatory minimum-staffing requirements on LTC facilities.

106. *First*, the Final Rule *triples* the required hours per day of RN services. Both the Medicare and Medicaid statutes require that LTC facilities "[u]se the services of [an RN] for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id.* § 1396r(b)(4)(C)(i). But the Final Rule requires LTC facilities to have an RN "onsite 24 hours per day, for 7 days a week that is available to provide direct resident care" ("24/7 requirement"). 89 Fed. Reg. at 40997.

107. *Second,* the Final Rule abandons the flexible, qualitative statutory requirement that LTC facilities "provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1395i-3(b)(4)(C)(i); *accord id.* § 1396r(b)(4)(C)(i). Instead, the Final Rule now requires that "[t]he facility must meet or exceed a minimum of 3.48 hours per resident day ('HPRD') for total nurse staffing," which must include a "minimum of 0.55 [HPRD] for registered nurses," and a "minimum of 2.45 [HPRD] for nurse aides." 89 Fed. Reg. at 40996.

108. Before publication of the Final Rule, federal regulations mirrored Congress's *qualitative* statutory requirements to keep nursing staff available 24-hours per day. *See* 42 C.F.R. § 483.30.

109. Those regulations never specified a *quantitative* staffing requirement. *Id.*; *Cf.* 89 Fed. Reg. 40876, 40996-97. But by departing from the flexibility of both the Medicare and Medicaid statutes, the Final Rule now requires national compliance from LTC facilities "regardless of the individual facility's resident case-mix." 89 Fed. Reg. at 40877.

110. Regarding the statutory waivers, the Final Rule permits Medicare participants to qualify for a statutory waiver of the 24/7 RN requirement, but not the HPRD requirements. *Id*. at 40997-98.

111. The Final Rule also permits Medicaid participants to qualify for the statutory waiver concerning the new 24/7 RN requirement and 0.55 RN HPRD requirement, but not for the 3.48 total nurse HPRD nor 2.45 NA HPRD requirements. *Id*. at 40997.

112. The Final Rule proposes a "hardship exemption," ostensibly allowing partial relief from the 24/7 requirement and minimum HPRD requirements. *Id*. at 40998. However, this exemption is riddled with stringent criteria that make it virtually unattainable for most facilities to achieve.

113. To qualify for a "hardship exemption," the facility must establish that it meets *all four* regulatory requirements: (1) proving a significant local shortage of health care staff; (2) demonstrating unsuccessful recruitment efforts despite offering competitive wages; (3) documenting financial expenditures on staffing relative to revenue; and (4) qualified facilities must publicly disclose their exemption status. *Id*. at 40998.

114. This façade of an exemption is not only limited in scope, but explicitly departs from the statutory waiver criteria already laid out by Congress. Even *if* granted on the case-by-case determination, *see* 89 Fed. Reg. at 40886, the exemption only provides an 8-hour reprieve from the 24/7 RN requirement, leaving facilities with the requirement to staff for a minimum of 16 hours per day, 7 days per week. *Id*. at 40998.

115. Even the narrow allowance of a "hardship exemption" can still be denied if a facility is designated as a "Special Focus Facility," or those with recent staffing-related

citations. *Id*. Ultimately, LTC facilities currently struggling with staffing recruitment or retention will be incapable of qualifying for even a "hardship exemption."

D. CMS Fails to Explain the Final Rule

116. In the Final Rule, CMS fails to explain why it implemented the 24/7 requirement and departed from the statutory requirements of both the Medicare and Medicaid Acts that only require onsite RN services for only 8 hours per day, 7 days a week (hereinafter "8/7 requirement").

117. Nowhere in the Abt Study does it suggest that LTC facilities across the country should require an on-site RN 24 hours per day, 7 days per week.

118. CMS fails to explain how it determined its 3.48, 0.55, or 2.45 HPRD requirements. It claims that the 3.48, 0.55, and 2.45 HPRD levels "were developed using case-mix adjusted data sources." 89 Fed. Reg. at 40877.

119. CMS claims that the 0.55 and 2.45 levels, but not the 3.48 level, were discussed during the notice of proposed rulemaking. *See* 88 Fed. Reg. 61352 (Sept. 6, 2023); 89 Fed. Reg. at 40891.

120. In the notice of proposed rulemaking, CMS indicated that based on findings from the Abt Study, additional data sources, "two listening sessions," and literature reviews, they proposed minimum staffing levels of 0.55 HPRD for RNs and 2.45 HPRD for NAs. 88 Fed. Reg. at 61369.

121. However, the Abt Study does not substantiate these specific levels. Moreover, a "review of existing literature" does not provide a valid evidentiary basis for establishing these requirements.

122. CMS also fails to establish how other data assessments support the published staffing levels.

123. CMS provides no rationale for the 3.48 HPRD requirement in either the notice of proposed rulemaking or the Final Rule, aside from vaguely stating it was developed using "case-mix adjusted data sources." 89 Fed. Reg. at 40877. This explanation departs from those used to establish other staffing levels in the notice of proposed rulemaking.

124. Moreover, CMS's minimum staffing ratios require LTC facilities to ignore the variability in resident acuity and needs across different facilities. Some facilities with higher acuity residents may need increased staffing, while others with lower acuity residents may not require an RN present 24/7. CMS fails to explain why requiring facilities with lower acuity residents to maintain higher staffing than needed is necessary for increasing quality of care.

125. CMS's rationale for the Final Rule is premised on truncated data that does not accurately capture the staffing realities in nursing homes. The Final Rule requires the use of Payroll Based Journaling ("PBJ") data to monitor and enforce the HPRD and 24/7 requirements. *See* 89 Fed. Reg. at 40882-83.

126. However, PBJ data fails to accurately account for the specific periods when LTC staff are working and need to comply with the Final Rule. For instance, if an LTC facility employs three RN's who each work 8-hour dayshifts but no overnight shifts, it would appear on paper that they meet the 24/7 requirement. But in reality, they are not. CMS thus fails to explain how PBJ data is an accurate metric of tracking compliance.

127. CMS fails to account for the ongoing shortage of nursing staff across the country—one that will surely be exacerbated by CMS's mandate that will make compliance virtually impossible in rural areas.

128. Instead of addressing the reality of the nationwide workforce shortage, CMS would rather throw $75 million to help "increase the [LTC] workforce" that it "expects" will be used for "tuition reimbursement." 89 Fed. Reg. 40885-86. This $75 million is only a miniscule fraction of what is *needed* to comply or alleviate many of the affected LTC facilities. Moreover, $75 million does not address the foundational problem.

129. Ultimately, CMS's explanation for the determination of these levels lacks transparency and does not adequately explain how such arbitrary figures and standards were determined.

HARM TO THE PLAINTIFFS

A. Financial Burden

130. The Final Rule imposes a monumental financial burden on LTC facilities, with costs (conservatively) projected to exceed $5 billion per year after the Final Rule is fully implemented. 89 Fed. Red. at 40970, tbl. 22; *see id*. at 40949. Outside studies point that number even higher—upwards of $7 billion per year by some estimates. *Id*. at 40950.

131. All of Plaintiff States' LTC facilities that receive Medicare and Medicaid will incur financial costs with the implementation of this Final Rule.

132. LTC facilities in Kansas are a prime example of how the Final Rule creates a daunting financial burden.

133. The total cost for Kansas nursing facilities to comply with the Final Rule's minimum staffing requirement—in the first year alone—ranges between $64 million and $92.7 million, with an average cost of $211,905 per facility.

134. In Indiana, the Indiana Health Coverage Program and Indiana PathWays for Aging provide coverage for long-term care services provided to eligible members with an

applicable level-of-care determination. CMS estimates that complying with the 24/7 RN Requirement will cost over $10.9 million annually in Indiana. 89 Fed. Reg. at 40962, tbl. 18. Statewide, CMS estimates that complying with this rule will cost Indiana long-term care facilities $151.2 million. *Id.* at 40984, tbl. 28. Much of this cost will be passed on to health plans, like Indiana Health Coverage Program and Indiana PathWays for Aging. So Indiana will face increased costs to cover long-term care services.

135. Plaintiff LeadingAge Kansas represents a significant number of small, rural, and stand-alone nursing homes who will be unable to absorb the incessant compliance costs.

136. LTC facilities operated by LeadingAge Kansas have historically relied on underfunded Medicaid and Medicare reimbursement while serving senior citizens in their communities who can already ill afford escalating costs of healthcare.

137. The estimated financial burden caused by the Final Rule will also include costs for both employing new staff and the use of contracted nursing agency workers—which is significantly more expensive.

138. For example, the average contracted RN rate is estimated at $72 per hour, while the average W2 RN employee rate is around $40 per hour. The averaged contracted NA rate is $38 per hour, while the average W2 NA employee rate is around $19 per hour.

139. For LeadingAge South Carolina, each LTC facility is estimated to have to pay $550,818 in compliance costs, which will potentially close most facilities.

140. Wesley Commons, one of LeadingAge South Carolina's LTC facilities, had to hire two additional RNs to comply with the Final Rule—incurring costs of $14,650, excluding night and weekend shifts.

141. Additionally, for compliance with the Final Rule, it reinstated two full-time nursing assistants to meet the HPRD requirement—adding an additional $66,560 per year.

142. These changes were necessary to comply with the Final Rule, despite previously meeting both state and federal requirements. Moreover, to retain and recruit more staff due to the new requirements, Wesley Commons increased pay, costing an additional $164,428 per year.

143. Facilities in rural areas that are operated by LeadingAge South Carolina will struggle to compete with urban LTC facilities.

144. For example, South Carolina Baptist Ministries of Aging paid over $1.25 million in 2022 to staffing agencies. In 2024 alone, and in order to come into compliance with the Final Rule, it paid an additional $500,000 to staffing agencies ahead of time to come into compliance.

145. Another LTC operated by LeadingAge South Carolina—The Woodlands at Furman—had to raise its pay rates by over 20% in the past year.

146. It is now forced to compete with private hospital systems that are continuously raising their RN and NA pay rates. Thus, the Final Rule's staffing mandate has had the downstream effect of creating a market where LTC facilities will have to limit their offerings or even shut their doors to elderly patients who need care.

147. The financial strain, along with inadequate Medicaid reimbursement rates, threatens many LTC facilities with closure, especially in rural communities with thin operating margins.

148. CMS has allocated only $75 million for nursing program tuition reimbursement—far less than what is needed. The Final Rule's cost burden will affect providers, private facilities, and Plaintiff States' taxpayers.

149. For example, 60 percent of nursing home residents in Kansas are on Medicaid. Since the COVID-19 Pandemic, Kansas lost 1,273 nursing home beds and 47 facilities closed or reduced services. Thus, the Final Rule will place a crippled LTC industry in dire straits.

B. Administrative Burdens

i. Staffing Issues

150. Not only is the Final Rule costly, but compliance will impact an overwhelming majority of LTC facilities across the country, especially those who do not cut corners and allocate resources primarily to resident care. Indeed, even by CMS's own estimate, more than 79 percent of LTC facilities in the United States will have to find additional staff just to comply with the new minimum-staffing requirements. 89 Fed. Reg.at 40877. This "exceed[s] the existing minimum staffing requirements in nearly all states." *Id*.

