IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

STATE OF MISSOURI, STATE OF NEBRASKA, STATE OF ARKANSAS, STATE OF KANSAS, STATE OF IOWA, STATE OF WYOMING, STATE OF ALASKA, STATE OF SOUTH DAKOTA, STATE OF NORTH DAKOTA, and STATE OF NEW HAMPSHIRE, *Plaintiffs*, v. JOSEPH R. BIDEN, Jr., in his official capacity as the President of the United States of America, *et al.*, *Defendants*.	No. 4:21-cv-01329

PLAINTIFF STATES' MEMORANDUM IN SUPPORT
OF MOTION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Other Authorities

INTRODUCTION

Plaintiffs, the States of Missouri, Nebraska, Arkansas, Kansas, Iowa, Wyoming, Alaska, South Dakota, North Dakota, and New Hampshire, challenge the Centers for Medicare and Medicaid Services' ("CMS") Interim Final Rule with Comment Period ("IFC") entitled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination." 86 Fed. Reg. 61,555 (Nov. 5, 2021). That IFC, also referred to as the "CMS vaccine mandate," "CMS mandate," or "mandate," imposes an unprecedented federal vaccine mandate on nearly every employee, volunteer, and third-party contractor working at a wide range of healthcare facilities.

This mandate threatens to exacerbate an alarming shortage of healthcare workers, particularly in rural communities, that has already reached a crisis point. Indeed, the circumstances in the Plaintiff States—facts that CMS, which skipped notice-and-comment rulemaking, did not meaningfully consider—foreshadow an impending disaster in the healthcare industry. By ignoring the facts on the ground and unreasonably dismissing concerns about workforce shortages, the CMS vaccine mandate jeopardizes the healthcare interests of rural Americans.

This mandate is unlawful for at least five reasons. First, it is arbitrary and capricious under the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701–706. Second, it exceeds CMS's statutory authority and conflicts with law. Third, it violates the U.S. Constitution. Fourth, it violates numerous procedural requirements of the APA and the Social Security Act. And fifth, CMS failed to prepare a required regulatory impact analysis ("RIA") on the impact the IFC will have on the operations of Plaintiff States' small rural hospitals. Because the CMS mandate is unlawful, and because it threatens to devastate healthcare throughout the country, the Court should enjoin it pending final resolution on the merits.

STATEMENT OF FACTS

A. The Healthcare Worker Shortage Crisis in the Plaintiff States.

"[C]urrently there are endemic staff shortages," CMS admits, "for almost all categories of employees at almost all kinds of health care providers and supplier[s]." 86 Fed. Reg. at 61,607. "1 in 5 hospitals," CMS notes, "report that they are currently experiencing a critical staffing shortage." *Id.* at 61,559. In addition, "approximately 23 percent of [long-term-care] facilities report[] a shortage in nursing aides; 21 percent report[] a shortage of nurses; and 10 to 12 percent report[] shortages in other clinical and non-clinical staff categories." *Id.* It is thus not surprising, CMS relayed, that "[o]ver half (58 percent) of nursing homes participating in a recent survey . . . indicated that they are limiting new admissions due to staffing shortages." *Id.*

The Plaintiff States' experience confirms this. Healthcare facilities through the Plaintiff States affirm that they have been and still are experiencing serious workforce shortages. *See, e.g.*, Strong Decl. ¶ 4 (Ex. F); Kahl Decl. ¶ 7 (Ex. Q); McNea Decl. ¶ 9 (Ex. S); Barber Decl. ¶ 11 (Ex. N); Mazanec Decl. ¶ 11 (Ex. R); Glaubke Decl. ¶ 11 (Ex. U); Sroczynski Decl. ¶¶ 4–7 (Ex. T); Johansson Decl. ¶¶ 2, 5–6 (Ex. DD). A recent study shows that 97 of Missouri's 114 counties have a nursing shortage. Lori Schneidt, Anne Heyen & Tracy Greever-Rice, *Show Me the Nursing Shortage: Location Matters in Missouri Nursing Shortage*, 12 J. Nursing Reg. 52 (2021). In addition, staff nurse turnover in Missouri is the highest it has been in 20 years. *See* Missouri Hospital Association, *2021 Workforce Report* (2021), *available at* https://www.mhanet.com/mhaimages/Workforce/2021/2021_WF_report.pdf. Thus, to fill open positions, there has been a boom in demand for travel nurses, but this further harms small rural hospitals that cannot afford to pay their nurses more to stay and cannot afford the exorbitant rates of travel nurses. *See* Leticia Miranda, *Rural hospitals losing hundreds of staff to high-paid*

traveling nurse jobs (Sept. 15, 2021), https://www.nbcnews.com/business/business-news/rural-hospitals-losing-hundreds-staff-high-paid-traveling-nurse-jobs-n1279199.

The staffing shortages have gotten so bad that it has prompted emergency measures by state officials. Just a few months ago, on August 27, 2021, Missouri Governor Michael L. Parson signed Executive Order 21-09 declaring a targeted State of Emergency for Missouri's healthcare system. Mo. Exec. Order 21-09 (Aug. 27, 2021), *available at* https://www.sos.mo.gov/library/reference/orders/2021/eo9 (last visited Nov. 8, 2021). The Order, which remains in effect until December 31, 2021, declared that "a state of emergency exists relative to *staff shortages in the State's healthcare system* and the State's recovery efforts from the COVID-19 public health threat." *Id.* (emphasis added). Likewise, on August 26, 2021, Nebraska Governor Pete Ricketts issued Executive Order No. 21-12 declaring that "Nebraska hospitals, clinics, and other health care facilities are facing a shortage of health care professionals" and that "a hospital capacity emergency exists." Neb. Exec. Order 21-12 (Aug. 26, 2021), *available at* https://www.dropbox.com/s/sm3dpu7t094ymum/Executive%20Order%2021-12%20-%20Additional%20Healthcare%20Workforce%20Capacity.pdf?dl=0. Governor Ricketts issued the order, which temporarily waived certain regulations governing healthcare workers and which remains in effect until December 31, 2021, to "protect[] the citizens of Nebraska from the public health threat of a hospital capacity and workforce emergency." *Id.* In addition, on September 21, 2021, Wyoming Governor Mark Gordon activated the Wyoming National Guard to provide temporary assistance to healthcare facilities throughout Wyoming. Governor Gordon called approximately 97 soldiers to provide additional staffing for "Wyoming hospitals, long term care facilities, and public health departments statewide." Johansson Decl. ¶ 3 (Ex. DD).

B. President Biden's September 9, 2021 Speech Announcing Vaccine Mandates.

For the first six months of President Biden's Administration, none of his agencies sought to impose vaccine mandates on the American people. As recently as July 23, 2021, the White House announced that mandating vaccines is "not the role of the federal government." Press Briefing by Press Secretary Jen Psaki (July 23, 2021), The White House, https://www.whitehouse.gov/briefing-room/press-briefings/2021/07/23/press-briefing-by-press-secretary-jen-psaki-july-23-2021/.

Yet on September 9, 2021, amid flagging poll numbers due to the crisis in Afghanistan and on the southern border, the Administration's policy on federal vaccine mandates underwent a dramatic about-face. That day, President Biden gave a speech announcing his six-point Plan to "turn the tide on COVID-19." Joseph Biden, Remarks at the White House (Sept. 9, 2021), https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/ ("Biden Speech"). He announced the first plank of his plan: to "require more Americans to be vaccinated." *Id.* Toward that end, the President called for several federal vaccine mandates—(1) a mandate from the Occupational Safety and Health Administration ("OSHA") for companies with more than 100 employees, (2) a mandate for federal employees, (3) a mandate for employees of federal contractors and subcontractors, and (4) the CMS vaccine mandate challenged here. *Id.* The stated purpose of these mandates was to increase the number of vaccinated people by any coercive power available to the federal government. *Id.*

President Biden also expressed a dismissive view of States that have used their constitutionally guaranteed police powers to adopt contrary public-health policies. *Id.* He stated: "Let me be blunt. My plan also takes on elected officials and states that are undermining . . . these

lifesaving actions." *Id.* Speaking scornfully of "governor[s]" who oppose the new federal mandates, he promised that "if these governors won't help us beat the pandemic, I'll use my power as President to get them out of the way." *Id.*

C. CMS's November 5, 2021 Vaccine Mandate.

On November 5, 2021, nearly two months after President Biden announced his federal vaccine mandates, CMS published the IFC challenged here. 86 Fed. Reg. 61,555. In creating that rule, however, CMS did not comply with notice-and-comment requirements or consult with the States. *See* 5 U.S.C. § 553(b)–(c) (APA requirements), 42 U.S.C. § 1395hh(b)(1) (Social Security Act requirements), 42 U.S.C. § 1395z ("Secretary shall consult with appropriate State agencies").

CMS openly recognized that its action was unprecedented—never before had the agency mandated vaccination. *See, e.g.*, 86 Fed. Reg. at 61,567 ("We have not previously required any vaccinations"); *see also* Compl. ¶ 121 (collecting other cites). CMS nevertheless took this action to nationalize the COVID-19 vaccination response, explaining that "the inconsistent web of State, local, and employer COVID-19 vaccination requirements have established a pressing need for a consistent Federal policy mandating staff vaccination in health care settings." 86 Fed. Reg. at 61,584. And the agency chose the draconian course of mandating vaccines because it determined that the "most important inducement [for vaccination] will be the fear of job loss." *Id.* at 61,607.

The CMS vaccine mandate covers fifteen categories of Medicare- and Medicaid-certified providers and suppliers, including Rural Health Clinics ("RHCs"), Critical Access Hospitals ("CAHs"), other hospitals, Psychiatric Residential Treatment Facilities ("PRTFs") for individuals under age 21, and long-term-care ("LTC") facilities. *Id.* at 61,556. By expanding its reach in this way, the mandate broadly sweeps in a "diverse" set of healthcare providers. *Id.* at 61,602.

CMS applies its vaccine mandate to practically every full-time employee, part-time worker, trainee, student, volunteer, or third-party contractor working at covered facilities. The mandate requires vaccination for all "facility staff"—a term that includes employees, trainees, students, volunteers, and contractors—"who provide any care, treatment, or *other services* for the facility," "*regardless of . . . patient contact*." *Id.* at 61,570 (emphasis added). This includes "administrative staff" and "housekeeping and food services." *Id.* CMS also imposed its mandate on "any individual that . . . has the *potential* to have contact with anyone at the site of care." *Id.* at 61,571 (emphasis added). This includes "staff that primarily provide services remotely via telework" but "occasionally encounter fellow staff . . . who will themselves enter a health care facility." *Id.* at 61, 570. Illustrating its breadth, the mandate also covers a "crew working on a construction project whose members use shared facilities (restrooms, cafeteria, break rooms) during their breaks[.]" *Id.* at 61,571. CMS allows exemptions only to the extent necessary to "comply with applicable Federal anti-discrimination laws and civil rights protections," such as medical exemptions required by the Americans with Disabilities Act ("ADA") and religious exemptions required by Title VII of the Civil Rights Act of 1964. *Id.* at 61,568.

Recognizing the mandate's breadth, CMS acknowledges its "near-universal applicability" to health-care staff and its demand that "virtually all health care staff in the U.S. [must] be vaccinated for COVD-19." *Id.* at 61,573. CMS estimates that approximately 10.3 million employees will fall under the mandate. *Id.* at 61,603.

CMS expressly rejected the option of allowing workers to undergo "daily or weekly [COVID-19] testing" instead of mandatory vaccination, and it did so for only one reason: because the agency believes that "vaccination is a more effective infection control measure" than regular testing. *Id.* at 61,614.

CMS was "aware of concerns about health care workers choosing to leave their jobs rather than be vaccinated" and knew that "there might be a certain number of health care workers who choose to do so." *Id.* at 61,569. But CMS dismissed these concerns because "there is insufficient evidence to quantify" that risk and balance it against others. *Id.* Instead, based on the experiences of a few private healthcare facilities that implemented vaccine mandates in mostly urban areas, CMS optimistically "believe[d] that the COVID-19 vaccine requirements . . . will result in *nearly all* health care workers being vaccinated." *Id.* (emphasis added); *see also id.* at 61,609 (finding that only a "relatively small fraction" of turnover "will be due to vaccination").

The IFC was immediately effective on November 5, 2021—the day it was published. *Id.* at 61,555. Covered providers must implement the vaccine mandate in two 30-day phases. *Id.* at 61,571. Phase 1 requires staff to receive the first vaccine dose or request a medical or religious exemption by December 6, 2021. *Id.* And Phase 2 mandates that non-exempt staff be fully vaccinated by January 4, 2022. *Id.* Covered healthcare providers that do not comply are subject to termination of their Medicare/Medicaid provider agreement. *Id.* at 61,574; *see also* Compl. ¶ 127 (citing other support). Because the decision to get vaccinated must occur by December 6, the Plaintiff States need relief before that date.

D. The CMS Vaccine Mandate's Commandeering of the States.

The CMS mandate overrides state laws and commandeers state officials at every turn. The agency repeatedly says that it intends for the mandate to preempt any arguably inconsistent state and local laws. *See, e.g.*, 86 Fed. Reg. at 61,568 ("We intend . . . that this nationwide regulation preempts inconsistent State and local laws"); *see also* Compl. ¶ 121 (collecting cites).

CMS also requires "State-run facilities that receive Medicare and Medicaid funding" to enforce and administer the vaccine mandate by "imposing [it] on their employees." 86 Fed. Reg.

at 61,613. This includes complying with overbearing record-keeping obligations, such as "tracking [the] vaccination status" of staff who are not covered by the mandate, and documenting the "vaccination status of any staff who have obtained any booster doses" even though the mandate does not require boosters. *Id.* at 61,571. The Plaintiff States operate many state-run hospitals. *See, e.g.*, Huhn Decl. ¶¶ 3, 6–12, 15–18 (Ex. J); York Decl. ¶¶ 1–3 (Ex. B); Johansson Decl. ¶¶ 1–2, 6 (Ex. DD); Kahl Decl. ¶¶ 8–10 (Ex. Q); White Decl. ¶¶ 3–4 (Ex. C); Ringling Decl. ¶ 3 (Ex. CC); Jones Decl. ¶ 3 (Ex. AA).

CMS additionally coopts "State surveyors . . . to assess compliance with" the mandate. 86 Fed. Reg. at 61,574. Those surveyors are employed by the States. *See* Bollin Decl. ¶ 5 (Ex. H); Gayhart Decl. ¶ 3 (Ex. A); Wehbi Decl. ¶ 4 (Ex. BB). They must "review[] the entity's records of staff vaccinations" and "interview[] staff to verify their vaccination status." 86 Fed. Reg. at 61,574. And they must "cite providers and suppliers when noncompliance is identified." *Id.*

E. The CMS Vaccine Mandate's Disruptive Impact on Healthcare.

Vaccination rates, as CMS admits, "are disproportionately low among nurses and health care aides" in rural locations and other "communities that experience social risk factors," 86 Fed. Reg. at 61,566, and "rural hospitals are having greater problems with employee vaccination . . . than urban hospitals," *id.* at 61,613. A recent survey also shows that a substantial portion of "unvaccinated workers"—a whopping 72%—"say they will quit" rather than submit to a vaccine mandate. Chris Isidore and Virginia Langmaid, *72% of unvaccinated workers vow to quit if ordered to get vaccinated*, CNN.com (Oct. 28, 2021), https://www.cnn.com/2021/10/28/business/covid-vaccine-workers-quit/index.html. The confluence of these developments have created the perfect storm for healthcare calamity in rural America.

Healthcare facilities throughout the Plaintiff States confirm this. The leadership at Callaway District Hospital—a Small Rural Hospital and Critical Access Hospital in Callaway, Nebraska—is deeply distressed. Eggleston Decl. ¶¶ 1, 4–5 (Ex. L). Around 20 members of its 65-person staff are not vaccinated, and over half of those unvaccinated workers are nurses. *Id.* at 12, 14. Sadly, Callaway "project[s] [the] loss of approximately 30% of [its] staff" from the CMS mandate—losses that "will almost certainly lead to closure of [the] facility" and "leave [that] rural community without essential healthcare services." *Id.* at ¶¶ 16–17.