151. By CMS's estimates, LTC facilities across the country will have to hire almost 15,906 additional RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement. 89 Fed. Reg. at 40958, 40977-80.

152. Additionally, LTC facilities will have to hire 77,611 NAs to meet the 2.45 NA HPRD requirement and the 3.48 total nurse HPRD requirement. *Id*. Hiring 90,000 new staff to fall in compliance with the Final Rule is practically impossible when LTC facilities are already experiencing staffing shortages, recruitment issues, and employment retention.

153. Kansas is a prime example of how the Final Rule's adverse effects will irreparably harm Plaintiffs. According to CMS data, the state of Kansas will need an

additional 230 RNs to comply with both the 24/7 Requirement and 0.55 RN HPRD requirement for LTC facilities. *See* 89 Fed. Reg. at 40059, 40077-79.

154. CMS has already indicated that 109 LTC facilities are out of compliance with the 24/7 RN requirement. 89 Fed. Reg. at 40062. Furthermore, Kansas will have to hire an additional 523 NAs to comply with the Final Rule's HPRD ratios. *See id*. at 40077-79.

155. Nearly 85,000 Kansans live in areas with only one LTC facility within a 30-minute drive, and the closure of such facilities would significantly increase travel time, creating a lack of access to care and essential services.

156. Additionally, with the aging population in Kansas projected to grow by 208,000 by 2036, the capacity to provide adequate care will be severely strained if more facilities are forced to reduce capacity or close entirely.

157. LTC facilities in Kentucky, according to the CMS data, will need to hire an additional 185 RNs and to comply with both the 24/7 requirement and the 0.55 RN HPRD requirement. See 89 Fed. Reg. 40965, 40977-80.

158. Furthermore, CMS estimates that Kentucky facilities will need to hire an additional 1336 NA staff just to comply with the Final Rule's HPRD ratios. *See id.* at 40977-80.

159. CMS data estimates that 211 LTC facilities in Kentucky do not currently meet the Final Rule's staffing requirements.

160. The Kentucky Association of Health Care Facilities, which represents skilled nursing facilities and personal care homes in Kentucky, estimates that only 6% of nursing homes currently have sufficient nursing staff to comply with all the Final Rule's requirements. Yet, a workforce survey report by the Kentucky Hospital Association predicted a worsening

shortage of nursing staff available in Kentucky for LTCs to hire. *See* Morgan Watkins, *New studies show scope of Kentucky's health care worker shortage, as a coalition promotes solution*s, available at https://perma.cc/XLT5-TMR9.

161. Most of Montana consists of health professional shortage areas (HPSAs). Many of these LTC facilities are located in small towns or remote areas of Montana and likely have difficulty hiring RNs or contracting for visiting nursing staff to meet the minimum staffing requirements in the Final Rule.

162. LTC facilities in South Carolina, according to CMS data, will need to hire an additional 159 RNs to comply with both the 24/7 requirement and the 0.55 RN HPRD requirement. *See* 89 Fed. Reg. 40958, 40978-80.

163. Furthermore, South Carolina facilities will need to hire an additional 1,045 NA staff just to comply with the Final Rule's HPRD ratios. *See id*. at 40978-80. However, these numbers are low.

164. Based on LeadingAge South Carolina's data, facilities in South Carolina will need to hire 411 additional RNs and over 1170 NAs to meet the minimum staffing ratio provision in the Final Rule.

165. South Carolina is also projected to have the 4th largest nurse shortage by 2030. The additional hiring necessitated by the Final Rule will thus make compliance virtually impossible for LTC facilities.

166. According to the South Carolina Workforce Publication on Nursing, 53% of RNs work in hospital settings, whereas only 4.4% of RNs work in LTC settings.

167. Virginia's HPRD requirement, which goes into effect on July 1, 2025, is more than ten percent less than the Final Rule's requirement. Senate Bill No. 1339, 2023 Gen

Assemb., Reg. Sess. (Va.), https://tinyurl.com/c3f58meh (to be codified at Va. Code § 32.1-127(B)(32)) (requiring nursing homes "to provide at least 3.08 hours of case mix-adjusted total nursing staffing hours per resident per day on average").

168. Accordingly, any kind of required increase in staffing will have to account for (1) the national shortage in the healthcare labor force, and (2) the detraction of nurses from hospital settings. Ultimately, detrimental negative externalities cascade from the Final Rule and jeopardize the health care system, state agencies, and state hospitals.

ii. Enhanced Facility Assessment ("EFA")

169. The Final Rule's EFA implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs. 89 Fed. Reg. 40881, 40906.

170. Specifically, the Final Rule mandates LTC facilities to ensure the "active involvement" of direct care staff and their representatives, and to "solicit and consider input" from residents, their representatives, and family members. *Id*. at 40908. LeadingAge Kansas has requested guidance from the state survey agency contracted by CMS to carry out healthcare surveys of nursing home providers in Kansas on this provision but did not receive adequate guidance.

171. The Final Rule requires facilities to "review and update" the EFA at least annually, without clear guidance on when updates are "necessary"—thus, leading to potential civil penalties. *Id*. at 40999.

172. LTC facilities must also create "contingency planning," despite already having emergency plans in place. *Id*. at 41000. Overall, the EFA imposes significant administrative burdens and vague requirements that could result in fiscal penalties.

173. Furthermore, staff hours and costs for the EFA vary facility-to-facility. For LeadingAge Kansas members like Wesley Towers and the Dooley Center, the initial EFA ranged from 16 hours to 89 hours.

174. The estimated cost for each update to comply with the assessment ranges from $400 to $600. The Final Rule's vague language requiring continual updates means that costs can quickly escalate.

175. Facilities that already cut costs and operate below an acceptable standard of care often do have resources for adding additional personnel. Under the Final Rule, these bad actors will be more likely able to comply without significant impact to their profit-over-patients business models. Raising costs puts more strain on facilities who rightly focus resources toward resident care and creates a competitive advantage for the industry's worst actors: profiteers. Squeezing good actors out will thus have the opposite effect on the elder care industry than the Final Rule's intent.

176. CMS estimates the cost at $4,955 per facility, *see* 89 Fed. Reg. at 40939, but that number is woefully low. The Final Rule requires EFAs conducted on all LTC facilities without considering the acuity and needs of the residents to determine staffing levels or evaluate unique circumstances. These factors, coupled with the lack of clear guidance and the risk of civil penalties, significantly contribute to the administrative burden imposed by the Final Rule.

C. Harm to Plaintiff States

177. Many Plaintiff States have their own state-run nursing homes.

178. For example, Arkansas has a state-operated 310-bed psychiatric nursing home, the Arkansas Health Center, which would be required to comply with these new minimum staffing quotas. See Ark. Code Ann. § 25-10-401.

179. Idaho has at least five state-run nursing homes, all which receive Medicaid payments. Four of the nursing homes are run by the Idaho Division of Veterans Services, and one is run by the Idaho Department of Health and Welfare.

180. Montana operates several LTC facilities that receive CMS fund and that would be subject to CMS regulations.

181. West Virginia's Department of Health Facilities operates four nursing homes: Hopemont Hospital, John Manchin, Sr. Health Care Center, Lakin Hospital, and Welch Community Hospital. *See* West Virginia Department of Health Facilities, https://tinyurl.com/3ykbt2tw (last visited Oct. 4, 2024). Altogether, West Virginia's state-run nursing homes have 312 beds. *See id.*

182. Those States facilities would incur the same harm as any LTC as noted above.

183. Non-State-run nursing homes would incur the same harm as any LTC as noted above. The resulting burdens may result in nursing homes closing, causing harm to state citizens.

184. Alaska is largely a frontier and rural state, with uniquely difficult workforce shortage challenges. According to a recent report, "hospital-based registered nurses had a vacancy rate of 21%, and it took an average of 118 days to fill a vacant position. Alaska is competing with the rest of the country for a limited number of healthcare workers. Projections indicate Alaska is expected to have the most significant shortages moving forward of any state. In 2022, Alaska programs graduated fewer than 900 healthcare workers in key positions,

while the number of healthcare workers needed for those positions was 3,232. Travel nurses can be used to meet short-term staffing needs; however, this solution comes at a higher cost. In 2023, traveling registered nurses in Alaska earned 57% more pay on average than non-traveling RNs." Alaska Hospital & Healthcare Association, *2023 Alaska Healthcare Workforce Analysis*, 1 (Dec. 2023), https://www.alaskahha.org/_files/ugd/ab2522_bde54b435a474ca48101c58d9239da21.pdf.

185. The Final Rule's 24/7 RN requirement will exacerbate the nursing workforce shortage.

186. The Final Rule's requirements disincentivize nursing homes from accepting Medicaid and Medicare, placing vulnerable Alaskans at risk of losing access to needed care.

187. The State of Alaska provides licensing oversight for LTCs. The Final Rule would impose additional financial costs and resource burdens on state agencies monitoring compliance and reviewing waivers under section 483.35(f).

188. The Final Rule also requires states, through their Medicaid agencies, to provide "institutional payment transparency reporting" which means they must provide to the Defendants a yearly report on the percentage of Medicaid payments that are spent on direct compensation services versus administrative overhead costs. *See* 89 Fed. Reg. 40,995. The Final Rule also requires that this information be posted on state websites. 89 Fed. Reg. 40,990.

189. Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on States well before that. The Final Rule acknowledges as much by estimating the cost to the States in *year one* to be $183,851. *Id.*

CLAIMS FOR RELIEF

COUNT ONE

(APA – Lack of Statutory Authority)

190. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

191. Under the APA, a court shall "hold unlawful and set aside agency action, findings, and conclusions found to be . . . in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C).

192. CMS, like all administrative agencies, is a "creature[] of statute," and accordingly "possess[es] only the authority that Congress has provided." *Nat'l Fed'n of Indep. Bus. v. Dep't of Labor*, 595 U.S. 109, 117 (2022); *see also, e.g.*, *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986) ("[A]n agency literally has no power to act . . . unless and until Congress confers power upon it.").

193. The Final Rule exceeds CMS's statutory authority in violation of the APA, 5 U.S.C. § 706(2)(C) in multiple ways.

A. The 24/7 RN Requirement

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

195. The Final Rule ignores this by stating an LTC "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40997.

196. CMS acknowledges that the statutory provisions establishing the 8/7 requirement for RN staffing do not authorize it to adopt the 24/7 RN requirement. *See* 89 Fed. Reg. at 40891.

197. CMS nevertheless asserts that "various provisions" elsewhere in §§ 1395i-3 and 1396r contain "separate authority" for this novel requirement, *id.* at 40879, 40890-91, pointing to provisions stating that: (1) The Secretary may impose "such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary," 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B); (2) An LTC facility "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care," 42 U.S.C. § 1396r(b)(2), *accord* 42 U.S.C. § 1395i-3(b)(2); and (3) An LTC facility "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A); *accord* 42 U.S.C. § 1395i-3(b)(1)(A).

198. The only provision that arguably allows authority for CMS to engage in rulemaking is 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B), that requires LTCs 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." (emphasis added).

199. That statutory provision is in a broader subsection that refers to "[r]equirements relating to *administration and other matters*." *See* 42 U.S.C. § 1396r(d), *accord* 42 U.S.C. § 1395i-3(d) (emphasis added).

200. Drilling down further the subsection right above this rulemaking authority CMS latches onto is entitled "Miscellaneous." *See* 42 U.S.C. § 1396r(d)(4), *accord* 42 U.S.C. § 1395i-3(d)(4).

201. Finally, the specific statutory subsection relied on for authority is entitled "other" and refers to "other requirements relating to the health and safety…as the Secretary may find necessary." 42 U.S.C. § 1396r(d)(4)(B), *accord* 42 U.S.C. § 1395i-3(d)(4)(B).

202. The best reading of the only statutory authority CMS relies on for rulemaking is that it is related to administrivia for the health and safety of LTC patients that the rest of the Medicare and Medicaid statute does not already cover.

203. Congress covered the mandatory hours for nurse staffing for LTCs in a separate statutory provision and as such, there is no universe where they gave authority to CMS to alter that through rulemaking in a "miscellaneous" statutory provision.

204. None of the other general provisions CMS relies on allows it to impose a 24/7 statutory requirement either when a more specific statute only requires 8/7 nursing services. That's because "[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." *E.g.*, *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)).

205. Yet that is what the Final Rule does. Even CMS recognizes that the Final Rule "revises" the statutory 8/7 RN requirement codified at 42 U.S.C. §§ 1395i-3(b)(4)(C)(i) and 1396r(b)(4)(C)(i) by replacing it with CMS's 24/7 RN requirement. *See* 89 Fed. Reg. at 40898.

206. Congress did not leave that decision open for CMS to make. CMS lacks statutory authority to impose the 24/7 RN requirement, and the Final Rule must be set aside. *See* 5 U.S.C. § 706(2).

B. The HPRD Requirements

207. The same is true for the Final Rule's HPRD requirements. Congress carefully considered whether to enact quantitative staff-to-patient ratios for LTC facilities, and it chose not to do so.

208. Instead, Congress opted for a qualitative standard, leaving quantitative staff-to-patient ratios to the states: LTC facilities must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord* § 1395i-3(b)(4)(C)(i).

209. The Final Rule unlawfully substitutes CMS's current policy views for Congress' considered judgment. Instead of accommodating the wide variation of resident needs in different states, the Final Rule inflexibly mandates that each facility in each state meet an arbitrary numerical staffing threshold: "[a] minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides." 89 Fed. Reg. at 40996.

210. Once again, CMS does not rely on § 1395i-3(b)(4)(C) or § 1396r(b)(4)(C) as authority for these new requirements.

211. And once again, CMS invokes the Secretary's "miscellaneous" authority to make "other" rules that Congress did not already cover for the health and safety of residents, as well as provisions requiring LTC facilities to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and "promote

maintenance or enhancement of the quality of life of each resident." 89 Fed. Reg. at 40879, 40890-91; *see* 42 U.S.C. §§ 1395i-3(b)(1)(A), (b)(2), (d)(4)(B); 1396r(b)(1)(A), (b)(2), (d)(4)(B).

212. But none of those general provisions authorizes CMS to impose nationwide HPRD requirements for RNs, NAs, and total nursing staff. CMS's general authority over Medicare and Medicaid does not permit it to modify "matter[s] specifically dealt with in another part of the same enactment." *RadLAX Gateway Hotel*, 566 U.S. at 646; *see also* 42 U.S.C. § 1302(a) (the Secretary may not promulgate regulations that are "inconsistent with" statutory requirements).

213. Congress carefully considered what staffing levels to require from LTC facilities, and it decided to require that each facility maintain staffing levels "sufficient to meet the nursing needs of its residents." 42 U.S.C. §§ 1396r(b)(4)(C), 1395i-3(b)(4)(C).

214. CMS cannot utilize general authority to supersede Congress' judgment with its own arbitrary numerical requirements. Simply put, CMS does not have the authority to override Congress' judgment.

C. Major Questions Doctrine

215. The Final Rule also flunks the Major Questions Doctrine. The history of Congress' actions in this area, the "breadth of the authority" CMS now asserts, and "the economic and political significance" of that asserted authority confirm that CMS does not have the power to impose these new staffing mandates. *West Virginia v. EPA*, 597 U.S. 697, 721 (2022).

216. CMS proposes to revamp the entire nursing home industry to the tune of *at least* $43 billion dollars in compliance costs. The actual cost is likely much higher. The Supreme

Court has held that $50 billion qualifies as a Rule of vast economic significance. *Alabama Association of Realtors v. Department of Health and Human Services*, 594 U.S. 758, 764 (2021).

217. Beyond the costs, the breath of authority CMS now asserts is monumental. The Final Rule would fundamentally alter the landscape of the nursing home industry in a manner that impacts 97% of all nursing homes and will put many of them out of business. Furthermore, it would exceed the minimum staffing requirements for nursing homes in "nearly all states." 89 Fed. Reg. 40,877.

218. Finally, because Congress only required 8/7 staffing requirements and allowed flexibility for LTCs based on the needs of their facilities, states have moved to fill that void. The Final Rule acknowledges that 38 states and the District of Columbia have adopted their own staffing standards that vary between them. *See* 89 Fed. Reg. 40,881.

219. "When an agency claims the power to regulate vast swaths of American life, it not only risks intruding on Congress's power, it also risks intruding on powers reserved to the States." *West Virginia*, 597 U.S. at 744. (Gorsuch, J. concurring). CMS has "intruded" on powers traditionally reserved to the States by forcing this staffing rule on them.

220. When the major questions doctrine is triggered, as it is in this case, "clear authorization" and not some "vague statutory grant" is required in order for a court to find it lawful. *Id.* at 732.

221. CMS fails this test because they rely *exclusively* on a vague statutory grant and do not come close to clear authorization as the Final Rule *conflicts* with a separate Congressional statute.

222. The Final Rule flunks the Major Questions Doctrine and should be set aside.

D. Constitutional Doubt

223. If Congress truly gave CMS the authority to implement a regulation that costs at least $43 billion to comply with and overrides another one of its provisions, then it supplies no intelligible principle to guide how that power should be exercised.\

224. If CMS' interpretation was accepted as the one Congress intended it would present serious nondelegation concerns. *See Kentucky v. Biden*, 23 F.4th 585, 607, n.14 (6th Cir. 2022). ("If the government's interpretation were correct—that the President can do essentially whatever he wants so long as he determines it necessary to make federal contractors more 'economical and efficient'—then that *certainly* would present non-delegation concerns.")

225. The constitutional-doubt canon requires this Court to interpret the Rule to avoid these severe constitutional problems.

226. As the Supreme Court has explained, its "application of the nondelegation doctrine principally has been limited to the interpretation of statutory texts, and, more particularly, to giving narrow constructions to statutory delegations that might otherwise be thought to be unconstitutional." *Mistretta v. United States*, 488 U.S. 361, 373, n.7 (198

227. The Supreme Court thus reads statutes with this principle in mind, *see, e.g.*, *Gundy v. United States*, 139 S.Ct. 2116 (2019), and this Court should do the same.

COUNT TWO

(APA – Contrary to Law)

228. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

229. The Final Rule is not in accordance with law in violation of the APA, 5 U.S.C. § 706(2)(A). Even if CMS had *some* authority to set staffing requirements through vague statutory provisions, it could not utilize that limited authority to contradict what Congress had already put into place.

230. "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). The Final Rule is a crude attempt by CMS to play sorcerer.

A. The 24/7 RN Requirement

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

232. *First*, it triples the hours of mandatory RN staffing. It does this by replacing the 8/7 RN requirement enacted by Congress with a mandate that all LTC facilities "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40997.

233. As noted above, Congress only requires 24-hour nursing staff sufficient to meet the needs of nursing home patients. 42 U.S.C. §1396r(b)(4)(C)(i)(I)

234. This indicates that there are at least *some* situations where Congress did not expect nursing homes to require 24-hour nursing staff without seeking a waiver.

235. By requiring 24-hour nurse staffing for *all* nursing homes, CMS has directly contradicted the statute it claims to interpret. This they cannot do.

236. *Second*, the Final Rule replaces the statutorily set scope of services to be rendered by RNs. It does so by changing the requirement to "use the services of" an RN, including in administrative or supervisory roles, with a new requirement to have an RN "available to provide direct resident care." *Id.*

237. The Final Rule effectively rewrites this statutory provision to fit the views of CMS. This is an attempt to play sorcerer which the agency cannot do.

B. The HPRD Requirements

238. Under existing law, each LTC facility must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. § 1396r(b)(4)(C)(i); *accord* § 1395i-3(b)(4)(C)(i). The States are then free to set their own HPRD requirements. As CMS acknowledges, "38 States and the District of Columbia have minimum nursing staffing standards" for nursing homes. 89 Fed. Reg. at 40880.

239. But instead of accommodating the wide variation of resident needs in different states, the Final Rule inflexibly mandates that each LTC facility nationwide must meet an arbitrary numerical staffing threshold: "[a] minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides." 89 Fed. Reg. at 40996.

240. Because the Final Rule's nationwide one-size-fits-all HPRD requirements contradicts Congress's intended flexibility for LTC facility nursing services, the Final Rule is not in accordance with law and must be set aside. *See* 5 U.S.C. § 706(2).

COUNT THREE

(APA – Arbitrary and Capricious Agency Action)

241. Plaintiffs re-allege and incorporate by reference the preceding allegations as though fully set forth herein.

242. Under the APA, a court shall "hold unlawful and set aside agency action, findings, and conclusions found to be … arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

243. The Final Rule is arbitrary and capricious in violation of the APA, 5 U.S.C. § 706(2)(A).

244. The APA's arbitrary-and-capricious standard requires agency action to be "reasonable and reasonably explained." *E.g.*, *Texas v. United States*, 40 F.4th 205, 226 (5th Cir. 2022) (quoting *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021)). This standard "is not toothless"; instead, "it has serious bite." *Id.*

245. The court "must set aside any action premised on reasoning that fails to account for relevant factors or evinces a clear error of judgment." *Id.* Failing to account for costs is failure to consider an important part of the problem. *Michigan v. EPA*, 576 U.S. 743, 752-53 (2015). ("Agencies have long treated cost as a centrally relevant factor when deciding whether to regulate. Consideration of cost reflects the understanding that reasonable regulation ordinarily requires paying attention to the advantages *and* the disadvantages of agency decisions.")

246. And when an agency changes a longstanding policy, it must "show that there are good reasons for the new policy" and "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *Encino Motorcars,*

LLC v. Navarro, 579 U.S. 211, 221-22 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

247. By promulgating the Final Rule, CMS violated these requirements.

A. Sharp Departure from Past Practice

248. Over the past half century, CMS and its predecessors have consistently declined to deviate from the plain text of the Social Security Act by requiring nursing homes to provide "a specific ratio of nursing staff to patients." 39 Fed. Reg. at 2239 (In 1974, the Social Security Administration declined to adopt such a nationwide ratio requirement); *see also e.g.*, 45 Fed. Reg. at 47371 (In 1980, HHS expressly declined to propose "any nursing staff ratios or minimum number of nursing hours per patient per day.").