Likewise, Cherry County Hospital in rural Valentine, Nebraska fears that it will not survive CMS's mandate. Kellum Decl. ¶¶ 1, 4, 15 (Ex. P). Sixty-six of its 159 staff members are not vaccinated, and the hospital projects that the mandate will force 50 of those 66 to leave their positions. *Id.* at ¶¶ 11, 13–14. That will result in closing its dialysis and chemotherapy departments, dramatically reducing its ability to provide needed surgeries, and perhaps even shutting down the hospital. *Id.* at ¶ 15. In the CEO's words, "I cannot express the extent of what is about to happen." *Id.* at ¶ 16. Patients in that community "will not have the primary care services needed to stay healthy," and they "will not have the staff to care for them in an emergency." *Id.*

Similar evidence from Box Butte General Hospital, a Small Rural Hospital and Critical Access Hospital in Alliance, Nebraska, illustrates the systemic staffing issues. Mazanec Decl. ¶¶ 1, 4–5 (Ex. R). Box Butte has had open positions "since 2019 with no applications received" due to "existing health care worker shortages" and "challenges of the rural location." *Id.* at ¶ 11. Currently, 42% of Box Butte's 289 employees are unvaccinated, and those employees include senior leadership, physicians, and nurses. *Id.* at ¶¶ 10, 12. The hospital expects "to lose 15 percent of its total employees" from the CMS mandate, and those losses will "impact[] nearly all . . . departments," including emergency medicine. *Id.* at ¶ 13. Box Butte thus anticipates needing to

close departments, reduce services, and turn patients away. *Id.* at ¶ 14. And because the remaining employees "will be forced to work extended hours," this will feed a vicious cycle as they "experience an even greater amount of burnout" and will be likely to "leave health care" altogether. *Id.* at ¶ 15.

Community Hospital—which is in rural McCook, Nebraska, serves people from Southwest Nebraska and Northwest Kansas, and is 70 miles from the next closest facility providing similar services—also faces severe consequences from the CMS mandate. Bruntz Decl. ¶¶ 1, 9–10 (Ex. W). Seventy-eight of its 330 employees (24%) are unvaccinated, and 76 of the unvaccinated staff "have indicated they will not or are seriously considering not receiving the vaccination." *Id.* at ¶ 13. The hospital thus expects that it will "lose well more than 10% of its staffing," that its patients "will be harmed" when the facility is "forced to limit or close services," and that many of the remaining vaccinated staff "will resign due to the stress and burn out that will inevitably exist." *Id.* at ¶¶ 14–16.

The experience of Franciscan Care Services, a Small Rural Hospital and Critical Access Hospital in Northeast Nebraska, illustrates the interconnectedness of the healthcare industry. Toline Decl. ¶¶ 1, 4–5, 9 (Ex. Y). Just a few months ago, in June 2021, it experienced "increased volumes" after the closure of a critical access hospital 15 miles away. *Id.* at ¶ 9. Now it fears for the future since 23% of its staff are unvaccinated. *Id.* at ¶ 14. If it loses many of them as it expects, Franciscan will need "to reduce services in the clinic" to provide care for "emergency patients." *Id.* at ¶ 15. In turn, "[e]mergency room patient volumes . . . will increase due to inability to care for [patients] in the clinic setting." *Id.*

The leadership at a slightly larger hospital—Great Plains Health in North Platte, Nebraska—is also troubled by the vaccine mandate. It has a total staff of 1,197, and 311 of them

are not vaccinated. McNea Decl. ¶¶ 1, 8, 10 (Ex. S). The hospital projects that it will "lose a high percentage of these unvaccinated employees," in addition to already having 231 vacancies. *Id.* at ¶¶ 9–10. Such losses, which would lead to "a dangerously reduced number of staffed ICU beds," would have "negative effects" on patients. *Id.* at ¶ 11. Great Plains also fears that it will "need to close or reduce" its "behavioral health unit," requiring it to send patients to a different facility that "is nearly three hours away and itself facing staffing concerns." *Id.* at ¶ 12.

What's more, Scotland County Hospital in Memphis, Missouri, a 25-bed, non-profit Critical Access Hospital serving rural Northeast Missouri and Southeast Iowa, has "at least" five essential workers in critical areas who have "stated emphatically they will not be vaccinated," and the hospital's CEO believes the CMS vaccine mandate will cause these workers to quit or he'll have to fire them. The hospital has already "suffered staff resignations by 18%" during the pandemic, and the loss of "additional employees will cause significant difficulty in the continued quality and safe operations of SCH." Tobler Decl. ¶¶ 1–2, 4, 6–7 (Ex. G).

Evidence also shows that CMS's mandate will have substantially negative effects on hospitals with successful voluntary vaccination efforts. St. Anthony Regional Hospital, in rural Carroll, Iowa, has about 87% of its 750-person staff vaccinated. Smith Decl. ¶¶ 3, 4, 6 (Ex. D). But a recent survey of its unvaccinated employees shows that 40 employees are likely to resign rather than comply with CMS's mandate. *Id.* at ¶ 8. Given the hospital's significant struggles with filling and recruiting staff, the loss of 40 employees will force it "to evaluate the availability of needed healthcare services to the people" it serves. *Id.* at ¶ 5, 9, 11.

The mandate's unsettling effects on the healthcare industry reach beyond rural hospitals to skilled nursing and long-term-care ("LTC") facilities. Many long-term-care facilities in Missouri "have indicated that they would have to close their facilities" under the mandate. Strong Decl. ¶

6 (Ex. F). That "would displace thousands of residents across the state and affect the entire health care system" by "inundat[ing] hospital capacity" and "leaving little room for others in the community to receive the care they need." *Id.*

The Missouri Department of Health and Senior Services ("DHSS") echoed these concerns in a November 12, 2021 emergency amendment to Mo. Code Regs. Ann. tit. 19, § 30-82.010. *See* Emergency Amendment, Missouri Department of Health and Senior Services (Nov. 12, 2021), https://www.sos.mo.gov/CMSImages/AdRules/main/EmergenciesforInternet/19c30-82.010IE.pdf. According to DHSS, approximately 44% of staff working at Missouri's long-term-care facilities are not fully vaccinated. *Id.* DHSS anticipates that "many of the [44%] of unvaccinated staff working at these long term facilities will not choose to get vaccinated, even with this vaccine mandate from CMS." *Id.* DHSS thus predicts that because of the CMS vaccine mandate, some long-term-care facilities—namely, skilled nursing facilities and intermediate care facilities—"will not have enough staff to care for the residents in their facilities and be in compliance with federal and state law." *Id.* These facilities may be forced to temporarily close or consolidate until the staffing shortages are fixed. *Id.* The emergency amendment thus creates a temporary closure procedure for facilities should they need to "make plans to begin discharging residents and pursing temporary closures before" CMS's deadlines. *Id.*

Specific examples throughout the Plaintiff States support these broader concerns about long-term-care facilities. One troubling situation involves Kimball County Manor and Assisted Living, a nursing home in rural Nebraska. Monheiser Decl. ¶ 1 (Ex. V). Of that facility's 55 employees, 31 are unvaccinated, and at least 27 of them "have informed management that they will resign or be terminated rather than be vaccinated." *Id.* at ¶ 8. "Losing potentially 48% of [its] workforce, including a substantial percentage of [its] already depleted nursing staff[,] will force"

the manor to reduce its services and transfer "current patients" to facilities further away. *Id.* at ¶ 9. It will also jeopardize the manor's "very existence." *Id.* at ¶ 9. Fearing its impending doom, the manor has already placed "a hold on admitting new patients in anticipation of [the] loss of staff." *Id.* at ¶ 7.

A similar situation faces Monroe City Manor Care Center, a nursing home in Missouri. It has an employee vaccination rate under 50%, and "[w]hen surveyed, a majority of the[] unvaccinated staff stated they would choose to leave healthcare completely over being forced to get [a] covid-19 vaccine." Vanlandingham Decl. ¶ 7 (Ex. E). That loss of 25% of its total staff "will cause significant difficulty in the continued operation" of the facility. *Id.* at ¶ 8.

Scotland County Care Center ("SCCC"), another nursing home in Missouri, is similarly situated. SCCC, a political subdivision of the State of Missouri, derives 50% of its total operational revenues from CMS, and is currently experiencing a shortage of nursing staff. This has already led SCCC to contract-out nursing services at a substantial premium. And now, the CMS vaccine mandate will cause SCCC to "lose more staff, struggle to fill those vacancy spots with agency staffing, causing even more financial hardship." Twenty out of 65 of SCCC's employees are "vehemently opposed to taking the vaccine and if the CMS mandate is indeed imposed, they will quit working at SCCC." "If that happens," SCCC "will lose about 30% of [its] workforce"—a loss that will cause SCCC to cease its operations. Schrage Decl. ¶¶ 1–2, 4–5, 7, 9 (Ex. I).

Emerald Health Care, which operates four skilled nursing facilities throughout Nebraska, anticipates that the CMS mandate will cause it to lose between 25% and 10% of its staff at each of its locations. Sroczynski Decl. ¶¶ 4–7 (Ex. T). Considering that the staffing at these facilities is already extremely deficient, Emerald's long-term prospects are quite grim. *Id.* Even if it survives, the mandate "will result in each [Emerald] facility turning away patients." *Id.* at ¶ 8.

State-run healthcare facilities will also be significantly impacted. The Alaska Psychiatric Institute ("API") estimates that "[d]espite the availability of medical and religious exemptions," it "is likely to lose approximately 20 employees (8% of [its] workforce) as a result of the vaccine mandate." York Decl. ¶ 9 (Ex. B). "Losing even 5% of its workforce would cause substantial harm to API because it would be extremely difficult to fill those positions." *Id.* at ¶ 10. Similarly, 37% of the staff at Arkansas's seven state-run healthcare facilities are unvaccinated, and the State "expects that the CMS vaccine mandate will result in increased staffing shortages" for those providers. White Decl. ¶¶ 8–9 (Ex. C). South Dakota likewise expects staff loss at its state-run psychiatric hospital and fears that it might result in "individuals needing emergency inpatient psychiatric treatment [being] held in jail settings or emergency rooms until capacity is available." Ringling Decl. ¶¶ 3, 7–8 (Ex. CC).

That the CMS mandate would ignite these healthcare catastrophes was not a secret. In Missouri, for example, it has been publicly discussed and widely anticipated for the last few months that vaccine mandates will prompt widespread resignations and intensify existing staffing shortages in the healthcare sector—as healthcare facilities described their prospects under the threatened mandate as "dangling by a thread."[1] National media also covered this issue. *See, e.g.*, *As Vaccine Deadlines Approach, Hospitals Fear Staffing Shortages Will Occur*, NPR.org (Sept. 27, 2021), https://www.npr.org/sections/coronavirus-live-updates/2021/09/27/1041047608/

[1] *See, e.g.*, Emily Manley, *Missouri Health Care Association says vaccine mandate will worsen staffing shortage*, Fox 2 News (Sept. 14, 2021), https://fox2now.com/news/missouri/missouri-health-care-association-says-vaccine-mandate-will-worsen-staffing-shortage/; Allison Kite and Tessa Weinberg, *'Dangling by a thread': Nursing home industry warns of staff exodus over vaccine mandates*, Missouri Independent (Sept. 15, 2021), https://missouriindependent.com/2021/09/15/dangling-by-a-thread-nursing-home-industry-warns-of-staff-exodus-over-vaccine-mandates/; Mike Stunson, *Missouri hospital fears staff may quit over Biden vaccine mandate*, Kansas City Star (Oct. 14, 2021), https://www.kansascity.com/news/coronavirus/article254948037.html.

vaccine-deadlines-hospitals-fear-staffing-shortages. All this shows that these adverse impacts, especially in rural and underserved areas, have been widely anticipated for many weeks.

ARGUMENT

Courts consider four factors in determining whether to grant a preliminary injunction: "(1) the likelihood of the movant's success on the merits; (2) the threat of irreparable harm to the movant in the absence of relief; (3) the balance between that harm and the harm that the relief would cause to other litigants; and (4) the public interest." *Watkins Inc. v. Lewis*, 346 F.3d 841, 44 (8th Cir. 2003) (citing *Dataphase Sys., Inc. v. C.L. Sys., Inc*., 640 F.2d 109, 114 (8th Cir. 1981) (en banc)). Here, all four factors favor Plaintiff States.

I. The Plaintiff States Are Likely To Succeed on the Merits of Their Claims.

The Plaintiff States are likely to succeed on the merits of their claims that (1) the CMS vaccine mandate is arbitrary and capricious, (2) it exceeds CMS's statutory authority and conflicts with law, (3) it violates the Constitution, (4) it contravenes multiple procedural rulemaking requirements, and (5) CMS failed to produce a required regulatory impact analysis.

A. The CMS Vaccine Mandate Is Arbitrary and Capricious in Violation of the APA.

The CMS vaccine mandate is arbitrary and capricious under the APA. As an initial matter, the APA undoubtedly applies to this case. The United States Department of Health and Human Services ("HHS"), which delegated its authority to and acted through CMS, is a federal agency. *See Soucie v. David*, 448 F.2d 1067, 1073 (D.C. Cir. 1971) ("[T]he APA . . . confers agency status on any administrative unit with substantial independent authority in the exercise of specific functions."). And the IFC is final agency action because (1) it "mark[s] the consummation of the agency's decisionmaking process," and (2) it is a pronouncement "by which rights or obligations have been determined, or from which legal consequences will flow." *Bennet v. Spear*, 520 U.S.

154, 177–78 (1997). Indeed, the IFC directly determines which healthcare facilities will be eligible to receive Medicare and Medicaid funding. In CMS's words, "[p]rovider and supplier compliance with the Federal rules issued under these statutory authorities are mandatory for participation in the Medicare and Medicaid programs." 86 Fed. Reg. at 61,560.

Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary" or "capricious." 5 U.S.C. § 706(2)(A). "The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1158 (2021). Courts must ensure that "the agency has acted within a zone of reasonableness and, in particular, has reasonably considered the relevant issues and reasonably explained the decision." *Id.* "[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins.Co.*, 463 U.S. 29, 43 (1983). The arbitrary-and-capriciousness standard also requires the agency "to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns." *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1915 (2020). Under these principles, the IFC establishing the CMS vaccine mandate is arbitrary and capricious for at least seven reasons.

First, CMS failed to reasonably explain its decision to impose its vaccine mandate despite the alarming healthcare workforce shortages and the obvious risk that the mandate will exacerbate an already unstable situation. In fact, CMS's analysis goes a long way toward showing that the vaccine mandate will indeed throw gasoline on the fire.

CMS repeatedly admits that the current "endemic staff shortages" in the healthcare industry "may be made worse if any substantial number of unvaccinated employees leave health care

employment altogether." 86 Fed. Reg. at 61,607; *see also id.* at 61,608 ("[T]here may be disruptions in cases where substantial numbers of health care staff refuse vaccination and are not granted exemptions and are terminated, with consequences for employers, employees, and patients"); *id.* at 61,609 ("[I]t is true that compliance with this rule may create some short-term disruption of current staffing levels for some providers or suppliers in some places."). And CMS went further by acknowledging that "[e]ven a small fraction" of unvaccinated healthcare workers leaving their jobs "could disrupt facility operations." *Id.* at 61,612.

CMS also discussed facts showing that potential calamity awaits rural communities in particular. For instance, CMS acknowledged that "vaccination rates are disproportionately low among nurses and health care aides" in rural locations and other "communities that experience social risk factors." *Id.* at 61,566. And it admitted that "early indications are that rural hospitals are having greater problems with employee vaccination . . . than urban hospitals." *Id.* at 61,613.

Despite these acknowledged concerns about intensifying an already-existing healthcare crisis, CMS decided to move forward anyway. It did so because it thought that the unvaccinated employees would get jobs in other healthcare positions, such as "physician and dental offices," that are not covered by the CMS vaccine mandate. *Id.* at 61,607. Yet this speculation does nothing to abate the debilitating harm soon to be inflicted upon the *healthcare facilities* falling under this mandate. Indeed, it does not suggest that the healthcare worker shortage will improve but only that shortages will be further concentrated among the covered healthcare facilities.