249. In 1986, an HHS-commissioned study concluded that "prescribing simple staffing ratios clearly is inappropriate."[3]

250. In 2002, the Secretary of HHS informed Congress that, after studying the issue for several years, it was not recommending the imposition of minimum-staffing ratios on LTC facilities.[4]

251. Most recently, in 2016, CMS again rejected requests to adopt minimum-staffing rules, reiterating that it is not reasonable to adopt "a 'one size fits all' approach" toward LTC facilities. 81 Fed. Reg. at 68755; *see id.* at 68754-56, 68758.

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[3] *See* Inst. of Med., *Improving the Quality of Care in Nursing Homes* 102-03 (Mar. 1986), https://archive.ph/KFNCi.

[4] Letter from Tommy G. Thompson, Sec'y of Health & Human Servs., to J. Dennis Hastert, Speaker of House of Representatives 1 (Mar. 19, 2002) ("Thompson Letter"), reprinted in *Office of Asst. Sec'y for Planning & 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 (Nov. 2003), https://archive.ph/wip/KQWPt.

252. With that longstanding position in view, CMS failed to provide a reasoned explanation for departing from it, especially when the study they utilized to justify the mandates did not provide sufficient evidence for it. This is arbitrary and capricious.

B. Failure to Consider Reliance Interests

253. In addition to failing to reasonably explain its sharp departure from prior practice, CMS also failed to consider reliance interests in its decision-making.

254. Longstanding policy has left decisions on staffing primarily up to the states. And States responded by crafting their own staffing requirements. Both States and LTCs have relied on this flexibility for decades.

255. State Medicaid rates for nursing home services vary from $170 per day to over $400 per day. AHCA Cmt.6. Some States have a relatively steady supply of RNs and NAs, while other States are facing a massive shortage. *See, e.g.*, 89 Fed. Reg. at 40957, 40976; 81 Fed. Reg. at 6755 (noting "geographic disparity in supply" of nursing staff).

256. Rather than "highlight[ing] the need for national minimum-staffing standards," the "widespread variability in existing minimum staffing standards" adopted by 38 States and the District of Columbia underscores that "different local circumstances . . . make different staffing levels appropriate (and higher levels impracticable) in different areas of the country." *Compare* 89 Fed. Reg. at 40880, *with* AHCA Cmt.6.

257. By imposing rigid nationwide requirements that "exceed the existing minimum staffing requirements in nearly all States," 89 Fed. Reg. at 40877, CMS not only ignored Congress but also state governments whose state-law minimum staffing requirements reflect local conditions.

258. Arkansas sets a general HPRD monthly standard lower than the Final Rule and does not establish specific quotas for RNs and NAs. See Ark. Code Ann. § 20-10-1402(a)(2) (requiring "direct care services by direct care staff equivalent to at least three and thirty-six hundredths (3.36) Average Direct Care Hours Per Resident Day").

259. Kentucky does not set a numerical staffing requirement for nursing homes. Rather, Kentucky adopts a flexible approach requiring "twenty-four (24) hour nursing services with a sufficient number of nursing personnel on duty at all times to meet the total needs of residents." 902 Ky. Admin. Reg. 20:048, § 3(2)(a). Although Kentucky requires a charge nurse to be always on duty, a licensed practical nurse may serve in that role if a registered nurse is on call. *Id*. at § 2(10)(l).

260. Missouri's minimum staffing requirements for skilled nursing facilities and residential care facilities are set by the Missouri Code of State Regulations. 19 C.S.R. § 20-85.042; *id.* § 30-86.042 & .043. Skilled nursing facilities must have an RN on duty in the facility for the day shift, and either an LPN or RN for both evening and night shifts. An RN also must be on call any time only an LPN is on duty. And all residential care facilities must have at least one employee for every forty residents. In addition, Missouri residential care facilities must employ a licensed nurse for eight hours per week per thirty residents to monitor each resident's condition and medication.

261. North Dakota has, for decades, set a minimum staffing requirement obligating facilities to have an RN on duty for eight hours per day. *See* N.D. Admin. Code § 33-07-03.2-14 (effective July 1, 1996). And as of the first quarter of 2023, only *one* of North Dakota's 76 nursing facilities would comply with the Rule's new HPRD standards.

262. South Carolina requires each nursing home to have one RN on call, but not on site, whenever residents are present in the facility. S.C. Code Ann. Regs. 61-17.

263. And South Carolina's HPRD requirement for FY 2024-2025 is less than half of that required by the Final Rule. S.C. Gen. Approp. Bill § 31.18 (requiring South Carolina nursing homes to provide "one and sixty-three hundredths (1.63) hours of direct care per resident per day from the non-licensed nursing staff" and requiring nursing homes to "maintain at least one licensed nurse per shift for each staff work area.") (https://tinyurl.com/3kjw4mtv).

264. West Virginia requires each nursing home in the State to have an RN on duty in the facility for at least eight consecutive hours, seven days a week. W. Va. Code R. § 64-13-8.14.4. If there is not an RN on duty, West Virginia law requires an RN to be on call. *Id.* § 64-13-8.14.5. West Virginia also requires nursing homes to provide at least "2.25 hours of nursing personnel time per resident per day." *Id.* § 64-13-8.14.1.

265. CMS concedes that its 24/7 RN requirement imposes a one-size-fits-all requirement, 89 Fed. Reg. at 40908. And CMS acknowledges that "more than 79 percent of nursing facilities nationwide" cannot meet the new requirements with their current staff, but its own findings belie the notion that anywhere close to 79 percent of U.S. nursing homes are failing to meet "minimum baseline standards for safety and quality." 89 Fed. Reg. at 40887.

266. Yet CMS's own survey process indicates that "roughly 95 percent of facilities" are already "providing 'sufficient nursing staff'" without the new requirements. AHCA Cmt.25.

267. CMS's explanation for abandoning its decades-old rejection of one-size-fits-all staffing requirements boils down to this: Some LTC facilities are chronically understaffed,

and "evidence demonstrates the benefits of increased nurse staffing in these facilities." 89 Fed. Reg. at 40881; *see id.* at 40893-94.

268. The general proposition that increased staffing in understaffed facilities can lead to better outcomes is not a reasonable consideration of the reliance interests of both states and LTCs who have had flexibility for decades. Such a failure is arbitrary and capricious.

C. Failure to Consider Important Aspects of the Problem

269. The Final Rule is arbitrary and capricious for another reason as well: It fails to consider important aspects of the problems, and it does so in two ways.

270. *First*, it fails to consider the possibility that compliance with the Final Rule poses undue financial strain on LTCs while also delivering adequate resident care.

271. As detailed in various comments on the proposed rule, it will be an unreasonable burden for many LTC facilities to implement CMS's new minimum-staffing requirements because of the inadequate supply of RNs and NAs. *See* AHCA Cmt.1-2, 5, 11-13, 18; LeadingAge Cmt.1-2, 4; THCA Cmt.1-2.

272. Even CMS acknowledges the new requirements "exceed the existing minimum staffing requirements in nearly all States" and will require increased staffing "in more than 79 percent of nursing facilities nationwide." 89 Fed. Reg. at 40877.

273. And CMS estimates that LTC facilities will need to hire an additional 15,906 additional RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement (an increase of about 11.8%), plus an additional 77,611 NAs to meet the 2.45 NA HPRD requirement and 3.48 total nurse HPRD requirement (an increase of about 17.2%). *See id.* at 40958, 40977-80.

274. Those increases are nearly unattainable at a time when many LTC facilities are already experiencing difficulty finding qualified RNs and NAs to fill vacant positions, and when staffing shortages are expected only to worsen. *See, e.g.*, AHCA Cmt.5; LeadingAge Cmt.1. Put simply, "staffing mandates do not create more caregivers, nor do they drive caregivers to work in long term care." AHCA Cmt.1.

275. The Final Rule also irrationally discounts the vital role of LPNs/LVNs, who hold nearly 230,000 jobs in LTC facilities across the country and undisputedly "provide important services to [their] residents." 89 Fed. Reg. at 40881; *see* AHCA Cmt.6; LeadingAge Cmt.2.

276. As commenters pointed out, the Final Rule creates an incentive for LTC facilities "to terminate LPN/LVNs and replace them with . . . [less qualified] nurse aides" in order to meet the 2.45 NA HPRD requirement.

277. CMS recognized this problem in both the proposed rule and the Final Rule, but concluded that "[a] total nurse staffing standard will guard[] against" it. 89 Fed. Reg. at 40893; *see* 88 Fed. Reg. at 61366, 61369.

278. But that's wrong. For example, a facility that already provides high-quality care through average staffing of 0.55 RN HPRD, 1.25 LVN/LPN HPRD, and 1.7 NA HPRD would satisfy the 3.48 total nurse HPRD requirement but would need an additional 0.75 NA HPRD to satisfy the 2.45 NA HPRD requirement.

279. The Final Rule thus pressures LTC facilities to replace experienced LPNs/LVNs with less-qualified new hires to meet CMS's arbitrary quota of 2.45 NA HPRD. This gives bad actors a competitive advantage by employing less qualified and lower paid nurse aides to increase profits while leaving good actors with a dilemma: pay the higher costs to meet the Final Rule's staffing requirements or risk substandard care.

280. The Final Rule does not deny that there are not nearly enough RNs and NAs available to enable the 79 percent of LTC facilities that are not presently in compliance with the agency's new mandates.

281. CMS asserts that the Final Rule's phase-in period will "allow all facilities the time needed to prepare and comply with the new requirements specifically to recruit, retain, and hire nurse staff as needed." 89 Fed. Reg. 40894.

282. But delaying the deadline for compliance does nothing to fix the underlying problems. Regardless of whether it goes into effect tomorrow or two or three years from now, the Final Rule is a multi-billion-dollar unfunded mandate that many LTC facilities will have no realistic way to meet. And there is no reason to think that the shortage of RNs and NAs will ease over the next two to three years.

283. In fact, it is projected to become even worse, as "hundreds of thousands are expected to retire or leave the health care profession entirely in the coming years." AHCA Cmt.5; *see id.* at 2 ("The phase-in provisions are frankly meaningless considering the growing caregiver shortage."); LeadingAge Cmt.7 (similar).

284. CMS says that it "fully expect[s] that LTC facilities will be able to meet [the Final Rule's] requirements," 89 Fed. Reg. at 40894, but it fails to cite any evidence to support this wishful thinking.

285. Moreover, the staggered implementation timeframe risks "pit[ting] urban and rural areas against each other as staff are first recruited away from rural areas to fulfill the needs of urban nursing homes, then 1-2 years later rural areas are scrapping to bring staff back." LeadingAge Cmt.7.

286. Finally, CMS's "hardship exemption" process is a wholly inadequate response to the staffing shortage and economic constraints facing LTC facilities.

287. For one thing, such exemptions are available only to facilities that have been surveyed and cited for failure to meet the new staffing standards—and "facilities cannot request" (or receive) "a survey specifically for the purpose of granting an exemption." 89 Fed. Reg. at 40902.