CMS also conjectured that staffing deficiencies at facilities covered by the mandate "might be offset by persons returning to the labor market who were unwilling to work at locations where some other employees are unvaccinated." *Id.* at 61,607. This was pure speculation. CMS cited no evidence that such vaccinated workers exist, and it strains credulity to suggest that they do. A

worker who harbors such fears would still have to regularly work with unvaccinated *patients*, and it is irrational to assume that they would be willing to work with unvaccinated patients but not unvaccinated coworkers.

In the end, CMS dismissed the concerns about staffing because, it believed, "there is insufficient evidence to quantify" those concerns and balance them against other risks. *Id.* at 61,569. Instead, based on the experiences of a few private healthcare facilities that implemented vaccine mandates in mostly urban settings, which have much larger labor-market pools and higher community vaccination rates, CMS optimistically "believe[d] that the COVID-19 vaccine requirements . . . will result in *nearly all* health care workers being vaccinated." *Id.* (emphasis added). But CMS did not reference data on any past efforts to mandate COVID-19 vaccines in rural areas. Making such a rosy across-the-board projection based on nothing more than the experiences of a few cherry-picked healthcare providers is decidedly unreasonable.

The arbitrariness is particularly apparent in CMS's decision to act based on such scant and inapposite anecdotes instead of soliciting public comment and state input, as applicable statutes required the agency to do. *See* 5 U.S.C. § 553(b)–(c) (APA), 42 U.S.C. § 1395hh(b)(1) (Social Security Act), 42 U.S.C. § 1395z ("Secretary shall consult with appropriate State agencies"). Obtaining insight from those sources would have provided the agency with important information on the looming healthcare disaster. Had CMS sought public comment, it would have heard about countless situations like those recounted in the declarations supporting this motion (and in Section E under the Statement of Facts above). With the fate of our strained national healthcare industry hanging in the balance, it is the height of arbitrariness not to solicit input from key stakeholders.

Despite the obvious concerns about the vaccine mandate upending significant sectors of the healthcare industry, CMS remarkably concluded that existing staffing shortages are actually *a*

reason to impose the mandate. In CMS's words, "the urgent need to address COVID-related staffing shortages that are disrupting patient access to care[] provides strong justification as to the need to issue this" mandate. 86 Fed. Reg. at 61,567. Because "unvaccinated staff" are purportedly "at greater risk for infection" and "absenteeism," CMS elaborated, allowing providers to continue hiring them might "create staffing shortages." *Id.* at 61,559. But this speculation irrationally ignores the obvious: that maintaining a larger pool of potential workers, even if some might have a bout with COVID-19, is better than categorically excluding an entire class of individuals. In short, CMS's discussion of the mandate's projected effect on the existing healthcare crisis is unreasonable from beginning to end.

Second, CMS failed to consider the reliance interests of healthcare providers (including state-run facilities) and healthcare workers. For years, CMS has had regulations setting the conditions for Medicare and Medicaid participation. *See id.* at 61,555 (listing the regulations amended by the IFC). Yet never before had CMS mandated any vaccines for staff members. And six months ago, when CMS adopted an IFC requiring two groups of healthcare providers covered by this mandate—long-term-care ("LTC") facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICFs-IID")—to educate their staff on COVID-19 vaccines, it did not go so far as to mandate them. *See* Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs-IID) Residents, Clients, and Staff, 86 Fed. Reg. 26306-01 (May 13, 2021). So when CMS adopted the vaccine mandate, the agency was "not writing on a blank slate," and thus it needed to consider reliance interests. *Regents*, 140 S. Ct. at 1915.

Many healthcare providers relied on CMS's prior rules by hiring staff members regardless of their vaccination status. *See, e.g.*, McNea Decl. ¶ 9 (Ex. S); Naiberk Decl. ¶ 11 (Ex. M); Sharp Decl. ¶ 12 (Ex. X); Kahl Decl. ¶ 13 (Ex. Q). In fact, Nebraska specifically sought out unvaccinated applicants because the State's executive-branch officials decided that they would not mandate vaccination as a condition of working in state-run healthcare facilities. Kahl Decl. ¶ 13 (Ex. Q). By relying on the then-existing regulations, many healthcare facilities assembled workforces without concern for vaccination. But now those facilities stand to abruptly lose significant portions of their staff because of CMS's change in course. And the impact of that will reach far beyond the providers themselves and directly harm the people in the communities they serve. CMS did not discuss these reliance interests when adopting its mandate.

Nor did CMS consider any of the reliance interests of healthcare workers. Those individuals have "embarked on careers" and taken jobs in reliance on the prior CMS rules. *Regents*, 140 S. Ct. at 1914. Now they stand to lose those jobs because of CMS's mandate. And the consequences of that would "radiate outward" to injure not only those workers' families but also the very people they once cared for. *Id.* "These are certainly noteworthy concerns," and it was CMS's duty to consider them, "but the agency failed to do it." *Id.* Ignoring these critical worker-focused reliance interests violates the APA.

Third, CMS completely "failed to consider" other "important aspects of the problem" before it. *Id.* at 1910 (quoting *State Farm*, 463 U.S. at 43) (cleaned up). Critically, CMS did not acknowledge that it was infringing on a well-established area of state sovereignty. "[T]he police power of a state" includes the authority to adopt regulations seeking to "protect the public health," including the topic of mandatory vaccination. *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905). Though these matters "do not ordinarily concern the national government," *id.* at 38, CMS

never recognized that it was trampling on traditional State prerogatives and disrupting the existing federal-state balance of authority. Instead, CMS made explicit its desire to override contrary state law on vaccine issues. *See, e.g.*, 86 Fed. Reg. at 61,568 ("We intend . . . that this nationwide regulation preempts inconsistent State and local laws").

Fourth, CMS's own discussion betrays the illogic of its refusal to exempt healthcare workers who have been previously "infected by SARS-CoV-2" and thus have developed infection-induced immunity, also called natural immunity. *Id.* at 61,614. The agency cast aside that option because it perceives "uncertainties about [sic] as to the strength and length of [natural] immunity." *Id.* But CMS similarly acknowledges that vaccine "immunity decreases" over time "after the primary vaccine series." *Id.* at 61,562. And the agency elsewhere recognized the value of natural immunity when it said that each day 100,000 people are "recover[ing] from infection," that they "are *no longer sources of future infections*," and that their natural immunity "reduce[s] the risk to both health care staff and patients substantially." *Id.* at 61,604 (emphasis added). Simply put, CMS's inconsistencies on natural immunity demonstrate the unreasonableness of its decision.

CMS also ignored key evidence indicating that natural immunity effectively guards against the Delta variant. A widely publicized study of a large population of patients in Israel found that *vaccinated* people who had not been previously infected had 13 times higher odds of experiencing a breakthrough infection with the Delta variant than patients who had recovered from COVID but were never vaccinated. Sevan Gazit et al., *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: Reinfections versus breakthrough infections*, medRxiv Preprint (2021), https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1). It is unreasonable for CMS to pretend that this evidence does not exist.

Fifth, CMS's pronouncement about the necessity of the vaccine mandate is an impermissible "*post hoc* rationalization." *Regents*, 140 S. Ct. at 1908 (citation omitted). The agency did not first identify the mandate as necessary to protect public health and then produce the rule. Rather, the President directed CMS to impose the mandate as part of a comprehensive plan to federalize the public-health response to COVID-19, and then the agency spent nearly two months reverse-engineering a justification for it. Such *post hoc* rationalizations cannot satisfy APA review.

Sixth, the exceedingly broad scope of healthcare providers covered by the CMS vaccine mandate is arbitrary. The mandate reaches categories of healthcare facilities, such as Psychiatric Residential Treatment Facilities ("PRTFs") for individuals under age 21, *see* 86 Fed. Reg. at 61576, that are not related to CMS's asserted interest in protecting elderly and infirm patients from COVID-19. Indeed, CMS recognizes that "risk of death from infection from an unvaccinated 75- to 84-year-old person is 320 times more likely than the risk for an 18- to 29-years old person." *Id.* at 61,610 n.247. CMS provides no reasoned explanation for this overbroad approach.

Seventh, the vast range of workers, volunteers, and third-party contractors compelled by the mandate is inexplicable. It applies to onsite "administrative staff" and "housekeeping and food services" staff "*regardless of . . . patient contact*." *Id.* at 61,570 (emphasis added). It also reaches "any individual that . . . has the *potential* to have contact with anyone at the site of care." *Id.* at 61,571 (emphasis added). This includes "staff that primarily provide services remotely via telework" but "occasionally encounter fellow staff . . . who will themselves enter a health care facility." *Id.* at 61, 570. And the mandate also covers a third-party vendor's "crew working on a construction project whose members use shared facilities (restrooms, cafeteria, break rooms) during their breaks." *Id.* at 61,571. The sheer breadth of this mandate is far removed from the

purported purpose of protecting patient safety. For all these reasons, the CMS vaccine mandate is arbitrary and capricious under the APA.

B. The CMS Vaccine Mandate Exceeds Statutory Authority And Is Not In Accordance With Law.

Under the APA, a court must "hold unlawful and set aside agency action" that is "not in accordance with law" or "in excess of statutory . . . authority[] or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C). The CMS vaccine violates this command in two ways. First, the mandate exceeds statutory authority because the statutes that CMS cites do not support imposing a vaccine mandate. Second, the mandate conflicts with 42 U.S.C. § 1395 by impermissibly authorizing CMS officials to control the selection of healthcare workers.

1. The mandate exceeds CMS's statutory authority.

CMS's purported statutory authority for its vaccine mandate rests on two sets of laws. *See* 86 Fed. Reg. at 61,567. First, the agency relies on two statutes that give general rulemaking power to HHS. *See* 42 U.S.C. § 1302(a) ("the Secretary of Health and Human Services . . . shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which [he] is charged under this Act"); 42 U.S.C. § 1395hh(a)(1) (providing that the "Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under" Title 18 of the Social Security Act). Second, CMS invokes other more specific statutes that supposedly give it authority to impose the mandate on the covered classes of healthcare facilities. 86 Fed. Reg. at 61,567.

Before analyzing the statutory text, it is important to assess the magnitude of what CMS has done. Amidst an ongoing political debate about whether governments should mandate COVID-19 vaccines, President Biden announced that his administration would implement a slew of them, including CMS's mandate. *See* Biden Speech, *supra*. This is a brazen attempt to

federalize a national public-health response to COVID-19, and it is something that CMS admits it has never done before. These statutes do not give CMS that kind of power.

Start with three important background principles of statutory construction often referred to as clear-statement rules. First, courts "expect Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance." *Alabama Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2489 (2021) (per curiam); *see also Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) (Congress does not "hide elephants in mouse-holes"). Exercising power of vast economic and political significance is precisely what CMS has done here. It seeks to settle a federal-state struggle on politically controversial public-health matters by implementing a heavy-handed policy that threatens to inflict economic ruin on significant segments of the healthcare industry.

Second, "'it is incumbent upon the federal courts to be certain of Congress' intent before finding that federal law overrides' the 'usual constitutional balance of federal and state powers.'" *Bond v. United States*, 572 U.S. 844, 858 (2014) (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991)). CMS's mandate seeks to usurp the police power of the States to "protect the public health" by addressing mandatory vaccination—a topic that "do[es] not ordinarily concern the national government." *Jacobson*, 197 U.S. at 24–25, 38.

Third, "[w]here an administrative interpretation of a statute invokes the outer limits of Congress' power," courts "expect a clear indication that Congress intended that result." *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Engineers*, 531 U.S. 159, 172 (2001). As explained in the constitutional argument below, affording a federal agency the power to mandate vaccines reaches beyond even the outer limits of Congress's power.

For all these reasons, Congress must speak unambiguously to authorize CMS to mandate vaccines. Yet it has not done so, as an examination of the relevant statutory texts demonstrates.

Turning to that text, the two general rulemaking statutes that CMS invokes do not suffice. Those statutes give CMS the authority to create regulations "necessary to the efficient administration" of its functions, 42 U.S.C. § 1302(a), or "necessary to carry out the administration" of Title 18 of the Social Security Act, 42 U.S.C. § 1395hh(a)(1). But CMS may exercise this authority only if it is connected to a specific aspect of the agency's duties. That is why CMS attempts to tie each part of the vaccine mandate to a more specific statute. *See* 86 Fed. Reg. at 61,567. Thus, CMS's supposed authority under these general statutes piggy-backs entirely on its reliance on the more specific statutes. And those specific statutes do not grant CMS the power it has exercised here.

The specific statutes are best divided into two groups. The first includes statutes stating that CMS may set "standards," "criteria," or "requirements" for certain facilities.[2] But those laws do not connect the referenced standards, criteria, or requirements to vaccines specifically or even to health or safety in general. *See* Compl. ¶¶ 136–39, 143. By their own terms, then, they do not remotely authorize a vaccine mandate.

The second group includes statutes indicating that CMS may create rules or conditions

[2] *See* 42 U.S.C. § 1396d(h)(1)(B)(i) (governing Psychiatric Residential Treatment Facilities ("PRTFs") and mentioning "standards as may be prescribed in regulations by the Secretary"); 42 U.S.C. § 1396d(d)(1) (governing Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICFs-IID") and mentioning "standards as may be prescribed by the Secretary"); 42 U.S.C. § 1395i–4(e) (governing Critical Access Hospitals ("CAHs") and mentioning "criteria as the Secretary may require"); 42 U.S.C. § 1395rr(b)(1)(A) (governing End-Stage Renal Disease ("ESRD") facilities and mentioning "requirements as the Secretary shall by regulation prescribe"); 42 U.S.C. § 1395x(iii)(3)(D)(i)(IV) (governing Home Infusion Therapy ("HIT") suppliers and mentioning "requirements as the Secretary determines appropriate").

concerning the health and safety of the individuals served. Most of these statutes permit regulations that "ensure," or are "necessary" for, the "health and safety" of patients or recipients of services,[3] while a few generically authorize CMS to adopt health and safety "standards" or "conditions" without mentioning necessity.[4] Though these statutes mention health and safety, they too fail to authorize vaccine mandates.

A statute's surrounding words and sentences inform an agency's "grant of authority by illustrating the kinds of measures that could be necessary." *Alabama Ass'n of Realtors*, 141 S. Ct. at 2488. Under "the doctrine of *noscitur a sociis*," courts apply the rule that "a word is known by the company it keeps" to "avoid ascribing to one word" or phrase "a meaning so broad that it is inconsistent with its accompanying words, thus giving unintended breadth to the Acts of Congress." *Gustafson v. Alloyd Co.*, 513 U.S. 561, 575 (1995) (cleaned up). Surrounding nearly all

[3] *See* 42 U.S.C. § 1395eee(f) (addressing Programs of All-Inclusive Care for the Elderly ("PACE") facilities and allowing provisions "provisions to ensure the health and safety of individuals enrolled"); 42 U.S.C. § 1395x(aa)(2)(K) (addressing Rural Health Clinics ("RHCs") and mentioning "requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services"); 42 U.S.C. § 1395x(ff)(3)(B) (addressing Community Mental Health Centers ("CMHCs") and mentioning "conditions as the Secretary shall specify to ensure . . . the health and safety of individuals being furnished such services"); 42 U.S.C. § 1395x(e)(9) (addressing hospitals and mentioning "requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services"); 42 U.S.C. § 1395x(dd)(2)(g) (addressing hospices and mentioning "requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services"); 42 U.S.C. § 1395x(cc)(2)(J) (addressing Comprehensive Outpatient Rehabilitation Facilities ("CORFs") and mentioning "conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services"); 42 U.S.C. § 1395i–3(d)(4)(B) (addressing LTC facilities and mentioning "requirements relating to the health, safety, and well-being of residents . . . as the Secretary may find necessary"); 42 U.S.C. § 1396r(d)(4)(B) (same); 42 U.S.C. § 1395x(o)(6) (addressing Home Health Agencies ("HHAs") and mentioning "conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services").

[4] *See* 42 U.S.C. § 1395k(a)(2)(F)(i) (addressing Ambulatory Surgical Centers ("ASCs") and mentioning "health, safety, and other standards"); 42 U.S.C. § 1395x(p) (addressing facilities that provide outpatient physical therapy and speech-language pathology services and mentioning "conditions relating to the health and safety of individuals who are furnished services").

the health and safety language in the statutes that CMS cites are explicit statutory standards, conditions, and requirements. Those express conditions, as one statute illustrates, generally address topics like administrative matters ("maintain[ing] clinical records"), staff qualifications (nurses must be "licensed"), and the services that the facility provides ("24-hour nursing service"). *See* 42 U.S.C. § 1395x(e) (listing conditions for hospitals).

Yet those kinds of requirements are entirely unlike vaccine mandates in at least three ways. First, vaccines seek to safeguard patients by keeping staff members from getting sick in the first instance. Second, vaccines require staff members to submit to a personal medical intervention. Third, as CMS acknowledges, vaccines entail some risks of "[s]erious adverse reactions" to staff members even though "they are rare." 86 Fed. Reg. at 61,565. No other statutory condition expressly listed in CMS's statutes exhibits any, much less all, of these characteristics. Because vaccine mandates differ in kind (and not merely degree) from the statutory conditions, CMS's cited statutes do not afford the vast power the agency claims.

Finally, reading these statutes to give CMS the authority to mandate vaccines throughout the healthcare field would create a serious nondelegation problem. The nondelegation doctrine requires Congress to "lay down by legislative act an intelligible principle to which the person or body authorized to fix such rates is directed to conform." *Panama Ref. Co. v. Ryan*, 293 U.S. 388, 429–30 (1935). But if nondescript language about health and safety requirements is so broad that it allow CMS to mandate vaccines, the intelligible principle that precedent demands is nowhere to be found. For all these reasons, CMS exceeded its statutory authority in adopting its mandate.

2. The Mandate conflicts with 42 U.S.C. § 1395 by authorizing CMS officials to control the selection of healthcare workers.

The CMS vaccine mandate not only exceeds the agency's lawful authority but also violates a provision in the Social Security Act. That statute—42 U.S.C. § 1395—states:

> Nothing in [Title 18 of the Social Security Act] shall be construed to authorize any Federal officer or employee *to exercise any supervision or control* over the practice of medicine or the manner in which medical services are provided, or *over the selection, tenure, or compensation of any officer or employee* of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 U.S.C. § 1395 (emphases added). The CMS vaccine mandate violates 42 U.S.C. § 1395 because it authorizes federal officials at CMS to exercise "supervision" and "control" over the "selection" and "tenure" of employees (including state employees) and other persons "providing health services." *Id.* It does so by prohibiting covered healthcare facilities from hiring unvaccinated employees and forcing those facilities to terminate—and thus end the "tenure" of—unvaccinated employees. *Id.* In addition, CMS's mandate violates this statute because it authorizes CMS officials to exercise "supervision" and "control" over the "administration" and "operation" of institutions, agencies, and persons that provide health services (including state facilities and employees). *Id.* Indeed, the mandate controls the administration and operation of these institutions by dictating their hiring and firing policies. Thus, CMS's actions conflict directly with the plain meaning of 42 U.S.C. § 1395 and are not in accordance with law.

C. The CMS Vaccine Mandate Unconstitutionally Infringes on the Authority of the States and Exceeds Congress's Enumerated Powers.

"[E]ven in a pandemic, the Constitution cannot be put away and forgotten." *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 68 (2020). The Constitution "leaves to the several States a residuary and inviolable sovereignty, reserved explicitly to the States by the Tenth Amendment." *New York v. United States*, 505 U.S. 144, 188 (1992) (cleaned up). As that Amendment says, "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X.

As already discussed, "the police power of a state" includes the authority to adopt

regulations seeking to "protect the public health," including the topic of mandatory vaccination. *Jacobson*, 197 U.S. at 24–25. The States "did not surrender" these powers "when becoming . . . member[s] of the Union." *Id.* at 25. Thus, in our constitutional order, "[t]he safety and the health of the people . . . are, in the first instance, for [the States] to guard and protect." *Id.* at 38. To the extent that health measures like vaccine mandates "can be [implemented] by any government, they depend, primarily, upon such action as the state, in its wisdom, may take." *Id.*

By seeking to impose its vaccine mandate on millions of state and private healthcare workers, CMS is arrogating to itself powers that belong to the States. CMS admits that it never before has attempted to mandate vaccines on state or private employees. 86 Fed. Reg. at 61,568 ("[W]e have not, until now, required any health care staff vaccinations"). Often "the most telling indication of a severe constitutional problem is the lack of historical precedent" for it. *NFIB v. Sebelius*, 567 U.S. 519, 549 (2012). That is certainly true here.

Confirming the Tenth Amendment violation, nothing in the Constitution gives the federal government the power CMS seeks to exercise. While Congress has Spending Clause authority, U.S. Const. art. I, § 8, cl. 1, that power does not support the CMS mandate for two reasons.

First, the federal government cannot use Congress's spending power to "commandeer[] a State's . . . administrative apparatus for federal purposes," *NFIB*, 567 U.S. at 577, or "conscript state [agencies] into the national bureaucratic army," *id.* at 585; *see also Printz v. United States*, 521 U.S. 898, 926, 933 (1997) (explaining that Congress "may not compel the States to . . . administer a federal regulatory program," and holding that Congress cannot require state officials to conduct a background check on prospective gun purchasers). But that is exactly what CMS has done—forcing "State surveyors" to enforce the mandate by verifying healthcare providers' compliance with it. 86 Fed. Reg. at 61,574. If States instruct their surveyors not to enforce the

mandate, that will disqualify Medicare- and Medicaid-certified providers and suppliers in their States. Kahl Decl. ¶ 12 (Ex. Q). Forcing States to administer the mandate or jeopardize *all Medicare and Medicaid funds flowing into their States* (even to private healthcare providers) is "a gun to the head" that compels States to participate against their will. *NFIB*, 567 U.S. at 581.

It is not only state surveyors that must enforce the vaccine mandate; it is also the state officials who run state-run healthcare facilities. Those officials now must demand that their employees get vaccinated and fire them if they demur. They have become administrators of this federal COVID-19 mandate. Nor is it possible for all the state-run health facilities in the Plaintiff States to immediately forego all Medicare and Medicaid funding. That money often amounts to a substantial percentage of a facility's annual budget. *See, e.g.*, Huhn Decl. ¶ 22 (Ex. J) (89% of the Missouri Department of Mental Health's budget); Kahl Decl. ¶ 10 (Ex. Q) (62% of one state facility's expenditures). But States have been given a mere month to either give up all that funding (and thereby imperil the people served by those facilities) or submit to this federal strong-arming by demanding that their employees get vaccinated. Forcing this choice on such an abrupt timeline is another way in which CMS is compelling the States to enforce this unconstitutional mandate.

Second, CMS's claimed statutory authority for its mandate did not provide "clear notice" to the States that the agency could impose vaccine requirements. *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). "[W]hen Congress attaches conditions to a State's acceptance of federal funds, the conditions must be set out 'unambiguously.'" *Id.* (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). But as explained above, the relied-upon statutes do not authorize CMS's unprecedented action, must less did they furnish clear

notice of that power. *See NFIB*, 567 U.S. at 584 ("[T]he spending power . . . does not include surprising participating States with post-acceptance . . . conditions.").

Just as the Spending Clause does not authorize CMS's mandate, neither does the Commerce Clause. Art. I, § 8, cl. 3. Indeed, the mandate does not "regulate Commerce"—that is, it does not regulate ongoing commercial activity. *Id.* Rather, it demands action—in the form of compulsory vaccines—from millions of people. *NFIB*, 567 U.S. at 555 ("The Framers gave Congress the power to *regulate* commerce, not to *compel* it"). But the Commerce Clause is not a license to act "whenever enough [people] are not doing something the [federal] Government would have them do." *Id.* at 553. Much like Congress lacks authority under the Commerce Clause to directly mandate the purchase of personal health insurance, so also it lacks authority to directly mandate vaccination. *See id.* Moreover, Defendants' mandate does not merely require *activities* in the workplace; it intrudes upon a deeply *personal* health decision that transcends commerce and work issues. "Any police power to regulate individuals as such, as opposed to their activities, remains vested in the States" and has not been given to the federal government. *Id.* at 557. Defendants have thus exceeded their authority by attempting to impose their mandate.

D. The CMS Vaccine Mandate Violates Procedural Notice-and-Comment and State-Consultation Requirements.

Under the APA, a court must "hold unlawful and set aside agency action" that is "without observance of procedure required by law." 5 U.S.C. § 706(2)(D). The APA requires federal agencies to publish "notice of proposed rule making . . . in the Federal Register" and then "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(b)–(c). The Social Security Act similarly requires CMS to "provide for notice of [a] proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon." 42 U.S.C. § 1395hh(b)(1).

Before promulgating its vaccine mandate, CMS admittedly did not publish notice of proposed rulemaking in the Federal Register or give all interested members of the public an opportunity to comment. Thus, the agency violated the governing notice-and-comment requirements unless it showed "good cause" that those procedural regularities "are impracticable, unnecessary, or contrary to the public interest" under the circumstances. 5 U.S.C. § 553(b)(B) (APA); 42 U.S.C. § 1395hh(b)(2)(C) (incorporating 5 U.S.C. § 553(b)(B) into the Social Security Act). But CMS failed to demonstrate that "good cause" excuses its procedural failures.

"The burden is on the agency to establish that notice and comment need not be provided." *Nat. Res. Def. Council v. Nat'l Highway Traffic Safety Admin.*, 894 F.3d 95, 113–14 (2d Cir. 2018). "[J]udicial review of a rule promulgated under an exception to the APA's notice-and-comment requirement must be guided by Congress's expectation that such exceptions will be narrowly construed and only reluctantly countenanced." *Nw. Airlines, Inc. v. Goldschmidt*, 645 F.2d 1309, 1321 (8th Cir. 1981) (citation omitted). "The public interest prong of the good cause exception is met only in the rare circumstance when ordinary procedures—generally presumed to serve the public interest—would in fact harm that interest." *Mack Trucks, Inc. v. E.P.A.*, 682 F.3d 87, 95 (D.C. Cir. 2012).

Under these circumstances, notice-and-comment procedures would not have harmed the public interest. Far from it. Those procedural requirements would have created a vital forum for States, healthcare providers, and healthcare workers to submit critical information showing that the CMS vaccine mandate portends disaster for the healthcare industry, particularly in rural communities. This is one of the key purposes that notice-and-comment procedures serve. *See Int'l Union, United Mine Workers of Am. v. Mine Safety & Health Admin.*, 407 F.3d 1250, 1259 (D.C. Cir. 2005) (recognizing that the purpose of the procedural requirements is "to give affected

parties an opportunity to develop evidence in the record to support their objections" and "ensure that agency regulations are tested via exposure to diverse public comment"). By dispensing with those requirements, CMS plugged its ears and ignored the mountain of evidence showing that the mandate threatens devastating consequences to healthcare providers throughout the nation.

CMS purported to find "good cause to waive notice of proposed rulemaking" because it supposedly "would be impracticable and contrary to the public interest . . . to undertake normal notice and comment procedures." 86 Fed. Reg. at 61,586. Though CMS mentioned the alleged impracticability of fulfilling notice-and-comment requirements, the focus of its reasoning was on the public interest. CMS offered two different groups of justifications, but neither suffices.

First, CMS's good-cause discussion spills much ink rehashing its justifications for the mandate itself—reasons such as the efficacy of the COVID-19 vaccines, CMS's displeasure with current "levels of vaccination based on voluntary efforts," and "FDA's full licensure of the Pfizer-BioNTech's Comirnaty vaccine." *Id.* at 61,584. But it is not enough under the good-cause standard to recite the reasons for the rule itself; the agency must "point to something specific that illustrates a particular harm that will be caused by the delay required for notice and comment." *United States v. Brewer*, 766 F.3d 884, 890 (8th Cir. 2014) (citation omitted). These general reasons thus do not advance CMS's good-cause argument.

Second, CMS places much weight on "[t]he emergence of the Delta variant" in May and June 2021. 86 Fed. Reg. at 61,583; *see also id.* at 61,584 (mentioning "Delta-variant-driven surging case counts beginning in summer 2021"). But CMS undermines that reason when it acknowledges that "newly reported COVID-19 cases, hospitalizations, and deaths have begun to trend downward at a national level." *Id.* at 61,583. CMS nonetheless claims, without citing any support, that "there are emerging indications of potential increases" in case counts arising in

"northern states where the weather has begun to turn colder." *Id.* at 61,584. CMS's undocumented and unexplained pronouncement of "emerging indications" cannot carry the day.

CMS also raises its concern that "the 2021–2022 influenza season" will soon begin. *Id.* Yet the agency simultaneously concedes that "the intensity of the upcoming 2021–2022 influenza season cannot be predicted" and that "influenza activity during the 2020–2021 season was low throughout the U.S." *Id.* Moreover, one would naturally assume that the onset of the flu season would be a reason to *avoid* critical staffing shortages at healthcare facilities for underserved communities—not to exacerbate them. For a "risk of future harm" to "justify a finding of good cause," the "risk must be more substantial than a mere possibility." *Brewer*, 766 F.3d at 890. Because CMS's influenza concerns raise no more than a "mere possibility" of harm, they are insufficient to establish good cause.

Another consideration further weakens CMS's good-cause claim: the agency's professed need to immediately implement the rule is "undermined" by its own "delay in promulgating the [IFC]." *Id.* President Biden announced the CMS mandate nearly two months before the agency released it. That delay hardly suggests a situation so dire that CMS may dispense with notice-and-comment procedures and the important purposes they serve.

Not only did CMS violate notice-and-comment requirements under the APA and Social Security Act, it also flouted the statutory obligation to "consult with appropriate State agencies" before issuing rules like this. The relevant statute—42 U.S.C. § 1395z—provides that "the Secretary shall consult with appropriate State agencies . . . and may consult with appropriate local agencies" when "carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (j)(15), (o)(6), (cc)(2)(I), and[] (dd)(2), and (mm)(1) of section 1395x of this title, or by ambulatory surgical centers under section

1395k(a)(2)(F)(i) of this title." This statute gives the States a direct procedural interest in being consulted before decisions such as this.

The statute applies to CMS's mandate because this agency action purports to establish "conditions of participation" for many of the referenced "providers of services." These include hospitals under 42 U.S.C. § 1395x(e)(9), long-term-care facilities (also known as skilled nursing facilities) under 42 U.S.C. § 1395x(j) and 42 U.S.C. § 1395i–3, Home Health Agencies ("HHAs") under 42 U.S.C. § 1395x(o)(6), Comprehensive Outpatient Rehabilitation Facilities ("CORFs") under 42 U.S.C. § 1395x(cc)(2), hospices under 42 U.S.C. § 1395x(dd)(2), Critical Access Hospitals ("CAHs") under 42 U.S.C. § 1395x(mm)(1) and 42 U.S.C. § 1395i–4(e), and Ambulatory Surgical Centers ("ASCs") under 42 U.S.C. § 1395k(a)(2)(F)(i).

CMS admitted that it did not comply with the requirement to "consult with appropriate State agencies." 86 Fed. Reg. at 61,567. By failing to seek that input before issuing the mandate, CMS violated 42 U.S.C. § 1395z.

CMS counters that it has not violated the statute because it "intend[s] to engage in consultations with appropriate State agencies . . . following the issuance of th[e] rule." 86 Fed. Reg. at 61,567. This position is baseless. The statute plainly requires that the consultation with States occur *before* a rule is issued. Consultation *after* a rule is finalized is essentially meaningless—allowing the States to discuss a *fait accompli*. Accordingly, the statute's text demands the consultation when the Secretary is "carrying out his functions[] relating to determination of conditions of participation by providers of services." 42 U.S.C. § 1395z. The Secretary, via CMS, already made the determination that the vaccine mandate should be a condition of participation. It was at that time CMS was required to consult with the States. Indeed, the whole purpose of this consultation requirement is to enable States, which are so intimately involved with and affected

by these Medicare and Medicaid rules, to provide the agency critical information that it might be ignoring. Allowing this to occur after the rule takes effect defeats the point. Since CMS did not consult with the States ahead of time, the agency ran afoul of 42 U.S.C. § 1395z.

E. CMS Failed to Prepare the Regulatory Impact Analysis Required Under 42 U.S.C. § 1302.

CMS violated another mandatory obligation when it failed to prepare a regulatory impact analysis ("RIA") under 42 U.S.C. § 1302. That statute requires that whenever the Secretary publishes a rule—and, therefore, "publishes a general notice of proposed rulemaking"—"that *may* have a significant impact on the operations of a substantial number of small rural hospitals, the Secretary *shall* prepare and make available for public comment an initial regulatory impact analysis." 42 U.S.C. § 1302(b)(1) (emphases added).