288. Thus, instead of being able to proactively explain why it should be entitled to an exemption, facilities that cannot meet CMS's arbitrary requirements will face a perpetual risk of being sanctioned for non-compliance. *See* AHCA Cmt.6, 33-34; LeadingAge Cmt.6 (criticizing CMS's approach as "unnecessarily punitive").

289. In all events, the waivers are "no solution for the ongoing nationwide shortage in nursing staff" or the lack of funds available to implement the new requirements. AHCA Cmt.7.

290. CMS repeatedly emphasizes that the hardship exemption is meant for "limited circumstances," 89 Fed. Reg. at 40894, and that many facilities in areas of the country with severe shortages of available RNs and NAs would not qualify for an exemption because there are so many "other requirements" that must be met "to obtain an exemption." *Id.* at 40953.

291. *Second*, the Final Rule fails to reasonably consider the staggering costs, which underscores its arbitrary and capricious nature.

292. According to CMS, the Final Rule will cost over $5 billion per year to implement once fully phased in, *see* 89 Fed. Reg. at 40949, 40970. Other estimates place the costs as high as $7 billion per year, *see id.* at 40950.

293. The Final Rule does not provide any additional funding for Medicare or Medicaid, so CMS "assume[s] that LTC facilities . . . will bear the[se] costs." *Id.* at 40949.

294. And many LTC facilities are in no position to take on this huge financial burden, when those LTC facilities already allocate adequate resources for resident care. AHCA Cmt.5; LeadingAge Cmt.1-2; THCA Cmt.3. Almost 60 percent of LTC facilities already have negative operating margins; more than 500 LTC facilities closed over the course of the COVID-19 pandemic; and the costs associated with these new staffing mandates would likely force many more facilities to close. AHCA Cmt.5; *see* LeadingAge Cmt.1-2.

295. CMS's imposition of this massive, unfunded staffing mandate, despite the ongoing workforce crisis and economic realities, is neither "reasonable" nor "reasonably explained." *Cf. Texas*, 40 F.4th at 226.

296. It instead simply touts a new initiative that seeks to encourage people to pursue careers in nursing by "investing over $75 million in financial incentives such as tuition reimbursement." 89 Fed. Reg. 40894.

297. But this "one-time workforce effort" is "a drop in the bucket compared to the funding that will be needed to train [the] additional nursing staff" necessary to meet the new mandates. AHCA Cmt. 23; LeadingAge Cmt.1-2. It "is not going to fix the workforce crisis," and it does practically nothing to offset the $5 billion to $7 billion per year in costs that the Final Rule imposes on LTC facilities. AHCA Cmt.23; LeadingAge Cmt.1-2.

298. Additionally, many LTC facilities are experiencing financial harms now. The Final Rule's EFA, implemented on August 8, 2024, requires providers to conduct a comprehensive evaluation of their facility, residents, staff, and resident families to determine staffing and other needs.

299. This assessment imposes a significant burden on LTC facilities. CMS estimates the cost of the EFA to be around $4,955 per facility, but that number is likely low.

300. The Final Rule also requires each facility to "review and update that assessment, as necessary, and at least annually." The facilities lack further guidance as to when such updates are "necessary," imposing a further burden of continuously updating a plan or being subject to potential civil penalties.

301. The EFA also requires facilities to create "contingency planning," even though the facilities already are required to have emergency plans for, among other things, staffing issues.

302. In total, the EFA imposes unreasonable administrative burdens on the facilities and subjects them to vague requirements that could result in steep civil penalties.

303. The Final Rule is arbitrary and capricious agency action and must be set aside.

PRAYER FOR RELIEF

1. Plaintiffs pray for the following relief from the Court:

2. A declaration, pursuant to 28 U.S.C. §2201, that the 24/7 RN requirement exceeds CMS's statutory authority and is arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

3. A declaration, pursuant to 28 U.S.C. §2201, that the HPRD requirements exceed CMS's statutory authority and are arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

4. A declaration, pursuant to 28 U.S.C. § 2201, that the enhanced facility assessment exceeds CMS's statutory authority and is arbitrary, capricious, or otherwise not in accordance with the law in violation of the APA.

5. An order vacating and setting aside the 24/7 RN requirement and permanently enjoining Defendants from taking any action to enforce that requirement.

6. An order vacating and setting aside the HPRD requirements and permanently enjoining Defendants from taking any action to enforce those requirements.

7. An order vacating and setting aside the enhanced facility assessment requirement and permanently enjoining Defendants from taking any action to enforce that requirement.

8. Any costs and reasonable attorneys' fees to which Plaintiffs may be entitled by law.

9. Any further relief that the Court deems just and proper.

Respectfully submitted,

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**Pro Hac Vice forthcoming*

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION

STATE OF KANSAS, et al., Plaintiffs, vs. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	No. C24-110-LTS-KEM **ORDER ON MOTION FOR PRELIMINARY INJUNCTION**

I. INTRODUCTION

This case is before me on the plaintiffs'[1] motion (Doc. 30) for preliminary injunction. The defendants[2] filed a resistance (Doc. 72) and the plaintiffs filed a reply (Doc. 78). On December 5, 2024, I heard oral arguments by teleconference.

II. PROCEDURAL AND FACTUAL HISTORY

On October 8, 2024, the plaintiffs filed a complaint (Doc. 1) alleging that the Biden-Harris administration's Final Rule – "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional

[1] The plaintiffs include 20 states, 17 affiliates of LeadingAge (a trade association of non-profit nursing facilities) and two Kansas nursing home facilities. I will refer to all of the plaintiffs collectively as "the plaintiffs," the state plaintiffs as "the States" and the non-state plaintiffs as "the Organizations."

[2] The named defendants are Xavier Becerra, in his official capacity as Secretary of the United States Department of Health and Human Services, the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services and Chiquita Brooks-Lasure, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. I will refer to all of the defendants collectively as "the Government."

Payment Transparency Reporting" (Final Rule) – violates various provisions of the Administrative Procedure Act (APA). 89 Fed. Reg. 40876 (May 10, 2024). Specifically, the plaintiffs argue that the Final Rule (1) lacks statutory authority, (2) is contrary to law and (3) is arbitrary and capricious. Doc. 1 at 42-61. The plaintiffs filed their motion for a preliminary injunction on October 22, 2024.

A. Medicaid and Medicare Statutes

In 1965, Congress established the Medicaid and Medicare programs by amending the Social Security Act. Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965). Medicare provides health insurance to "nearly 60 million aged or disabled Americans." *Northport Health Servs. of Ark., LLC v. U.S. Dep't of Health & Hum. Servs.*, 14 F.4th 856, 863 (8th Cir. 2021) (quoting *Azar v. Allina Health Servs.*, 587 U.S. 566, 569 (2019)); *see also* 42 U.S.C. § 1395 *et seq*. Medicaid is a joint federal-state program in which the federal government provides approximately $600 billion in financial assistance to states to offer healthcare coverage to low-income individuals. *See* 42 U.S.C. § 1396 *et seq*.; *see also Northport*, 14 F.4th at 863. The Secretary of the Department of Health and Human Services (HHS) administers both programs through the Centers for Medicare and Medicaid Services (CMS), a sub-agency of HHS. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, CMS.gov (last visited Jan. 5, 2025).

Nursing homes that participate in Medicare and Medicaid must comply with certain statutory requirements. *See* 42 U.S.C. § 1395i-3 (Medicare); *see* 42 U.S.C. § 1396r (Medicaid). As these statutory requirements under Medicare and Medicaid are largely the same, these nursing homes are often collectively known as "long-term care" (LTC) facilities. In addition, LTC facilities must comply with CMS's regulations, as they are applicable to all LTC facilities that participate in Medicare and/or Medicaid. *See* 42 C.F.R. §§ 483.1-.95; *see also Northport*, 14 F.4th at 863.

B. CMS Rulemaking Process and the Final Rule

On February 22, 2022, the Biden-Harris administration announced its intent to implement several reforms to "improve the safety and quality of nursing home care, hold nursing homes accountable for the care they provide, and make the quality of care and facility ownership more transparent so that potential residents and their loved ones can make informed decisions about care." *FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's NursingHomes*, THE WHITE HOUSE (Feb. 28, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/. To this end, the administration directed CMS to "conduct a new research study to determine the level and type of staffing needed to ensure safe and quality care and [] issue proposed rules within one year." *Id.* CMS commissioned Abt Associates to complete this research study. *See* ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report (June 2023), https://edit.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf.

Abt Associates' study (the study) found that increased staffing improves patient welfare in LTC facilities but also recognized the pervasive staffing challenges in the industry. Specifically, the study found that nursing homes with higher staff-to-resident ratios provide better care and addressed the COVID-19 pandemic more successfully. *Id.* at 1; Doc. 72 at 17. However, the study noted that existing literature "does not provide a clear evidence basis for setting a minimum staffing level." ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report at xi. The study also found that increases in the nurse hours per resident per day result in a "corresponding increase in potential quality and safety improvements, and a decrease in expected delayed and omitted care." *Id.* at xiii; Doc. 72 at 17. Although Abt Associates found that increased staffing will lead to better care, the study recounted that nursing homes are struggling to hire and retain workers. Additionally, stakeholders expressed a variety of concerns, including

lack of adequate staffing as well as workforce and cost constraints. ABT ASSOCIATES, Nursing Home Staffing Study Comprehensive Report at xii. Moreover, some stakeholders suggested that resident acuity should be considered when setting a minimum staffing requirement. *Id.*

Upon completion of the study, CMS issued a notice of a proposed rule in September 2023. The proposed rule contained four main proposals: (1) a requirement that a registered nurse (RN) must be on site 24 hours per day, 7 days a week, (2) minimum nurse staffing standards of 0.55 hours per resident day (HPRD) for RNs and 2.45 HPRD for Nurse Aids (NAs), (3) enhanced facility assessment (EFA) requirements and (4) Medicaid reporting requirements. Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 88 Fed. Reg. 61352 (proposed Sept. 6, 2023). CMS received 46,520 comments in response to the proposed rule. *See* Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40883 (May 10, 2024).

CMS's Final Rule, promulgated on May 10, 2024, largely mirrors the proposed rule. 89 Fed. Reg. 40876. The Final Rule includes: (1) a requirement that a RN be on site 24 hours per day, 7 days per week, (2) a minimum nursing staffing standard of 3.48 HPRD of nursing care, with at least 0.55 RN HPRD and at least 2.45 NA HRPD, (3) revision of the existing facility assessment requirements and (4) Medicaid institutional payment transparency reporting requirements. 89 Fed. Reg. 40877. To ease some of the Final Rule's financial burden, CMS has dedicated over $75 million "to launch an initiative to help increase the long-term care workforce." 89 Fed. Reg. 40885. Moreover, the Final Rule provides additional time and flexibility for LTC facilities to implement the changes, including staggered implementation dates over a five-year period and providing for some exemptions from the minimum staffing standards. 89 Fed. Reg. 40886.