Congress's use of the word "shall" in statutes indicates mandatory action. "The first sign that the statute impose[s] an obligation is its mandatory language: 'shall.'" *Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1320 (2020). "Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement." *Id.* (citation omitted). This explains why courts in the Eighth Circuit have construed § 1302(b)(1)'s use of the word "shall" as a requirement. *See Ashley Cty. Med. Ctr. v. Thompson*, 205 F. Supp. 2d 1026, 1067 (E.D. Ark. 2002) ("[T]he Social Security Act provides that when HHS publishes a proposed rule under the Medicaid statute that may have a significant impact on the operations of a substantial number of rural hospitals, HHS *must* prepare a regulatory impact analysis.") (emphasis added) (citing 42 U.S.C. § 1302(b)(1)).

It is indisputable that § 1302(b)(1) applies to the CMS vaccine mandate because CMS's cited statutory authority falls under Titles 18 and 19 of the Social Security Act. 86 Fed. Reg. at 61,567. It's also indisputable that the IFC would cover small rural hospitals located in the Plaintiff

States. *See id*. at 61,613 (defining a "small rural hospital" as one "located outside of a metropolitan statistical area and has fewer than 100 beds"); Bruntz Decl. ¶ 4 (Ex. W); Tobler Decl. ¶ 2 (Ex. G). And it's also indisputable that the mandate *will*—not just "may"—have a significant impact on the operations of a substantial number of small rural hospitals. *See* Statement of Facts, *supra*, at § E. The plain language of § 1302(b)(1) does not require certainty of a significant impact; it merely requires possibility. The evidence the Plaintiff States have submitted readily meets that standard: The CMS vaccine mandate threatens to exacerbate already devastating shortages in healthcare staffing by forcing small rural hospitals to terminate their unvaccinated workers. That, in turn, will compel those hospitals to close certain divisions, cancel certain services, or shutter altogether. Eggleston Decl. ¶¶ 16–17 (Ex. L); Mazanec Decl. ¶ 14 (Ex. R).

These dire consequences stretch across rural America, and their collective force required CMS to prepare a regulatory impact analysis—something it failed to do. That critical procedural step would have forced CMS to "describe"—and thus address—"the impact of the proposed rule" on the Plaintiff States' small rural hospitals. 42 U.S.C. § 1302(b)(1). Thus, this RIA (along with commentary from key stakeholders) could have helped CMS address "important aspects of the problem" and consider legitimate reliance interests, as required under the APA. *Regents*, 140 S. Ct. at 1910, 1913. But CMS did not do that. And just as CMS's failure to comply with the APA's notice-and-comment requirements was "prejudicial error," so too was its "complete failure" to prepare a regulatory impact analysis under § 1302(b)(1). *Brewer*, 766 F.3d at 890–91 (cleaned up). For these reasons, CMS violated 42 U.S.C. § 1302(b)(1).

II. The Balancing of Harms and the Public Interest Support an Injunction.

The remaining preliminary-injunction factors include "(2) the threat of irreparable harm to the movant in the absence of relief; (3) the balance between that harm and the harm that the relief

would cause to other litigants; and (4) the public interest." *Watkins, Inc.*, 346 F.3d at 44. These factors also favor the States.

A. The States Face Irreparable Harm to Their Sovereign, Quasi-Sovereign, and Proprietary Interests.

Without an injunction, the States will suffer irreparable harm to their sovereign, quasi-sovereign, and proprietary interests. These injuries not only establish irreparable harm but also demonstrate why the States have standing to bring their claims.

First, the States face direct sovereign injuries from CMS's mandate. As noted above, the mandate expresses CMS's intent to preempt any contrary state statute or policy. *See* Compl. ¶ 121 (collecting cites). If not enjoined, the mandate will supersede all these sovereign state choices.

This includes numerous statutes and policies of the Plaintiff States. For example, Missouri has a statute that prohibits public health orders, including vaccine mandates, if they are not approved by the governing bodies of political subdivisions, Mo. Rev. Stat. § 67.265, and that statute may be partially preempted if the vaccine mandate goes into effect. CMS's mandate also ostensibly preempts an Alaska statute that (1) broadly protects the right to object to COVID-19 vaccines "based on religious, medical, or *other* grounds" and (2) forbids any person from "requir[ing] an individual to provide justification or documentation to support the individual's decision to decline a COVID-19 vaccine." 2021 Alaska Sess. Laws ch. 2, § 17 (emphasis added). Similarly, the mandate purportedly preempts Ark. Code § 20-7-143, which is currently in effect and prohibits public entities in the State from requiring vaccines, and Ark. Code § 11-5-118, which will go into effect in January and require that private employees be given a testing option in lieu of a vaccine mandate.

Preempting, and thus partially invalidating, duly enacted state statutes inflicts *per se* irreparable injury on the States as sovereigns. "Any time" a State is blocked "from effectuating

statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) (citing *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977) (Rehnquist, J., in chambers)). In other words, when a State is blocked from implementing its statutes, "the State necessarily suffers the irreparable harm of denying the public interest in the enforcement of its law." *Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013); *Coalition for Economic Equity v. Wilson*, 122 F.3d 718, 719 (9th Cir. 1997).

Second, the States face irreparable injuries to their quasi-sovereign or *parens patriae* interests in protecting substantial segments of their population. The Supreme Court has recognized that each State has "a quasi-sovereign interest in the health and well-being—both physical and economic—of its residents in general." *Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 607 (1982). This quasi-sovereign interest arises when a defendant's conduct threatens harm to a "sufficiently substantial segment of [a State's] population," especially where the "injury to the health and welfare of [the State's] citizens . . . is one that the State, if it could, would likely attempt to address through its sovereign lawmaking powers." *Id.* As noted above, several States have already enacted statutes to protect their citizens from vaccine mandates.

The States' quasi-sovereign interests manifest themselves in at least two ways. More broadly, the States seek to maintain the viability of healthcare providers within their borders. But the CMS mandate threatens to cripple healthcare in the States (especially in rural areas), create a critical shortage of services, and jeopardize the lives and wellbeing of vulnerable citizens. All this easily constitutes irreparable harm. *See Kai v. Ross*, 336 F.3d 650, 656 (8th Cir. 2003) ("danger to plaintiffs' health, and perhaps even their lives, gives them a strong argument of irreparable injury"). In addition, the States are home to tens of thousands of healthcare workers who are now

forced to accept an unwanted medical intervention or give up their livelihood. Illustrating the irreparable harm to these workers, the mere announcement of CMS's mandate has already compelled some to resign. Shackett Decl. ¶ 8 (Ex. Z).

Third, the States face irreparable injury to their proprietary interests. Those harms are readily apparent when the States operate their own healthcare facilities. They are forced to impose the CMS mandate on their own employees, and the resulting compliance costs, labor losses, disruptions in day-to-day operations, and decreased revenue from turning away patients are all irreparable injuries. *See Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 220–21 (1994) (Scalia, J., concurring) ("[A] regulation later held invalid almost always produces the irreparable harm of nonrecoverable compliance costs."). Irreparable injury to further proprietary interests also occurs when States direct their surveyors to spend time and resources "assess[ing] compliance" with the vaccine mandate by "reviewing . . . records of staff vaccinations," "interview[ing] staff to verify their vaccination status," and "cit[ing] providers and suppliers when noncompliance is identified." 86 Fed. Reg. at 61,574. In addition, States will incur irreparable pocketbook harm in the form of (1) lost tax revenue because of reduced healthcare services in the States and (2) a diversion of state resources to supply "State immunization" records to healthcare providers needing to document staff vaccination status. *Id*. at 61,572. All these irreparable harms show why the Plaintiff States need immediate relief.

B. The Balance of Harms and The Public Interest Support an Injunction.

When the party opposing the injunction is the federal government, the balance-of-harms factor "merge[s]" with the public-interest factor. *Nken v. Holder*, 556 U.S. 418, 436 (2009). That balance weighs heavily in the States' favor. On the one hand, as explained above, the States stand to suffer all sorts of irreparable harms absent an injunction. But on the other hand, an order

preventing CMS from enforcing its unlawful mandate will inflict no cognizable injury on the agency because government officials "do[] not have an interest in the enforcement of an unconstitutional law." *N.Y. Progress & Prot. PAC v. Walsh*, 733 F.3d 483, 488 (2d Cir. 2013). Similarly, the public interest supports an injunction because "[t]here is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters of United States v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016).

The mandate's anticipated adverse impact on the healthcare worker shortage also shows that the public interest calls for an injunction. The Plaintiff States have shown that many healthcare providers, particularly in rural areas, will be forced to fire desperately needed workers, cancel vital services, and even shut down completely. *See* Eggleston Decl. ¶¶ 16–17 (Ex. L); Mazanec Decl. ¶ 14 (Ex. R); Bruntz Decl. ¶¶ 14–16 (Ex. W); Naiberk Decl. ¶ 14 (Ex. M). All that directly harms the patients they serve and public health interests in their communities. *See* Eggleston Decl. ¶¶ 16–17 (Ex. L); McNea Decl. ¶ 11 (Ex. S); Bruntz Decl. ¶ 15 (Ex. W); Monheiser Decl. ¶¶ 7, 9 (Ex. V); Shackett Decl. ¶ 9 (Ex. Z); Cyboron Decl. ¶ 16 (Ex. K) ("This mandate will . . . create disparities in care quality and access here in our rural community."); Petik Decl. ¶ 15 (Ex. O) ("[The hospital] will be put in an almost impossible position to provide the same level and quality of services" as before). Given the interconnectedness of the healthcare industry, service reductions in one facility will place added burdens on other providers. *See* Toline Decl. ¶¶ 9, 14–15 (Ex. Y); Monheiser Decl. ¶ 9 (Ex. V); York Decl. ¶ 13 (Ex. B); McNea Decl. ¶ 12 (Ex. S). And the loss of staff will further burden remaining workers and risk driving them out of their jobs due to burnout. *See* Mazanec Decl. ¶ 15 (Ex. R); Bruntz Decl. ¶ 16 (Ex. W). The situation threatens to devolve quickly, absent immediate relief from this Court.

The public interest also favors vindicating the traditional balance of power between the federal government and the States. "[A] healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front." *Gregory*, 501 U.S. at 458. Casting aside these safeguards, CMS seeks to overtake an area of traditional state authority by imposing an unprecedented and oppressive demand to federally dictate the private medical decisions of millions of Americans. In our nation, the public interest favors federalism, and it favors freedom. The CMS vaccine mandate should be enjoined.

CONCLUSION

The Court should grant Plaintiffs' motion for a preliminary injunction.

DOUGLAS J. PETERSON
Attorney General of Nebraska

/s/ James A. Campbell
James A. Campbell
Solicitor General
Office of the Nebraska Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-2682
Jim.Campbell@nebraska.gov
Counsel for Plaintiffs

ERIC S. SCHMITT
Attorney General of Missouri

/s/ Jesus A. Osete
Jesus A. Osete, #69267MO
Deputy Attorney General
Maddie McMillian Green, #73724MO
Assistant Attorney General for Special Litigation
Office of the Missouri Attorney General
Post Office Box 899
Jefferson City, MO 65102
(573) 751-1800
Jesus.Osete@ago.mo.gov
Counsel for Plaintiffs

Additional counsel on the next page

LESLIE RUTLEDGE
Attorney General of Arkansas
/s/ *Dylan L. Jacobs*
Dylan L. Jacobs
Assistant Solicitor General
Office of the Arkansas Attorney General
323 Center St., Suite 200
Little Rock, AR 72201
(501) 682-2007
Dylan.Jacobs@arkansasag.gov
Counsel for the State of Arkansas

DEREK SCHMIDT
Attorney General of Kansas
/s/ *Kurtis Wiard*
Kurtis Wiard
Assistant Solicitor General
Office of the Kansas Attorney General
120 SW 10th Avenue, 2nd Floor
Topeka, Kansas 66612
Tel: (785) 296-2215
Fax: (785) 296-6296
E-mail: kurtis.wiard@ag.ks.gov
Counsel for the State of Kansas

JEFFREY S. THOMPSON
Solicitor General
/s/ *Samuel P. Langholz*
Samuel P. Langholz
Assistant Solicitor General
Office of the Iowa Attorney General
1305 E. Walnut Street
Des Moines, Iowa 50319
(515) 281-5164
jeffrey.thompson@ag.iowa.gov
sam.langholz@ag.iowa.gov
Counsel for the State of Iowa

BRIDGET HILL
Wyoming Attorney General
/s/ Ryan Schelhaas
Chief Deputy Attorney General
Wyoming Attorney General's Office
109 State Capitol
Cheyenne, WY 82002
Telephone: (307) 777-5786
ryan.schelhaas@wyo.gov
Counsel for the State of Wyoming

TREG R. TAYLOR
Attorney General of Alaska
/s/ Cori Mills
Cori M. Mills
Deputy Attorney General of Alaska
Alaska Department of Law
1031 W. 4th Avenue, Suite 200
Anchorage, AK 99502
(907) 269-5100
Cori.Mills@alaska.gov
Counsel for the State of Alaska

JASON R. RAVNSBORG
South Dakota Attorney General
/s/ David M. McVey
David M. McVey
Assistant Attorney General
1302 E. Highway 14, Suite 1
Pierre, SD 57501-8501
Phone: 605-773-3215
E-Mail: david.mcvey@state.sd.us
Counsel for the State of South Dakota

WAYNE STENEHJEM
Attorney General of North Dakota
/s/ Matthew A. Sagsveen
Matthew A. Sagsveen
Solicitor General
State Bar ID No. 05613
Office of Attorney General
500 North 9th Street
Bismarck, ND 58501-4509
Telephone (701) 328-3640
Facsimile (701) 328-4300
masagsve@nd.gov
Counsel for the State of North Dakota

JOHN M. FORMELLA
New Hampshire Attorney General
/s/ Anthony J. Galdieri
Anthony J. Galdieri
Solicitor General
NEW HAMPSHIRE DEPARTMENT OF JUSTICE
33 Capitol Street
Concord, NH 03301
Tel: (603) 271-3658
Anthony.J.Galdieri@doj.nh.gov
Counsel for State of New Hampshire

CERTIFICATE OF SERVICE

I hereby certify that, on November 12, 2021, a true and correct copy of the foregoing and any attachments were filed electronically through the Court's CM/ECF system, to be served on counsel for all parties by operation of the Court's electronic filing system and to be served on those parties that have not appeared who will be served in accordance with the Federal Rules of Civil Procedure by mail or other means agreed to by the party.

/s/ Jesus A. Osete
Counsel for Plaintiffs

EXHIBIT

A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, STATE OF NEBRASKA, *Plaintiffs*, v. JOSEPH R. BIDEN, JR., in his official capacity as the President of the United States of America; THE UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; XAVIER BECERRA in his official capacity as Secretary of the United States Department of Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; MEENA SESHAMANI in her official capacity as Deputy Administrator and Director of Center for Medicare; DANIEL TSAI in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services; *Defendants*.	No. 4:21-cv-01329

DECLARATION OF RENEE GAYHART

1. My name is Renee Gayhart, and I am the Director of the Division of Health Care Services (DHCS), a division of the Alaska Department of Health and Social Services. I have held that position for approximately three years. I am also a resident of Alaska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. As Director of DHCS, I am responsible for overseeing state employees on the Health Facility Licensure and Certification (HFLC) team who conduct surveys on behalf of the Centers for Medicare and Medicaid Services (State Surveyors).

3. There are currently 16 State Surveyor positions assigned to HFLC, with 11 of those positions filled as of this date. These are all state employees who perform the surveying work.

4. The State Surveyors inspect health facilities across the state to determine whether they meet state and federal standards; e.g., Medicare and Medicaid requirements. In addition, the team investigates complaints made against health facilities and agencies licensed or certified under our program. The purpose of the inspections is to determine a health care provider's ability to give services which are safe and of an acceptable quality.