In its Final Rule, CMS asserts that various provisions in Sections 1819 and 1919 of the Social Security Act [42 U.S.C. §§ 1395i-3 and 1396r] grant it authority for the issuance of the HPRD and 24/7 RN requirements.[3] *See* 89 Fed. Reg. 40890-91. First, CMS states that §§ 1819(d)(4)(B) and 1919(d)(4)(B) of the Social Security Act support its authority to establish these requirements, as these sections "instruct the Secretary to issue such regulations relating to the health, safety, and well-being of residents as the Secretary may find necessary." 89 Fed. Reg. 40890. Moreover, CMS contends that §§ 1819(b)(2) and 1919(b)(2) provide additional support for CMS's authority to establish these requirements, as those sections "require facilities to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." *Id.*

Finally, CMS states that §§ 1819(b)(1)(A) and 1919(b)(1)(A) "require that a SNF [skilled nursing facility] or NF [nursing facility] must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the safety and quality of life of each resident," which it asserts provides further support for the Final Rule's staffing requirements. 89 Fed. Reg. 40891. However, as the plaintiffs assert and the Government concedes in its brief, the only provisions of the Social Security Act that expressly permit the promulgation of additional requirements by the Secretary are §§ 1395i-3(d)(4)(b) and 1396r(d)(4)(B), which state that LTC facilities must "meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary." *See* Doc. 30-1 at 23; *see also* Doc. 72 at 21-22.

[3] The Medicare and Medicaid statutes speak directly to staffing requirements as well. They require LTC facilities to "provide 24-hour licensed nursing service which is sufficient to meet the nursing needs of its residents" and "use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week." *See* 42 U.S.C. § 1395i-3(b)(4)(C)(i) (Medicare); *see also* 42 U.S.C. § 1396r(b)(4)(C)(i) (Medicaid) (same). Both statutes permit waivers for these requirements. *See* 42 U.S.C. § 1395i-3(b)(4)(C)(ii) (Medicare) *and* 42 U.S.C. § 1396r(b)(3)(C)(ii) (Medicaid).

Although the statutory basis for CMS's promulgation of new Medicaid reporting requirements do not appear to be contested by the plaintiffs (*see* Doc. 30-1 at 6), CMS asserts that it relied on two main provisions of the Social Security Act to issue these requirements – §§ 1902(a)(30)(A) and 1902(a)(6). 89 Fed. Reg. 40914 (noting that § 1902(a)(30)(A) "requires State Medicaid programs to ensure that payments to providers are consistent with efficiency, economy, and quality of care. . ." and § 1902(a)(6) "requires State Medicaid agencies to make such reports. . . as the Secretary may from time to time require, and to comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports.").

The statutory basis for the EFA requirement appears similarly uncontested by the plaintiffs. *See* Doc. 30-1 at 6. Prior to the promulgation of the Final Rule, LTC facilities were already required to complete facility assessments. The Final Rule relocated the facility assessment requirement from a subpart to a stand-alone provision and added new substantive requirements. CMS did not articulate the statutory basis for the new substantive requirements in the Final Rule. *See* 89 Fed. Reg. 40905.

Each requirement of the Final Rule has a different implementation timeline. The 24/7 RN requirement must be implemented by May 11, 2026, for non-rural facilities and by May 10, 2027, for rural facilities as defined by the Office of Management and Budget. The HRPD requirements must be implemented by May 10, 2027, for non-rural facilities and by May 10, 2029, for rural facilities. The EFA requirement took effect on August 8, 2024, for all facilities. The Medicaid transparency reporting requirements must be implemented by all States and territories with Medicaid-certified facilities by May 10, 2028. 89 Fed. Reg. 40876.

Despite these different implementation timelines, the Final Rule acknowledges that costs will be incurred before the respective effective implementation dates. CMS estimated that the staffing requirements will result in an estimated cost of approximately $53 million in year one, $1.43 billion in year two and $4.38 billion in year three. 89

Fed. Reg. 40949. Additionally, CMS estimates that the Medicaid reporting provision will cost states $183,851 for the first four years. 89 Fed. Reg. 40991.

III. ANALYSIS

The plaintiffs seek entry of a preliminary injunction as to the entire Final Rule. They assert that the Final Rule exceeds CMS's statutory authority, violates the major questions doctrine and is arbitrary and capricious. *See* Doc. 30-1 at 20-35. Additionally, the plaintiffs assert that they are suffering irreparable harm from the financial burdens of the Final Rule and contend that the balance of equities and the public interest favor injunctive relief. *Id.* at 35-38. Finally, they request that the injunction apply nationwide to "preserve[] the national status quo and protect[] Plaintiffs from the Final Rule's destabilizing effects on nursing homes across the country." Doc. 30-1 at 39.

A. Preliminary Injunction Standard

The purpose of a preliminary injunction is to "preserve the relative positions of the parties until a trial on the merits can be held." *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). The Eighth Circuit Court of Appeals has stated:

> When evaluating whether to issue a preliminary injunction, a district court should consider four factors: (1) the threat of irreparable harm to the movant; (2) the state of the balance between this harm and the injury that granting the injunction will inflict on other parties; (3) the probability that the movant will succeed on the merits; and (4) the public interest.

Roudachevski v. All–American Care Centers, Inc., 648 F.3d 701, 705 (8th Cir. 2011) (citing *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc)). In this circuit, these are often referred to as the *"Dataphase"* factors. While no single factor is dispositive, the Eighth Circuit has stated that "likelihood of success on the merits is most significant." *Laclede Gas Co. v. St. Charles Cnty., Mo.*, 713 F.3d 413, 419 (8th Cir. 2013) (quoting *Minn. Ass'n of Nurse Anesthetists v. Unity Hosp.*, 59 F.3d 80, 83 (8th Cir. 1995)).

In applying these factors, the court must keep in mind that a preliminary injunction is "an extraordinary remedy never awarded as of right." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1016 (8th Cir. 2023) (citation omitted). As such, the party seeking injunctive relief bears the burden of proving that it is appropriate. *Roudachevski*, 648 F.3d at 705. "When there is an adequate remedy at law, a preliminary injunction is not appropriate." *Watkins Inc. v. Lewis*, 346 F.3d 841, 844 (8th Cir. 2003) (citing *Modern Computer Sys., Inc. v. Modern Banking Sys., Inc.*, 871 F.2d 734, 738 (8th Cir. 1989)).

B. Irreparable Harm

Although likelihood of success on the merits is often described as the most significant factor in a preliminary injunction analysis, a failure to show irreparable harm may be dispositive. *Adventist Health Sys./SunBelt, Inc. v. United States Dep't of Health & Hum. Servs.*, 17 F.4th 793, 806 (8th Cir. 2021) ("The failure to show irreparable harm is an 'independently sufficient basis upon which to deny a preliminary injunction.'") (citation omitted); *see also Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 371 (8th Cir. 1991) (irreparable harm is a "threshold inquiry" in granting or denying preliminary injunction). I will begin my analysis with this factor because, for the reasons discussed in detail below, it largely dictates the outcome of the plaintiffs' motion for a preliminary injunction.

To demonstrate irreparable harm, "a party must show that the harm is certain and great and of such imminence that there is a clear and present need for equitable relief." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1017 (8th Cir. 2023) (quoting *Dakotans for Health v. Noem*, 52 F.4th 381, 392 (8th Cir. 2022); *see also Tumey v. Mycroft AI, Inc.*, 27 F.4th 657, 665 (8th Cir. 2022) ("The movant must show that 'irreparable injury is *likely* in the absence of an injunction,' not merely a 'possibility' of irreparable harm before a decision on the merits can be rendered.") (emphasis in original) (quoting *Winter v. Natural Resources Defense*

Council, Inc., 555 U.S. 7, 22 (2008)). The irreparable harm requirement is demanding. *See Am. Meat Inst. v. U.S. Dep't of Agric.*, 968 F. Supp. 2d 38, 75 (D.D.C. 2013) ("There is no doubt that '[t]he irreparable injury requirement erects a very high bar for a movant.'") (quoting *Coalition for Common Sense in Gov't Procurement v. United States*, 576 F. Supp. 2d 162, 168 (D.D.C. 2008)).

1. The Parties' Arguments

The Organizations argue that they will suffer irreparable harm from the Final Rule because of the financial strain that it imposes, workforce shortages, current compliance costs and the burdensome EFA requirements. Doc. 30-1 at 35-36. First, they argue that the Final Rule will cost each LTC facility hundreds of thousands of dollars to implement.[4] *Id.* at 35. Further, they contend that the additional hiring required by the Final Rule is nearly impossible considering the healthcare workforce shortages, which are more exacerbated in the long-term care setting. *Id.* at 35-36. Because of these workforce challenges, the Organizations assert that many LTC facilities must start complying with the staffing mandates now to ensure that they will meet the requirements by the designated implementation dates. *Id.* at 36. Finally, they argue that the Final Rule's EFA requirement, which is already in effect, imposes significant costs and administrative burdens. *Id.*

The States contend that they will experience many of the same harms as the Organizations. First, they argue that state-run LTC facilities will experience the similar financial hardships as the organizational LTC facilities with the increased staffing requirements, workforce shortages and the EFA requirements. *Id.* at 36-37. The States assert that they will incur additional Medicaid and Medicare expenses and costs due to

[4] For example, the plaintiffs assert that in South Carolina the estimated implementation cost is over $550,000 per nursing home. This cost is even higher in Pennsylvania, with an estimated cost of $689,000 per provider. Doc. 30-1 at 35.

the Medicaid reporting requirement and the increased staffing costs at LTC facilities. *Id.* at 37. Finally, the States argue that they will incur additional administrative costs with complaints and waiver requests as they predict that LTC facilities will be unable to comply with the Final Rule. *Id.*

The Government asserts that because the 24/7 RN requirement and HPRD requirements will not be implemented for several years, the plaintiffs will not experience irreparable harm without an injunction. Doc. 72 at 60. The Government does not address irreparable harm regarding the EFA and Medicaid reporting requirements, as it contends that the plaintiffs do not substantively challenge those provisions.[5] *Id.* The Government asserts that the Final Rule has a staggered implementation for both the 24/7 RN requirement and the HPRD requirements. *Id.*; *see* 89 Fed. Reg. 40894 (discussing "phased implementation up to 5 years for rural facilities and up to 3 years for non-rural facilities"). The Government further notes that the earliest any facility could be harmed by the Final Rule is in two years—when the 24/7 RN rule will take effect in urban areas. Doc. 72 at 60; *see* 89 Fed. Reg. 40910. It asserts that this multi-year delay in implementation does not create irreparable harm, as the merits of the plaintiffs' challenge can be resolved in less than two years. Doc. 72 at 60. Moreover, the Government contends that the harms alleged by the plaintiffs are "purely economic," "self-inflicted" and, as to the plaintiffs' argument regarding workforce shortages—not caused by the Final Rule. *Id.* at 61. Finally, the Government argues that the plaintiffs' delay in filing

[5] In their reply brief and during oral argument, the plaintiffs maintained that they are challenging the entirety of the rule – not just the 24/7 RN requirement and the HPRD requirements. *See* Doc. 78 at 20-21; *see also* Doc. 94 at 26. However, the plaintiffs did not address either the EFA requirement or the Medicaid reporting requirement in their discussion of likelihood of success in their briefs. *See* Doc. 30-1 at 20-35; *see also* Doc. 78 at 4-17. Nonetheless, the plaintiffs assert that they made sufficient arguments as to likelihood of success as they contended that the EFA provision was "vague" and "unreasonable." Doc. 78 at 21. The Government maintains that the plaintiffs did not address likelihood of success on the merits with respect to the EFA requirement, but it asserts that in any case, the deadline for compliance with this requirement has already passed so irreparable harm cannot be alleged. Doc. 72 at 62.

the present motion for a preliminary injunction also undercuts their assertion that they are suffering irreparable harm. *Id.* at 62.

In response, the plaintiffs first contend that the economic nature of the harm is not a barrier to the court's entry of a preliminary injunction, as monetary damages cannot be recovered from the federal government due to sovereign immunity. Doc. 78 at 19. Additionally, they assert that the harms from the EFA requirement are continuous and ongoing. *Id.* Moreover, they dispute that they are engaged in "self-harm" by beginning to hire staff to meet the Final Rule's requirements, as they contend that the delayed implementation period was specifically designed for this purpose. *Id.* at 20. Finally, they assert that their delay in seeking injunctive relief was not unreasonable. *Id.* at 22.

2. Substantive Provisions of the Final Rule

Because the plaintiffs' allegations of irreparable harm primarily concern compliance costs associated with the Final Rule, I will first address that matter. There appears to be a circuit split as to whether compliance costs constitute irreparable harm. Some circuits have held that "compliance costs do not qualify as irreparable harm because they commonly result from new government regulation." *See Commonwealth v. Biden*, 57 F.4th 545, 556 (6th Cir. 2023) (recognizing that many of their "sister circuits" have held that compliance costs are not irreparable harm but holding that "the peculiarity and size of a harm affects its weight in the equitable balance") (citing *Freedom Holdings, Inc. v. Spitzer*, 408 F.3d 112, 115 (2d Cir. 2005), *Am. Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1331 (7th Cir. 1980), *and A.O. Smith Corp. v. FTC*, 530 F.2d 515, 527 (3d Cir. 1976)). Other circuits have found that complying with a regulation later held invalid almost always produces irreparable harm from nonrecoverable costs. *See Texas v. EPA*, 829 F.3d 405, 433 (5th Cir. 2016); *see also Crowe & Dunlevy, P.C. v. Stidham*, 640 F.3d 1140, 1157 (10th Cir. 2011).

Although this issue has never been squarely addressed by the Eighth Circuit, the court has stated that "[t]he importance of preliminary injunctive relief is heightened"

when monetary damages are unavailable because of sovereign immunity. *Entergy, Arkansas, Inc. v. Nebraska*, 210 F.3d 887, 899 (8th Cir. 2000). I hold that the compliance costs incurred to comply with a potentially invalid regulation, such as the Final Rule, may constitute irreparable harm. I will address each aspect of the Final Rule in turn.

a. 24/7 RN Requirement and HPRD Requirements

At this stage of the case, I will assume that the Final Rule's 24/7 RN requirement and HPRD requirements will impose tremendous costs on LTC facilities that could result in closures if compliance is not economically feasible. Additionally, the economic nature of the plaintiffs' alleged harms does not preclude relief. Although economic loss is not irreparable harm if damages are available, losses will not be recoverable from the Government due to sovereign immunity. *See Gen. Motors Corp. v. Harry Brown's LLC*, 563 F.3d 312, 319 (8th Cir. 2009) ("economic loss is not irreparable harm so long as losses are recoverable"); *see also Entergy, Arkansas, Inc.*, 210 F.3d at 899 ("[t]he importance of preliminary injunctive relief is heightened" when monetary damages are unavailable because of sovereign immunity).

However, because the 24/7 RN requirement and the HPRD requirements do not take effect until May 2026, at the earliest, I find that the plaintiffs' challenges to the financial and compliance burdens presented by those requirements are too speculative to constitute irreparable harm for purpose of a preliminary injunction.[6] In seeking injunctive relief, a party must show that the injury alleged is "of such *imminence* that there is a

[6] Additionally, the plaintiffs' argument that workforce shortages in the healthcare industry constitute irreparable harm is misplaced. The Final Rule did not create the workforce shortage in the healthcare industry. Such an argument is proper in challenging CMS's action as arbitrary and capricious—not in alleging that the Final Rule causes irreparable harm. *See McClung v. Paul*, 788 F.3d 822, 828 (8th Cir. 2015) (finding an agency decision arbitrary and capricious if an agency "entirely failed to consider an important aspect of the problem").

clear and present need for equitable relief." *Morehouse Enters., LLC v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 78 F.4th 1011, 1018 (8th Cir. 2023) (emphasis in original) (quotations omitted) (citations omitted). The plaintiffs allege that LTC facilities are bearing the costs of the 24/7 RN requirement and the HPRD requirements now because of the workforce shortages in the healthcare industry. Doc. 30-1 at 36. However, the extent to which LTC facilities are incurring hiring costs now to ensure compliance with the Final Rule is unclear. Indeed, while 26 plaintiffs submitted declarations, only a few state that they are currently engaged in hiring and incurring costs to ensure compliance with the minimum staffing requirements.[7] *See* Doc 30-22 at 9, ¶ 11 ("At least several of our nursing homes are already making staffing changes, attempting to hire additional RNs rather than LPNs, and increasing hiring efforts in preparation for the Final Rule's staffing mandates going into effect."); Doc. 30-10 at 8, ¶ 9 (LTC facilities in Iowa "are attempting to hire RNs over LPNs whenever possible. . . . and engaging in aggressive recruitment strategies such as sign-on and recruitment bonuses. . ."); Doc. 30-12 at 3-4, ¶ 6 ("our members have already begun to plan for the elimination of LPN positions"). While these declarations suggest that planning and attempts for hiring are currently taking place, the financial burden of these undertakings is unclear. None of the plaintiffs submitted data or cost breakdowns as to their *current* hiring efforts.

Instead, most of the declarations detail costs that the various plaintiffs will incur in the future. Indeed, many plaintiffs provided a wide range of potential costs. *See, e.g.*, Doc. 30-2 at 3, ¶ 9 (estimating that the total average costs for Idaho-operated LTC facilities to comply with the Final Rule's minimum staffing requirements to be $800,000

[7] The plaintiffs assert that a declaration from LeadingAge South Carolina provides additional support for their assertion that many providers are already expending resources towards hiring. Doc. 30-1 at 36 (citing Doc. 30-20 at 3, ¶ 4). However, LeadingAge South Carolina's declaration merely asserts that it is currently experiencing staffing shortages and that one facility has had an open RN position for over a year. Doc. 30-20 at 3, ¶ 4.

per facility); *see also* Doc. 30-8 at 5, ¶ 7 (asserting that the South Dakota Association of Health Care Organizations estimated that costs associated with temporary/travel nurses to be between $300,000 and $1,600,000 per year and estimates that this cost will increase "exponentially if the Final Rule's staffing mandate goes into effect"); *see* Doc. 30-22 at 2, ¶ 5 (stating that the "significant and irreparable harm that the Final Rule imposes on Virginia nursing home providers will be especially severe in rural and underserved areas"). These wide ranges demonstrate that while the staffing requirements of the Final Rule will certainly impose financial burdens, the extent of the harm is simply too uncertain at this point, as the earliest any facility could be subject to the Final Rule is May 11, 2026. This weighs against a finding of irreparable harm. *See S.J.W. ex rel. Wilson v. Lee's Summit R-7 Sch. Dist.*, 696 F.3d 771, 779 (8th Cir. 2012) ("Speculative harm does not support a preliminary injunction."); *see also Mock v. Garland*, 697 F. Supp. 3d 564, 577 (N.D. Tex. 2023) ("Irreparable harm must also be concrete, non-speculative, and more than merely de minimis.") (emphasis omitted).

Further, many of the plaintiffs' declarations note that the compliance costs associated with the Final Rule's staffing mandate could greatly vary depending on their use of contracting agencies to recruit staff. *See* Doc. 30-2 at 3, ¶ 10 (noting that hiring costs could be "higher or lower" depending on the state's reliance on contractor agencies); *see also* Doc. 30-8 at 6, ¶ 8 ("The cost for facilities will be even greater if contract staff are needed to meet the standards of the mandate."); Doc. 30-11 at 9, ¶ 12 ("Nursing homes will incur substantial costs, potentially requiring them to rely on contracted nursing agencies, which are significantly more expensive."). This also weighs against a finding of irreparable harm. *See, e.g.*, *Cayuga Nation v. Zinke*, 302 F. Supp. 3d 362, 373 (D.D.C. 2018) (finding that where "injuries depend on actions that may or may not be taken by. . . non-parties over which this Court does not have control, they are not certain[]" which "counsel[s] against granting preliminary injunctive relief.").

Nonetheless, some of the plaintiff declarations provided more precise estimates of future costs. *See, e.g.*, Doc. 30-9 at 3, ¶ 6 (Final Rule's requirements "will cost each

Colorado provider. . . an average of $399,123 per year"); *see also* Doc. 30-11 at 3, ¶ 6 (staffing mandate will cost each Kansas provider an average of $211,905 per year); *see also* Doc. 30-12 at 2, ¶ 5 (staffing mandate will cost each nursing home in Maryland an additional $642,000 per year); *see* Doc. 30-3 at 3, ¶ 10 (noting that over 70 percent of facilities in Iowa will be affected by the increased staffing requirements, which will cause an estimated state financial impact of over $25 million); *see* Doc. 30-10 at 3-4, ¶ 4a (noting that staffing requirements would result in $2.16 million annual costs on their members). While I appreciate the detailed assessments provided by many of the plaintiffs, I again find that because of the delayed implementation of the Final Rule, the plaintiffs have not adequately shown irreparable harm as to the staffing requirements. *See Wyoming v. United States Dep't of the Interior*, No. C16- 0280–SWS, 2017 WL 161428, at *11 (D. Wyo. Jan. 16, 2017) (holding that even though the Regulatory Impact Analysis stated that the Rule's requirements "would necessitate *immediate* expenditures," because many of the Rule's requirements "do not take effect for a year[,] . . . any alleged expenses associated with 'immediate action to begin Rule implementation and compliance planning' are simply too uncertain and speculative to constitute irreparable harm") (emphasis in original) (citation omitted); *cf. Chlorine Inst., Inc. v. Soo Line R.R.*, 792 F.3d 903, 915 (8th Cir. 2015) (noting that "[a]ppellants' assertion" that a harm would "inevitably result" was "too speculative" and thus insufficient to show irreparable harm).

The merits of the plaintiffs' challenges to the 24/7 RN requirement and the HPRD requirements can be addressed before May 2026, when the first staffing requirements of the Final Rule are to take effect. *See Am. Meat Inst. v. U.S. Dep't of Agric.*, 968 F. Supp. 2d 38, 75 (D.D.C. 2013) ("Perhaps the single most important prerequisite for the issuance of a preliminary injunction is a demonstration that if it is not granted the applicant is likely to suffer irreparable harm before a decision on the merits can be rendered."). The plaintiffs have not demonstrated that injunctive relief is necessary to prevent irreparable harm as to those aspects of the Final Rule.

b. EFA Requirement

The EFA requirement took effect on August 8, 2024. 89 Fed. Reg. 40876. As the initial compliance date for the EFA requirement has already passed, the Government asserts that the plaintiffs cannot demonstrate irreparable harm with respect to this aspect of the Final Rule. Doc. 72 at 62.