5. Federal law guarantees to Medicare beneficiaries that payment will be made for health care services furnished in or by entities that meet stipulated requirements of the Social Security Act. Specifically, State Surveyors have the following responsibilities related to the certification of entities to participate in the Medicare program:

A. Identifying potential Medicare participants, including laboratories seeking to participate in the Clinical Laboratory Improvement Amendments (CLIA) program;

B. Verifying how well the health care entities comply with federal Conditions of Participation or federal requirements;

C. Certifying and recertifying whether entities, including CLIA laboratories, are qualified to participate in the program, and periodically sending those certifications to the appropriate state or federal agencies;

D. Advising providers and potential providers regarding applicable federal regulations to enable them to qualify for participation in the Medicare program and to maintain standards of health care consistent with the federal Conditions of participation or federal requirements. This includes conducting periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities and nursing facilities

in order to present current regulations, procedures, and policies. These educational programs are required under sections 1819(g)(1)(B) and 1919(g)(1)(B) of the Social Security Act;

E. Operating toll-free telephone hotlines to collect, maintain, and continually update information on Medicare-certified home health agencies. The hotline is also used to receive complaints and answer questions about home health agencies; and

F. Entering data from surveys, follow-up visits, and complaint investigations into the national mainframe computer system that is used for maintaining and retrieving certification data. Surveyors update information about providers, suppliers, and CLIA laboratories in the system when indicated.

6. If a facility is not in compliance with federal Medicare and Medicaid regulations, the State Surveyors send the facility a violation report informing it of its deficiencies. If the applicable requirements are not met, the facility may not receive Medicare and Medicaid reimbursements.

Renee Gayhart

Renee Gayhart
Director, Division of Health Care Services
Department of Health and Social Services
State of Alaska

11.11.2021

Date

EXHIBIT

B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, STATE OF NEBRASKA, *Plaintiffs*, v. JOSEPH R. BIDEN, JR., in his official capacity as the President of the United States of America; THE UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; XAVIER BECERRA in his official capacity as Secretary of the United States Department of Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; MEENA SESHAMANI in her official capacity as Deputy Administrator and Director of Center for Medicare; DANIEL TSAI in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services; *Defendants*.	No. 4:21-cv-01329

DECLARATION OF SCOTT YORK

1. My name is Scott York, and I am the Chief Executive Officer (CEO) of the Alaska Psychiatric Institute ("API"), a division of the Alaska Department of Health and Social Services. I am also a resident of Alaska and over the age of majority. API is located in Anchorage, Alaska.

2. I have served as CEO of API since March 2020. I have worked in the healthcare

industry for approximately 37 years. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

3. API is required by state law to admit individuals ordered to receive treatment by the Alaska Superior Court. As CEO of API, I am responsible for managing API such that it can admit all patients who are under a court order for involuntary commitment for mental health treatment.[1]

4. Alaska Psychiatric Institute is licensed by the State of Alaska as a psychiatric hospital for the purpose of receiving reimbursement from the Center for Medicare and Medicaid Services ("CMS").

5. As a licensed hospital, API receives reimbursement from CMS to cover the cost of inpatient mental health treatment for individuals who are admitted to the hospital involuntarily.

6. As a certified hospital, API must comply with CMS Conditions of Participation in order to be reimbursed for treatment costs.

7. For the current fiscal year, API anticipates collecting approximately $7.5 in reimbursement from CMS, which comprises approximately 15.6 percent of the operating budget for the hospital.

8. Presently, API has 248 employees. Approximately 31% of API's employees are known to have not, or are reasonably believed to have not, received a COVID-19 vaccine.

9. Despite the availability of medical and religious exemptions, API nevertheless believes it is likely to lose approximately 20 employees (8% of API's workforce) as a result of the vaccine mandate.

[1] API also admits patients who are voluntarily receiving inpatient treatment, but the number of patients voluntarily admitted to API is relatively minimal.

10. Losing even 5% of its workforce would cause substantial harm to API because it would be extremely difficult to fill those positions with new workers.

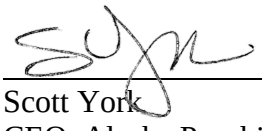
11. First, the positions could not be filled with other, unvaccinated workers. Second, Alaska faces a shortage of qualified healthcare workers. Due to its remote geographic location, high cost of living, and potentially other factors, it is difficult to attract qualified, high-quality healthcare workers to the State of Alaska.

12. API and its patients will be harmed by the negative consequences of the vaccine mandate. Even if a small percentage of API's workforce is lost, hospital operations will be negatively impacted, which, in turn will affect availability of treatment. Capacity will be further limited, and enrollment at API will decline. As a result, patients will be forced to seek treatment elsewhere in a community where the availability of healthcare is already relatively limited.

13. In the State of Alaska, there are a limited number of inpatient psychiatric services, with API being the only freestanding adult psychiatric facility. Thus, if API's capacity is limited, that could potentially impact other services, such as emergency rooms and correctional facilities, since patients at those facilities could not receive immediate treatment at API.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.



Scott York
CEO, Alaska Psychiatric Institute

EXHIBIT

C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI,
STATE OF NEBRASKA,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR.,
in his official capacity as the President of the United States of America;

THE UNITED STATES OF AMERICA;

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

XAVIER BECERRA in his official capacity as Secretary of the United States Department of Health and Human Services;

CENTERS FOR MEDICARE AND MEDICAID SERVICES;

MEENA SESHAMANI in her official capacity as Deputy Administrator and Director of Center for Medicare;

DANIEL TSAI in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services;

Defendants.

No. 4:21-cv-01329

DECLARATION OF MARK WHITE

Pursuant to 28 U.S.C. 1746, I declare:

1. I am over 18 years of age and have personal knowledge of the facts set out in this declaration.

2. I am employed by the Arkansas Department of Human Services (DHS) as the Deputy Director and Chief of Staff, Legal, and Legislative Affairs. Part of my responsibilities include

coordinating DHS's work and initiatives across its divisions and offices. I have served in a variety of capacities during my tenure at DHS, including in the Division of Aging, Adult, and Behavioral Health Services.

3. DHS is responsible for the operation of seven healthcare facilities that receive funds through Medicare and/or Medicaid. These facilities will be subject to the CMS vaccine mandate. These facilities serve some of Arkansas's most vulnerable populations including the elderly, children, intellectually disabled individuals, and the mentally ill.

4. The Arkansas Health Center is a nursing home with over 300 beds serving the needs of residents with psychiatric or other medical needs requiring specialized services or programs that are not generally available through community nursing facilities. The Arkansas State Hospital is the State-operated acute psychiatric inpatient hospital. DHS also operates five human development centers (HDC), which are residential facilities serving Arkansans with intellectual and developmental disabilities.

5. Since the inception of the COVID-19 pandemic, employee attrition at these facilities has increased. The following is a summary of employee attrition for fiscal years 2019 through 2021:

Facility	FY19	FY20	FY2021
Arkansas Health Center	20.50%	26.68%	33.33%
Arkansas State Hospital	19.00%	19.42%	26.63%
Arkadelphia HDC	58.77%	55.56%	78.21%
Booneville HDC	24.44%	30.8%	44.44%
Conway HDC	41.98%	40.47%	49.71%
Jonesboro HDC	62.08%	45.13%	79.32%
Southeast Arkansas HDC	45.76%	42.38%	58.06%

6. As these figures show, employee attrition has increased at all of these facilities during fiscal year 2021 compared to previous years. DHS expects attrition to increase as a result of the CMS vaccine mandate.

7. In addition to ongoing attrition, these facilities all currently have staffing shortages. Across these seven facilities, there are over 1,000 positions—representing over 40% of total positions—classified as being "open" or unfilled. Many of these positions would be filled but for the lack of necessary personnel. DHS expects the number of unfilled positions to increase as a result of the CMS vaccine mandate.

8. Approximately 63% of employees at these facilities have been vaccinated for COVID-19. State employees, including those at these DHS facilities, were previously offered a $200 incentive bonus for vaccination. The remaining 37% of the workforce at these facilities, representing nearly 1,000 individuals, have chosen not to become vaccinated.

9. DHS expects that the CMS vaccine mandate will result in increased staffing shortages at these seven facilities, exacerbating the shortages that already exist and increasing the already-high employee attrition. The potential effects of the CMS vaccine mandate are all the more concerning given the vulnerable populations served by these facilities.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 12th day of November, 2021.

Mark White

EXHIBIT

D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., et al., Defendants.	Case No. 4:21-CV-01329 **DECLARATION OF ED SMITH**

I, Ed Smith, declare under penalty of perjury that I have personal knowledge of the following:

1. I am a resident of Iowa and over the age of majority.

2. I serve as the President and CEO of St. Anthony Regional Hospital.

3. St. Anthony Regional Hospital is an independent, faith-based, rural hospital located in Carroll, Iowa. Carroll is in West Central Iowa equal distance (approximately 100 miles) between Omaha and Des Moines. St. Anthony provides a broad range of services to the citizens of west central Iowa. These services include: oncology, mental health, cardiology, orthopedics, obstetrics, and senior services. St. Anthony provides the public health function for Carroll County. As such, Carroll County Public Health has been a leader in the state in the response to the COVID-19 pandemic and facilitating vaccinations throughout the county.

4. St. Anthony employs over 750 staff. St. Anthony's current open positions are a reflection of the work force environment in healthcare generally, but also due to the extremely low unemployment rate in Carroll.

5. Currently, St. Anthony has 134 open positions, this includes 30 for our food and nutrition department and 30 on our med/surg/pediatric floor.

6. St. Anthony employees have responded very well to voluntarily becoming vaccinated from COVID-19. Currently, St. Anthony's vaccination rate for its employees is 87%.

7. St. Anthony has instituted a policy that requires employees declining the vaccine to wear an N95 mask and in some cases be tested prior to working each shift. This policy has been accepted by the unvaccinated and has resulted in no infections occurring within our workplace.

8. St. Anthony conducted a survey of unvaccinated employees to understand the amount of risk St. Anthony is facing should a vaccine mandate be implemented. At the time of the survey, we had 115 unvaccinated employees. 20 employees ultimately decided to be vaccinated. 55 employees indicated an intention to claim a religious or medical exemption. And 40 employees said that they would resign rather than comply with a vaccine mandate.

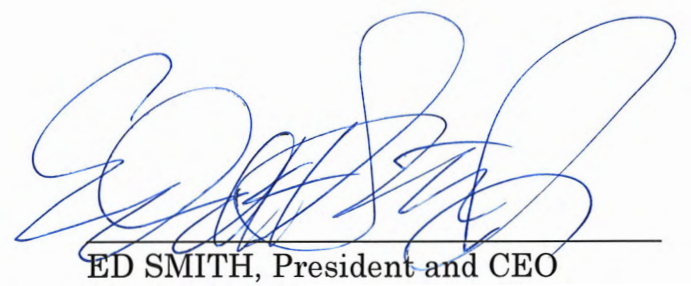
9. St. Anthony is struggling with recruitment of all staff positions in the current environment with qualified applications being limited. The proposed CMS vaccine mandate would only exacerbate our work force challenges.

10. As a rural health care provider, St. Anthony relies on Medicare and Medicaid as our dominant payor source. Medicare is 52% of revenues and Medicaid is 13% of revenues.

11. St. Anthony will be compliant with any CMS regulations. But that compliance will not be without cost. The loss of 40 employees coupled with the tight employment market will force us to evaluate the availability of needed healthcare services to the people in the region we serve.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on November 12, 2021.



ED SMITH, President and CEO
St. Anthony Regional Hospital

EXHIBIT

E

DECLARATION OF BRITTANY VANLANDINGHAM, ADMINISTRATOR MONROE CITY MANOR CARE CENTER

I, BRITTANY VANLANDINGHAM, being first duly sworn upon my oath, do hereby state as follows:

1. I am the Administrator of the Monroe City Manor Care Center (MCMCC) location at 1010 highway 24/36 East, Monroe City, Missouri. I am also a resident of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. MCMCC is a 60 Bed, for-profit nursing home in Monroe City, Missouri and has been in operation since 1977. MCMCC provides a wide variety of services including skilled nursing, physical therapy, occupational therapy, speech therapy, and custodial nursing care.

3. MCMCC employs no less than 60 employees, including no less than 20 nurses, 20 certified nurse aides, 10 kitchen staff, and 10 other staff members.

4. Each year, MCMCC provides services to approximately 90 patients whose care is paid for by the federal government's Centers for Medicare and Medicaid Services agency (CMS). CMS provides reimbursement to MCMCC for treatment of these patients through the federal Medicare and Medicaid programs. In 2020, MCMCC treated and billed CMS for the treatment of approximately 75 patients. MCMCC received approximately $2,000,000 in reimbursement from CMS in 2020.

5. Most if not all employees of MCMCC receive at least a portion of their

salaries from funds provided by the reimbursement of federal funds from CMS.

6. Due to media reports, I have become aware that CMS will require all employees of MCMCC to be fully vaccinated for COVID-19 no later than January 4, 2022. This information, which has been widely disseminated, indicates that providers who refuse to require vaccinations for all employees will no longer be eligible for CMS reimbursement or to participate in the CMS program.

7. There are a number of MCMCC employees who are refusing to be vaccinated for COVID-19. The vaccination rate of MCMCC employees is under 50%. When surveyed, a majority of these unvaccinated staff stated they would choose to leave healthcare completely over being forced to get the covid-19 vaccine. I believe that many additional employees will voluntarily quit working for MCMCC or I will be forced to terminate their employment at MCMCC on or before January 4, 2022 if the CMS mandate is ultimately imposed.

8. The loss of such additional employees will cause significant difficulty in the continued operation of MCMCC.

9. The recruitment of qualified employees is a significant consideration at MCMCC. I anticipate that the federal CMS vaccine mandate will limit the number of potential qualified applicants and as such will interfere with my ability to hire and maintain enough staff to effectively operate MCMCC. In addition, due to a shortage of qualified staff (particularly nursing staff), the market rates to hire new staff have skyrocketed. The approximate current hourly rate for a CNA at MCMCC is $13, an LPN is $21 and an RN is $26. The rates for these same staff

positions in late 2020 was $11, $18 and $22 respectively.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 10th day of November, 2021.

B. Vanlandingham RN LNHA

Brittany Vanlandingham, Administrator
Monroe City Manor Care Center

EXHIBIT

F

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF NIKKI STRONG

1. My name is Nikki Strong and I am the Executive Director of the Missouri Health Care Association. I am also a resident of the State of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. Missouri Health Care Association ("MHCA") is Missouri's largest association of licensed, long-term health care facilities, residential care facilities, and assisted living facilities. With nearly 350 facility members, MHCA represents a majority of Missouri's licensed skilled nursing care facilities along with many residential care and assisted living facilities. MHCA's facility members are licensed for approximately 35,000 beds and care for tens of thousands of residents across the state.

3. All of MHCA's skilled nursing facility members will be directly impacted by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Nearly all of MHCA's facility members are currently facing a staffing crisis

and barely able to meet minimum staffing levels to keep their doors open. There are thousands of job openings in skilled nursing facilities around the state.

5. A certain number of employees are necessary for a facility to be able provide care. Without a sufficient number of staff, skilled nursing care facilities cannot stay open and will be forced to close.

6. Many facilities across the state have indicated that they would have to close their facilities if CMS were to issue a vaccine mandate, which would displace thousands of residents across the state and affect the entire health care system. Skilled nursing care facilities are typically the only facilities that can provide the acute care services their residents need. The impact of skilled nursing facility closures due to the mandate will inundate hospital capacity leaving little room for others in the community to receive the care they need. This type of bottleneck to the health care system would likely create a healthcare access issue across the state.

7. A majority of Missouri's facilities have either slowed or stopped admitting new patients as a result of staffing shortages. The inability for skilled nursing facilities to admit new residents further burdens the hospitals in their area.

8. A significant number of facilities across the state have indicated that they could lose up to 25% of their employees or more if CMS were to issue a vaccine mandate. Because of the existing workforce shortage, the majority of facilities cannot afford to lose even 1% of their employees.