The Eighth Circuit has found that prior harm weighs against entering injunctive relief when a plaintiff can recover damages. *See CDI Energy Servs. v. West River Pumps, Inc.*, 567 F.3d 398, 403 (8th Cir. 2009) ("[I]t was appropriate for the district court to view the irreparable-harm factor as weighing against the issuance of a preliminary injunction. The harm that had already occurred could be remedied through damages."); *see also Adam–Mellang v. Apartment Search, Inc.*, 96 F.3d 297, 300 (8th Cir. 1996) (declining to enter a preliminary injunction when a plaintiff had "an adequate remedy at law, namely, the damages and other relief to which she will be entitled if she prevails"). Here, of course, the plaintiffs cannot recover damages from the Government due to sovereign immunity. Moreover, the Final Rule requires facilities to "review and update that assessment, as necessary, and at least annually." 89 Fed. Reg. 40999. Thus, the costs of compliance with the EFA requirement will recur on an ongoing basis. These factors tend to add some support for a finding that the EFA requirement will cause irreparable harm absent injunctive relief.

Because the plaintiffs have made a more feasible showing of irreparable harm with regard to the EFA requirement, I will consider their likelihood of success on their challenge to this provision. Ultimately, I agree with the Government that because the plaintiffs addressed the likelihood of success element only with respect to the 24/7 RN requirement and the HPRD requirements, they have not demonstrated that a preliminary injunction is appropriate with respect to the EFA requirement.

The plaintiffs raise only a few conclusory arguments regarding likelihood of success as to that requirement. First, they claim that they asserted that the EFA requirement is "vague" and "unreasonable." Doc. 78 at 21. During oral argument, the

plaintiffs asserted that the Final Rule is not severable and their arguments regarding the "arbitrary and capricious" nature of the Final Rule apply to the EFA requirement. Doc. 94 at 26-27. Moreover, the plaintiffs assert that *Missouri v. Biden*, 112 F.4th 531 (8th Cir. 2024), stands for the proposition that "irreparable harm does not need to be tied to any particular aspect of the rule that's being challenged." Doc. 94 at 26-27, 59.

These arguments are not compelling. The plaintiffs' conclusory argument that the EFA requirement is "vague" and "unreasonable" is insufficient to support a finding of likelihood of success on the merits.[8] Additionally, I do not find *Missouri v. Biden* to be particularly helpful. In that case, the Eighth Circuit stated the "district court only enjoined the ultimate forgiveness of loans, finding that States had not shown irreparable harm" with respect to two other provisions of the rule. *Biden*, 112 F.4th at 535. Notwithstanding the district court's injunction, the Government continued to forgive loans through a new "hybrid rule," which combined parts of the non-enjoined rule as well as provisions in another regulation. The Eighth Circuit noted that this hybrid rule "effectively rendered that injunction a nullity." *Id.* at 535.

Although the Eighth Circuit ultimately enjoined the entire rule, it did so only because the Government created a hybrid rule that made the district court's injunction useless. *Missouri v. Biden* does not stand for the proposition that a plaintiff may cherry-pick portions of a final rule, arguing likelihood of success as to some and irreparable harm as to others. Given plaintiffs' failure to make any serious argument that they are likely to succeed on their challenge to the EFA requirement, I find that they have failed to demonstrate that a preliminary injunction as to that requirement is appropriate.

[8] Indeed, "[w]hen a party seeks to enjoin a government regulation that is 'based on presumptively reasoned democratic processes,'. . . we apply a 'more rigorous threshold showing' than just a 'fair chance' of success on the merits. *Firearms Regul. Accountability Coal., Inc. v. Garland*, 112 F.4th 507, 517 (8th Cir. 2024) (quoting *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 730, 732 (8th Cir. 2008) (en banc). Therefore, such conclusory arguments do not come close to meeting the required showing.

c. Medicaid Transparency Reporting Requirements

The Medicaid institutional transparency reporting requirement does not take effect until May 10, 2028. 89 Fed. Reg. 40876. As with the 24/7 RN and the HPRD requirements, I find that this long-delayed effective date renders the alleged expenses associated with immediate action too uncertain and speculative to qualify as irreparable harm. Indeed, many of the plaintiffs' declarations make conclusory statements about the future economic harm they will incur. *See, e.g.*, Doc. 30-4 at 3, ¶ 8 ("Although this requirement does not take effect until four years after the Final Rule is published, it will impose costs on Nebraska well before that."); Doc. 30-3 at 3, ¶ 8 (same); Doc. 30-27 at 3, ¶ 8 (same); Doc. 30-7 at 3, ¶ 7 (same). Moreover, the merits of the plaintiffs' challenge to this provision can be resolved before this requirement takes effect. *See infra* Section III.B.2.a.[9]

d. Plaintiffs' Delay

Finally, the Government argues that the plaintiffs' delay in bringing a motion for a preliminary injunction of the Final Rule weighs against a finding of irreparable harm. For the reasons set forth above, it is largely unnecessary to address the "delay" argument. In short, the Government argues that the five-month delay between publication of the Final Rule and the request for a preliminary injunction was excessive and weighs against a finding of irreparable harm. The Government notes the Texas Health Care Association and several Texas-based LTC facilities filed suit challenging the Final Rule on the same grounds as the plaintiffs "less than two weeks after the promulgation of the Final Rule." Doc. 72 at 62*; see Am. Health 52 Care Ass'n v. Becerra*, 24C-114-Z-BR (N.D. Tex.) (filed May 23, 2024). Further, it asserts that the Eighth Circuit has held that a delay of

[9] Additionally, as with the EFA requirement, the plaintiffs did not make any arguments regarding the likelihood of success on the merits with respect to the Medicaid reporting requirement. *See generally* Doc. 30-1 *and* Doc. 78. Therefore, even if I found that the plaintiffs made a showing of irreparable harm, injunctive relief would not be appropriate. *See infra* Section III.B.2.b.

five months in seeking a preliminary injunction was sufficient to affirm the denial of a preliminary injunction. Doc. 72 at 63*; see Phyllis Schlafly Revocable Trust v. Cori*, 924 F.3d 1004, 1010, n.4 (8th Cir. 2019).

The plaintiffs contend that their delay was less than two months, as the EFA requirement did not take effect until August and they sought injunctive relief in October. Doc. 94 at 58. Additionally, they assert that the length of the delay is not outcome-determinative but, instead, turns on the facts of the case. Doc. 78 at 22. They argue that they were "forced to walk a tightrope," as if they challenged the rule earlier, the Government would have argued that their harms were speculative and uncertain. *Id.* By waiting, they contend that their harms are concrete because the EFA requirement took effect and many LTC facilities are beginning to take measures to ensure they can meet the staffing requirements. *Id.*

The "mere length of the delay is not determinative of whether the delay was reasonable." *Ng v. Board of Regents of University of Minnesota*, 64 F.4th 992, 998 (8th Cir. 2023) (noting that the Eighth Circuit has found delays of seven and eight months to be reasonable but has found delays of five and seventeen months to be unreasonable). And there can be little doubt that a comprehensive challenge to an agency final rule requires time and significant resources to litigate. *See McKinney ex rel. N.L.R.B. v. S. Bakeries, LLC*, 786 F.3d 1119, 1125 (8th Cir. 2015) (noting that "[c]omplicated labor disputes like this one require time to investigate and litigate"). Nonetheless, many of the plaintiffs participated in the rulemaking process and submitted analyses of the expected costs and hardships of the rule. This participation suggests that waiting five

months to challenge the rule was unnecessary, as many had already conducted research to assess the costs and harms that they would face.[10]

On the other hand, the delay in this case was not as egregious as delays seen in other cases. *See, e.g.*, *Adventist Health Sys.*, 17 F.4th at 805 (holding that the district court did not abuse its discretion in finding no irreparable harm where the plaintiffs did not challenge the Final Rule for a year after its adoption and fewer than five days before its scheduled implementation); *see also Novus Franchising, Inc. v. Dawson*, 725 F.3d 885, 894 (8th Cir. 2013) (finding that a delay of 17 months "rebuts any inference of irreparable harm"). Indeed, it appears that five months is the shortest time period that the Eighth Circuit has found to be unreasonable.

Ultimately, I find the plaintiffs' delay seeking a preliminary injunction is largely a non-factor that, at most, adds some additional, marginal support for the conclusion that the plaintiffs failed to demonstrate irreparable harm.

C. Summary

As noted above, a preliminary injunction is "an extraordinary remedy never awarded as of right." *Morehouse Enterprises, LLC*, 78 F.4th at 1016. With regard to nearly every aspect of the Final Rule, the plaintiffs have failed to demonstrate that a preliminary injunction is necessary in order to preserve the status quo and prevent irreparable harm during the pendency of these proceedings. The only potential exception involves the Final Rule's EFA requirement. However, the plaintiffs advanced no viable

[10] *See generally* "Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting," Regulations.gov, https://www.regulations.gov/document/CMS-2023-0144-0001/comment (Sept. 6, 2023); *see, e.g.*, Leading Age Nebraska, CMS-2023-0144-25564 (Nov. 3, 2023), https://www.regulations.gov/comment/CMS-2023-0144-25564 *and* Leading Age PA, CMS-2023-0144-25410 (Nov. 3, 2023), https://www.regulations.gov/comment/CMS-2023-0144-25410.

argument that they are likely to succeed on the merits of their challenge to that requirement.

Under these circumstances, I conclude that the issuance of a preliminary injunction is not appropriate.[11] I do find, however, that the interests of justice will be best served by proceeding quickly to the dispositive motions stage of this case, thus allowing the parties to address the merits directly, rather than through the lens of a motion for a preliminary injunction. In particular, the plaintiffs have raised substantial issues and concerns about Final Rule's 24/7 RN requirement and HPRD requirements. A schedule for dispositive motion briefing will be set forth below.

IV. CONCLUSION

For the reasons set forth herein, the plaintiffs' motion (Doc. 30) for a preliminary injunction as to the Final Rule is **denied**. The following schedule is hereby established with regard to dispositive motions:

1. Any dispositive motions must be filed on or before **March 3, 2025**.
2. Resistances must be filed on or before **April 3, 2025**.
3. Reply materials must be filed on or before **April 24, 2025**.

IT IS SO ORDERED this 16th day of January, 2025.

Leonard T. Strand
United States District Judge

[11] I will therefore not address the remaining *Dataphase* factors. I find it equally unnecessary to address the parties' arguments regarding severability at this time, as I have found that the plaintiffs are not entitled to injunctive relief as to any aspect of the Final Rule. Similarly, it is not necessary for me to address the plaintiffs' contention that any preliminary injunction should apply on a nationwide basis. *See* Doc. 30-1 at 38-40.