9. If mandated to receive the COVID-19 vaccine, many unvaccinated employees in Missouri's skilled nursing facilities have indicated they will quit their jobs. Due to the large number of job openings across the state in numerous sectors outside of the health care or within

the health care sector, employees in skilled nursing facilities have indicated they will leave for jobs outside the health care field where they can make similar or higher wages and either not be required to take the COVID-19 vaccine or have a testing option.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Nikki Strong, Executive Director
Missouri Health Care Association

EXHIBIT G

DECLARATION OF RANDALL W. TOBLER, MD, CEO
SCOTLAND COUNTY HOSPITAL

I, RANDALL W. TOBLER, being first duly sworn upon my oath, do hereby state as follows:

1. I am the CEO of Scotland County Hospital (SCH) located at 450 East Sigler Avenue, in Memphis, Missouri. I am also a resident of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. SCH is a 25-bed, non-profit, Critical Access Hospital in rural Northeast Missouri that also owns and operates four Rural Health Clinics. SCH provides a wide variety of medical services including primary healthcare, a 24-hour Emergency Department, general surgery department (Surgery Center), and obstetrics department (Women's Center) and a number of other specialty medical services.

3. As of today, SCH employs 177 full-time, part-time and PRN employees.

4. Each year SCH provides services to hundreds of patients, from in and around Northeast Missouri and Southeast Iowa, whose treatment is paid for by the federal government's Centers for Medicare and Medicaid Services agency (CMS). CMS provides reimbursement to SCH for treatment of these patients through the federal Medicare and Medicaid programs. In 2020, SCH's payer mix consisted of approximately 70% of our patients presenting to our facilities on federal insurances (Medicare/Medicaid).

5. On Friday, November 5, 2021, I received an email from the CMS.gov Newsroom stating "CMS Issued the Interim Final Rule Requiring Mandatory COVID-19 Vaccinations for Workers in Hospitals and Most Health Care Settings." This will require all employees of SCH to be fully vaccinated for COVID-19 no later than January 4, 2022.

Furthermore, employees who have not completed the FDA approved vaccination sequence (2-dose or single dose) by December 5, 2021, would be unable to work in our facility. I understand that providers who fail to ensure vaccinations for all employees working in our facility would no longer be eligible for CMS reimbursement or to participate in the CMS program.

6. Upon information and belief, there are a number of SCH employees who are choosing to not be vaccinated for COVID-19. As of today, 20 of our full-time and part-time staff are weighing whether to comply and at least 5 stated emphatically they will not be vaccinated. We have already suffered staff resignations by 18% during this worldwide pandemic. Presently, the five staff members unwilling to be vaccinated are considered essential workers in critical areas of our hospital & clinics in the nursing, clinical support departments and administration. I believe that several additional employees will voluntarily quit working for SCH or I will be forced to terminate their employment at SCH on or before January 4, 2022, if the CMS mandate is ultimately imposed.

7. The loss of such additional employees will cause significant difficulty in the continued quality and safe operations of SCH.

8. Any employees I would be potentially forced to terminate, pursuant to the federal CMS vaccine mandate, would likely apply for unemployment benefits. Assuming such benefits were granted, this would impose a significant additional financial cost to SCH. Furthermore, this would eliminate gainfully employed American's income taxes being collected by state and federal governments.

9. The recruitment and retention of qualified employees is a significant consideration at SCH. Our healthcare services provided in a remote and underserved area are

critical to our communities. I anticipate that the federal CMS vaccine mandate will limit the number of potential qualified applicants and, as such, will interfere with my ability to hire and maintain enough staff to effectively and safely operate SCH.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 10th day of November, 2021.

Randall W. Tobler, MD
CEO, Scotland County Hospital

EXHIBIT H

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al.,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR., et al.,

Defendants.

No. 4:21-cv-01329

DECLARATION OF STEVE BOLLIN, DIRECTOR OF THE DIVISION OF REGULATION AND LICENSURE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

1. My name is Steve Bollin and I am the Director of the Division of Regulation and Licensure ("DRL"), a division of the Missouri Department of Health and Senior Services ("DHSS"). I am also a resident of the State of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. DHSS is a state agency that serves the citizens of Missouri by working to improve the health and quality of life for Missourians of all ages.

3. DRL ensures the quality of a variety of entities including hospitals and ambulatory surgical centers, home health and hospice providers, long-term care facilities including residential care, intermediate care, and skilled nursing facilities, emergency medical services, pharmacies and persons authorized to prescribe or dispense controlled substances.

4. As Director of DRL, I am responsible for overseeing the state employees who conduct surveys on behalf of the Center for Medicare and Medicaid Services ("CMS").

5. There are currently approximately 251 surveyors housed within the Division of Registration and Licensing. All surveyors are employed by the State of Missouri.

6. The State Surveyors inspect health facilities across the state to determine whether they meet state and federal standards e.g., Medicare and Medicaid requirements. In addition, the team investigates complaints made against health facilities and agencies licensed or certified under our program. The purpose of the inspections is to determine a health care providers' ability to administer services which are safe and of an acceptable quality.

7. There are approximately 18 surveyors in the Bureau of Hospital Standards who are responsible for administering the state licensing programs for all Missouri hospitals, excluding state and federal facilities. Hospitals are required to renew their licenses annually based on compliance with state regulations in the areas of fire safety and sanitation, nursing service, dietary service, and organization and administration. These surveyors also conduct survey activities through a contract with CMS, related to certification of hospitals participating in the Medicare and Medicaid programs, and they conduct state licensure inspections for new construction and remodeling projects for hospitals, including life safety code.

8. There are approximately 13 surveyors in the Bureau of Ambulatory Care. They are responsible for administering the state licensing program for freestanding ambulatory surgical centers, birthing centers, and abortion facilities, excluding state and federal facilities. These facilities are required to renew their licenses annually based on compliance with state regulations in the areas of fire safety and sanitation, nursing service, dietary service and organization and administration. These surveyors also conduct survey activities through a contract with CMS, related to certification of ambulatory surgical centers and end stage renal dialysis facilities participating in the Medicare and Medicaid programs.

9. There are approximately 6 surveyors in the Bureau of Diagnostic Services. They are responsible for conducting survey activities through contracts with CMS related to certification and registration of rural health clinics, laboratories, and hospitals participating in the Medicare, Medicaid, and Clinical Laboratory Improvement Amendment ("CLIA") programs. They also register and inspect medical facilities that use ionizing radiation for diagnosis or treatment for compliance with state radiation safety regulations. These include diagnostic X-ray departments in hospitals, clinics, mobile diagnostic units, private medical offices, veterinarian offices, chiropractic offices, dental offices, podiatric offices, mammography providers and research/industrial sites. Surveyors also conduct surveys to determine compliance with federal certification standards of all mammography providers in Missouri.

10. There are approximately 15 surveyors in the Bureau of Home Care

and Rehabilitative Standards. They are responsible for conducting on-site surveys for Medicare certification at home health agencies, hospices, comprehensive outpatient rehabilitation facilities ("CORF) and outpatient physical therapy ("OPT") providers through contracts with CMS. They are also responsible for providing technical consultation regarding Missouri licensing requirements for home health agencies and hospices and Medicare standards for home health agencies, hospices, outpatient physical therapy providers and comprehensive outpatient rehabilitation facilities. Additionally, these surveyors conduct on-site surveys at home health agencies and hospices for compliance with state regulations, complete complaint investigations regarding allegations of inappropriate care and other patient concerns, and respond to phone calls received from the federally mandated toll-free "hotline" for the purpose of receiving questions about home health agencies and hospices, or for patients to lodge complaints concerning their provider agency or quality of care provided.

11. There are approximately 8 surveyors in the Bureau of Narcotics and Dangerous Drugs whose responsibilities include conducting on-site surveys for people holding BNDD registrations, ensuring compliance with state and federal controlled substance laws, and completing complaint investigations.

12. There are approximately 191 surveyors in the Section for Long Term Care who are responsible for conducting survey activities through a contract with CMS, related to certification of skilled nursing and intermediate care facilities participating in the Medicare and Medicaid programs. These surveyors conduct

survey inspections and complaint investigations at these facilities.

13. If a facility is not in compliance with federal Medicare and Medicaid regulations, the state surveyors send the facility a statement of deficiencies. If the applicable requirements are not met, the facility may not receive Medicare and Medicaid reimbursements.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 12 day of November, 2021.

Steve Bollin, Director
Division of Regulation and Licensure
Missouri Department of Health and Senior Services

EXHIBIT

I

DECLARATION OF TIM SCHRAGE, ADMINISTRATOR SCOTLAND COUNTY CARE CENTER

I, TIM SCHRAGE, being first duly sworn upon my oath, do hereby state as follows:

1. I am the Administrator of the Scotland County Care Center (SCCC) at 434 E. Sigler, Memphis, Missouri. I am also a resident of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. SCCC is a 96 bed, not-for-profit nursing home in Memphis, Missouri and has been in operation since 1969. We are considered local government, a political subdivision of the state of Missourui governed by an elected board of directors and supported, in part, by a local county tax base. SCCC provides a wide variety of services including long term care for the disabled, post hospital rehabilitation through the Medicare Skilled Nursing Home benefit, and a Residential Care Facility holding an additional 28 beds.

3. Like many of our rural nursing home districts, we are one of the largest employers in our county, second only to the school system. We have approximately 65 employees ranging from a licensed administrator, accountants, RN Director of Nurses, registered nurses, licensed practical nurses, certified nurses, dietary staff, med tecs, and a host of other staff who are necessary and essential in caring for our residents. CMS provides reimbursement to SCCC for treatment of these patients through the federal Medicare and Medicaid programs, providing some of the funding needed to meet our expenses.

4. Approximately 50% of our total operational revenues come from the Centers for Medicare and Medicaid Services (CMS). This is a huge portion of our income.

5. I have been an administrator for county nursing homes for the past 21 years. I can tell you that rural county nursing homes have faced enormous challenges over the last few years, even before the advent of COVID-19. We have been watching our reserves diminish rapidly because our expenses have overrun our revenues. Since January 2019, our reserves have decreased by 65%. We have had to dip into our reserves in order to meet expenses. For example: over the past three years, minimum wage has increased 33% while our state Medicaid reimbursement increased 1.3%. We are facing a workforce shortage like never before, and not just in nursing. The shortage of nursing staff has caused us to lean heavily "Agency Staffing". Contracting with agency staffing means instead of paying $15 dollars an hour aide,we are charged $40-50 an hour for a Certified Nurses Aide. We are having to pay licensed nurses $65 an hour as compared to about $22 an hour. In the recent 12 month period we have paid $385,000 to Agency Staffing because we had not been able hire enough of our own. If the vaccination mandate is imposed we will lose more staff, struggle to fill those vacancy spots with agency staffing, causing even more financial hardship. Furthermore agency staffing does not have enough staffing for the absence of nurses who are not willing to be vaccinated. We will be facing a huge problem! Without adequate staff we simply cannot take care of our residents. Another

challenge is finding qualified workers. In our rural areas, the pool of qualified workers for specific skills and knowledge is much smaller than the lon-rural areas. We face immense difficulties filling "key", "essential" positions.

6. On November 4, 2021 I received an emergency update notice from the Missouri Department of Health and Human Services. This notice informed us that the Biden-Harris administration issued an emergency regulation mandating that all nursing home staff be fully vaccinated by January 4, 2022 . Furthermore, facilities who failed to ensure ALL staff were vaccinated could no longer be eligible for reimbursement under the Medicare and Medicare programs. The impact of this emergency regulation will have dramatic and devastating consequences.

7. Out of about 65 employees, about 20 employees tell me they are vehemently opposed to taking the vaccine and if the CMS mandate is indeed imposed, they will quit working at SCCC. If that happens, I will lose about 30% of my workforce. If I lose 30% of my workforce, there is no way we can continue to operate.

8. I stand to lose key people who are the foundation of our organization. My billing and accounting person will leave if they are required to get the vaccine. I would have substantial disruption in my billing and accounts receivable which would cause a level of financial distress that I fear we could not overcome. My building plant manager says he will not be forced into taking the vaccination, even if that means losing his job. That would leave me with no one competent enough

to run my building and all the complicated systems and required inspections. You just can't fill these kinds of positions quickly, especially with today's workforce and being in a rural setting.

9. While the intent of this emergency regulation may be to protect our elederly nursing home residents, I fear the result of this regulation may actually create more harm. We could not continue to operate our facility with 30% decrease in our workforce. We would be forced to close our doors and displace the residents who enjoy residing in the Scotland County Care Center and who desire to live in the community where they have lived their entire lives.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 10 day of November, 2021.

Tim Schrage
Administrator, Scotland County Care Center

EXHIBIT

J

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF VALERIE HUHN, ACTING DIRECTOR, MISSOURI DEPARTMENT OF MENTAL HEALTH

1. My name is Valerie Huhn and I am the Acting Director of the Missouri Department of Mental Health ("DMH"). I am also a resident of the State of Missouri and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. DMH is a state agency that serves approximately 170,000 Missourians annually through state-operated facilities and contracts with private organizations and individuals.

3. DMH operates six psychiatric facilities, which provide inpatient psychiatric services for adults and children. These facilities are certified by the Center for Medicare and Medicaid Services ("CMS") as psychiatric treatment facilities for the purpose of receiving reimbursement from CMS.

4. These six facilities receive reimbursement from CMS to cover the

cost of inpatient and residential psychiatric treatment for individuals who are Medicaid and/or Medicare eligible.

5. As certified hospitals, these facilities must comply with CMS Conditions of Participation in order to be reimbursed for treatment costs and disproportionate share costs.

6. The Center for Behavioral Medicine is a 65-bed facility in Kansas City, Missouri. There are currently approximately 281 employees. Based on the most recently available information, only 34.6% of the staff at the Center for Behavioral Medicine are fully vaccinated.

7. Fulton State Hospital is a 449-bed facility in Fulton, Missouri. There are currently approximately 857 employees. Based on the most recently available information, 63% of the staff at the Fulton State Hospital are fully vaccinated.

8. Northwest Missouri Psychiatric Rehabilitation Center is a 108-bed facility in St. Joseph, Missouri. There are currently approximately 250 employees. Based on the most recently available information, 52.6% of staff at Northwest Missouri Psychiatric Rehabilitation Center are fully vaccinated.

9. Southeast Missouri Mental Health Center is a 323-bed facility in Farmington, Missouri. There are currently approximately 878 employees. Based on the most recently available information, 60.3% of staff at Southeast Missouri Mental Health Center are fully vaccinated.

10. St. Louis Forensic Treatment Center is a 230-bed facility in St. Louis, Missouri. There are currently approximately 524 employees. Based on the most

recently available information, 67.6% of staff at St. Louis Forensic Treatment Center are fully vaccinated.

11. Hawthorn Children's Psychiatric Hospital is a 28-bed inpatient psychiatric hospital and a 16-bed psychiatric residential treatment facility that provides inpatient and residential services to children and youth. There are currently approximately 170 employees. Based on the most recently available information, 84.7% of staff at Hawthorn Children's Psychiatric Hospital are fully vaccinated.

12. Additionally, DMH operates six habilitation centers, which provide 24-hour accommodation, board, personal care, active treatment, and basic health and nursing care services to individuals with developmental disabilities. These facilities are certified by CMS as Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICF/IID") for the purpose of receiving reimbursement from CMS.

13. These six facilities receive reimbursement from CMS to cover the cost of services for individuals with developmental disabilities and intellectual disabilities.

14. As certified ICF/IIDs, these facilities must comply with CMS Conditions of Participation in order to be reimbursed for treatment costs and disproportionate share costs.

15. Bellefontaine Habilitation Center is a 133-bed facility in St. Louis, Missouri. There are currently approximately 337 employees. Based on the most

recently available information, 63.8% of staff at Bellefontaine Habilitation Center are fully vaccinated.

16. Higginsville Habilitation Center is a 40-bed facility in Higginsville, Missouri. There are currently approximately 168 employees. Based on the most recently available information, 65.4% of staff at Higginsville Habilitation Center are fully vaccinated.

17. St. Charles Habilitation Center is a 72-bed facility in St. Charles, Missouri. South County Habilitation Center is a 72-bed facility in St. Louis, Missouri. Together, they are currently approximately 326 employees. Based on the most recently available information, 43.9% of staff at St. Charles Habilitation Center are fully vaccinated and 55.1% of staff at South County Habilitation Center are fully vaccinated.

18. SEMO Residential Services has two locations – a 35-bed facility in Poplar Bluff, Missouri and a 25-bed facility in Sikeston, Missouri. There are currently approximately 171 employees. Based on the most recently available information, only 29.6% of staff at the Poplar Bluff location are fully vaccinated and 41.4% of staff at the Sikeston location are fully vaccinated.

19. All twelve DMH facilities and their patients will be directly affected by the interim rule with comment period ("IFC") that Plaintiff States have challenged in this case.

20. In Fiscal Year 2021, 89 % of DMH's budget was funded with CMS federal funding from Medicaid/Medicare and Disproportionate Share payments.

21. As of September 2021, DMH's Division of Behavioral Health hospitals had a registered nurse vacancy rate of 35% and a 54% vacancy rate for licensed practical nurses. The overall vacancy rate for paraprofessionals within the Division of Behavioral Health hospitals was 28%. Within DMH's Division of Developmental Disabilities, the direct care vacancy rate ranges from 11% at St. Louis Developmental Disabilities Treatment Center to 50% at Higginsville Habilitation Center.

22. The loss of additional employees will cause significant difficulty in the continued operation of DMH facilities. Even if a small percentage of DMH's workforce is lost because of the vaccine mandate, operations will be negatively impacted.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 12th day of November, 2021.

Valerie Huhn
Acting Director, Missouri Department of Mental Health

EXHIBIT

K

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF ABIGAIL CYBORON

1. My name is Abigail Cyboron, and I am the Chief Executive Officer of Chase County Community Hospital in Imperial, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Chase County Community Hospital will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Chase County Community Hospital is a small rural hospital.

5. Chase County Community Hospital is a critical access hospital.

6. Chase County Community Hospital is licensed for 15 Medicare/Medicaid beds.

7. Chase County Community Hospital's average daily census is 1.6 (this does not include the following patients in swing beds, emergency room, extended emergency room, observation or outpatient surgery recoveries). Our average Medicare acute length of stay is

2.69 days and our average length of stay for swing bed patients is 8.94 days.

8. Chase County Community Hospital receives 64% or $8,079,621 of its annual net revenue/funding from Medicare and/or Medicaid reimbursements.

9. Chase County Community Hospital provides the following patient care: 24/7 emergency room, 24/7 hospital nursing floor, surgeries, radiology exams (CT/MRI/ultrasound/mammography/DXA/nuclear medicine), laboratory tests, physical therapy, respiratory therapy, cardiac rehabilitation, cardiac stress tests, endoscopic procedures, infusion/oncology, joint injections, diabetic education/support, specialty clinic providers and a Rural Health Clinic.

10. Chase County Community Hospital serves a patient population base of four thousand people within a geographic area of three counties.

11. Chase County Community Hospital employs 103 total staff, including 68 health care/clinical/practitioner staff.

12. Chase County Community Hospital is currently experiencing a workforce shortage of health care staff with eight vacancies (this does not include three non-clinical openings that are also difficult to fill). These eight clinical vacancies include one physician (open for the last ten months), three nursing floor registered nurses (open for 12+ months each), one laboratory technologist (open for 18 months), one and one-half radiology technologists (open 13 months), one clinical licensed practical nurse (open for one month), and one-half infection control registered nurse (open six months). These positions are extremely difficult to fill due to the shortage of healthcare staff, our remote location, and the already overburdened health care workforce. We count on traveling health care workers to staff our schedules in nursing, laboratory and radiology. We are currently paying a traveling registered nurse $150

per hour which still leaves us short by two registered nurses. We are having an extremely hard time covering our scheduled shifts due to these shortages. Our current staff is picking up the extra shifts and they are burning out. We have even provided retention bonuses for current healthcare staff along with shift incentives and paying extra money when uncovered shifts are picked up. We are already functioning at a crisis mode, if we lose even one nurse, radiology technologist or laboratory technologist due to this mandate, our 24/7 nursing floor and emergency room services could collapse.

13. Amongst the 103 Chase County Community Hospital's employees, 49 are known to have not or are reasonably believed to have not received a COVID-19 vaccine.

14. Chase County Community Hospital stands to lose ten of its total employees including seven clinical personnel as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

15. The patients served by Chase County Community Hospital will be affected by this mandate. Our facility is required to be staffed with at least one registered nurse 24/7. If we are unable to, at a minimum, maintain our staffing we may not be able to provide our emergency room services along with nursing floor services. Our laboratory and radiology departments are also needed to support the 24/7 services that our hospital provides so if they are also unable to maintain staffing levels, we won't have these services either. One of the most important jobs we have in our rural area is to provide emergent services. If someone is having a heart attack or a stroke, they may not make it to the other critical access hospital down the road 30 miles. This is assuming the critical access hospital 30 miles away is going to be able to keep their services going. During these surges of COVID we have also struggled terribly getting bed acceptance at larger facilities which has forced us to keep higher level

acuity patients in our facility. This has added additional pressure on all of our health care staff. Again, if we lose any staff, we may not be able to keep these key services going.

16. The healthcare industry has certainly experienced a tremendous amount of pressure brought on by COVID over the last two years. These circumstances have created an environment where it is more difficult to hire and maintain health care staff. The healthcare industry cannot sustain a mandate with this much impact at this time. This mandate will most certainly create disparities in care quality and access here in our rural community. Our healthcare staff fights hard and will continue to fight to provide excellent care for our community but they are reaching a breaking point.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Abigail Cyboron, CEO
Chase County Community Hospital

EXHIBIT

L

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF BRETT EGGLESTON

1. My name is Brett D. Eggleston, and I am the Chief Executive Officer of Callaway District Hospital and Medical Clinics in Callaway, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Callaway District Hospital and Medical Clinics will be directly affected by the CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Callaway District Hospital is a small rural hospital.

5. Callaway District Hospital is a critical access hospital.

6. Callaway District Hospital and Medical Clinics operates two rural health clinics located in Custer County, Nebraska.

7. Callaway District Hospital and Medical Clinics is licensed for twelve Medicare/Medicaid beds.

8. Callaway District Hospital and Medical Clinics' average daily census is 1.25 inpatients, 1 swing bed, 22.77 outpatients, 36.8 clinic patients, and 1.93 emergency patients.

9. Callaway District Hospital and Medical Clinics receives approximately 70% of its annual revenue / funding from Medicare and/or Medicaid reimbursements.

10. Callaway District Hospital and Medical Clinics provides inpatient and outpatient hospital care, emergency department, laboratory, radiology, mammography, outpatient specialty, outpatient endoscopy/coloscopy, outpatient geriatric psychiatry and outpatient primary care services.

11. Callaway District Hospital and Medical Clinics serves a primary geographic area of our 694 square mile hospital district. Additionally, more than 50% of patients travel to Callaway District Hospital and Medical Clinics from outside our hospital district boundaries. Many patients travel thirty to sixty miles to access healthcare services.

12. Callaway District Hospital and Medical Clinics employs a staff of sixty-five people.

13. Callaway District Hospital and Medical Clinics is currently experiencing a workforce shortage of health care staff with 4 hospital nursing vacancies. These positions have been open for greater than 6 months.

14. Amongst Callaway District Hospital and Medical Clinics' employees, 30% are known to have not or are reasonably believed to have not received a COVID-19 vaccine. This includes 5 Clinic Registered Nurses, 1 Clinic Office Support Staff, 5 Hospital Registered Nurses, 1 Hospital Licenses Practical Nurse, 1 Hospital Certified Nursing Assistant, 3 Hospital Office Support Staff, 1 Environmental Services Tech, 1 Laboratory Technician, and 2 Radiology Technologists.

15. Callaway District Hospital and Medical Clinics stands to lose 30% of our total staff as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

16. The projected loss of approximately 30% of our staff as a result of implementation of the CMS vaccine mandate will almost certainly lead to closure of our facility.

17. Closure of Callaway District Hospital and Medical Clinics would leave our rural community without essential healthcare services.

18. Based on my 5 years of experience in rural health care and 3 years as CEO of Callaway District Hospital and Medical Clinics, it is my reasoned opinion that the CMS vaccine mandate threatens rural healthcare infrastructure not only in Custer County but throughout Nebraska.

19. Callaway District Hospital and Medical Clinics is the largest employer in Callaway, Nebraska with an annual payroll of $4 million. Callaway District Hospital & Medical Clinics is a significant driver of the local business and agriculture economy.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11th day of November, 2021.

Brett D. Eggleston, MHA

Brett D. Eggleston, MHA Chief Executive Officer
Callaway District Hospital and Medical Clinics

EXHIBIT

M

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al.,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR., et al.,

Defendants.

No. 4:21-cv-01329

DECLARATION OF DON NAIBERK

1. My name is Don Naiberk, and I am the Administrator of Butler County Health Care Center in David City, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Butler County Health Care Center will be directly affected by the CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Butler County Health Care Center is a small rural hospital.

5. Butler County Health Care Center is a Critical Access Hospital.

6. Butler County Health Care Center is licensed for twenty (20) Medicare/Medicaid beds.

7. Butler County Health Care Center receives fifty four percent (54%) of twenty million two hundred fifteen and sixty dollars ($20,215,060) of net annual revenue from

Medicare and Medicaid reimbursements.

8. Butler County Health Care Center provides patient care as a Critical Access Hospital in David City Nebraska.

9. Butler County Health Care Center serves a patient population base of approximately nine thousand five hundred people in our service area which covers almost six hundred (600) square miles.

10. Butler County Health Care Center employs one hundred and thirty four (134) total staff. This includes seventy five (75) clinical staff and fifty nine (59) nonclinical staff. Butler County Health Care Center does not employee any Physicians/APP's, but there are five physicians and two physician's assistants that practice in the community and are part of the Butler County Health Care Center active medical staff.

11. Butler County Health Care Center is currently experiencing a workforce shortage of health care staff with vacancies for registered nurses and medical laboratory technologists. Recruitment efforts to fill the needs in these two areas have been unsuccessful for almost three months. Butler County Health Care Center has relied upon prior CMS rules that did not require COVID-19 vaccination for hiring staff.

12. Amongst Butler County Health Care Center's employees, fourteen percent (14%) are known to have not or are reasonably believed to have not received a COVID-19 vaccine. This includes fourteen percent (14%) of the nursing staff and sixty six percent (66%) of the laboratory staff. The active medical staff of Butler County Health Care Center has forty three percent (43%) of its members that are not vaccinated. This includes forty three percent (43%) of those that provide medical services in the emergency department, and sixty six percent (66%) of physicians that provide obstetric services at Butler County Health Care

Center.

13. Butler County Health Care Center is aware of the potential for medical and religious exemptions under federal law. It is with this awareness that Butler County Health Care Center projects to lose seven percent (7%) of its total staff if implementation of the CMS vaccine mandate occurs. This has been determined through surveying the current staff that is unvaccinated, and determining who might be seeking an exemption and those that do not intend to get vaccinated or seek an exemption.

14. The loss of seven percent (7%) of the total staff of Butler County would make it very difficult to continue operations. The unemployment rate in Butler County and surrounding areas is very low, and all health care facilities are struggling to find staff prior to this mandate. The vaccine mandate would prevent Butler County Health Care Center from providing consistent emergency department services, obstetric services, laboratory services, and acute nursing care.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Donald T. Naiberk, CEO
Butler County Health Care Center

EXHIBIT

N

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF ERIC BARBER

1. My name is Eric Barber, and I am the President and Chief Executive Officer of Mary Lanning Healthcare in Hastings, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Mary Lanning Healthcare will be directly affected by CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Mary Lanning Healthcare is a general acute hospital.

5. Mary Lanning Healthcare is licensed for 164 Medicare/Medicaid beds.

6. Mary Lanning Healthcare's average daily census is 85

7. Mary Lanning Healthcare receives approximately 55% of its annual revenue from Medicare and/or Medicaid reimbursements.

8. Mary Lanning Healthcare provides patient care in OB/GYN, NICU,

Cardiology, Neurosurgery, Orthopedics, Emergency Services, Neurology, Urology, Medical Oncology, Radiation Oncology, General Surgery, Psychiatry and Rehabilitation.

9. Mary Lanning Healthcare serves a patient population base of over 100,000 people within a geographic area of approximately 2500 square miles.

10. Mary Lanning Healthcare employs 1,245 total staff, including health care, clinical, physicians and advanced practitioners.

11. Mary Lanning Healthcare is currently experiencing a workforce shortage of health care staff with 42 RN vacancies and a total vacancy of 99.

12. Amongst Mary Lanning Healthcare's employees, 283 are known to have not or are reasonably believed to have not received a COVID-19 vaccine and 56 of those are RN's working in critical care areas.

13. Mary Lanning Healthcare stands to lose hundreds of employees as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

14. The patients served by Mary Lanning Healthcare will suffer as a result of these staffing shortages and will likely have to try and find care elsewhere. Mary Lanning Healthcare will be forced to make decisions regarding closure of departments, reduction of services, inability to accept patients, increased wait times for services, inability to staff beds, and is already experiencing an inability to transfer patients to alternative hospitals facing similar staffing challenges.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11 day of November, 2021.

Eric Barber, President & CEO
Mary Lanning Healthcare

EXHIBIT O

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF JASON PETIK

1. My name is Jason Petik, and I am the Chief Executive Officer of Sidney Regional Medical Center in Sidney, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Sidney Regional Medical Center will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Sidney Regional Medical Center is a small rural hospital.

5. Sidney Regional Medical Center is the 2nd Largest Critical Access Hospital System in the State of Nebraska and the nearest like level of services are 45 miles to the south or 90 miles to the north.

6. Sidney Regional Medical Center is licensed for 25 Acute Care Medicare/Medicaid beds. 63 Bed Long Term Care, 28 Beds Assisted Living, and a Rural Health Clinic.

7. Sidney Regional Medical Center's acute care average daily census is 9 Acute, 70 percent occupancy in Long Term Care, 60 percent in Assisted Living, and an average of 75 people through the Rural Health Clinic daily.

8. Sidney Regional Medical Center receives 58 percent of 61 million dollars of net annual revenue/ $35 million of Medicare and Medicaid reimbursements.

9. Sidney Regional Medical Center provides patient care in the Clinic, Radiology, Lab, Speech/Occupational/Physical Therapy, Dietitian Services, Orthopedic Surgery, General Surgery, Trauma Services, Urology Services, Acute Care, ICU Care, IV Therapy (chemo), Emergency Care, Long Term Care, Assisted Living.

10. Sidney Regional Medical Center serves a patient population base of approximately 15,000 people in our service area which covers over 9 Nebraska and 2 Colorado counties, 8,100 square miles.

11. Sidney Regional Medical Center employs 392 total staff, 22 Physician/APPs, 226 other clinical and 147 nonclinical.

12. Sidney Regional Medical Center is currently experiencing a workforce shortage of health care staff with the following vacancies: 1- Central Sterile Tech, 1-Certified Pharm Tech, 3- Cooks, 1- Housekeeper, 4- Patient Account Specialist, 5+- LTC Nurse Aides, 6+- RNs, 1- Respiratory Therapist, 3- Surgical Techs, and 1- Radiology Tech. These positions range in length of vacancies from 3-7 months. Currently there are no contracting companies able to fill our needs as well. Currently we are using 9 Contract employees to cover RN,

Surgical RN, Respiratory Therapist, Surgical Tech, and Speech Therapist positions. We have been attempting to hire health care staff to fill these vacancies without regard vaccination status in reliance upon prior CMS rules.

13. Amongst Sidney Regional Medical Center's employees, 44 percent are known to have not or are reasonably believed to have not received a COVID-19 vaccine. This is representation across all departments at Sidney Regional Medical Center.

14. Sidney Regional Medical Center stands to lose 5-10 percent or 18-39 of its total employees. The main number of losses will probably come from Certified Nurses Assistants, RNs, Therapists, and Pharmacist as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case. We have already lost a RN due to the mask mandate. This loss is projected with our awareness of the religious or medical exemptions which may be sought under federal law.

15. Rural communities like Sidney are challenged in many ways to provide quality health care. The most prevalent one is staffing. Recruitment and retention are our two biggest challenge. Base on my experience as a hospital administrator, it is my reasoned opinion that if this Mandate is upheld, SRMC will be put in an almost impossible position to provide the same level and quality of services.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the _12_ day of November, 2021.

Jason Petik, CEO
Sidney Regional Medical Center

EXHIBIT

P

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al.,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR., et al.,

Defendants.

No. 4:21-cv-01329

DECLARATION OF KYLE KELLUM

1. My name is Kyle Kellum, and I am the CEO of Cherry County Hospital in Valentine, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Cherry County Hospital will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Cherry County Hospital is a small rural hospital.

5. Cherry County Hospital is a critical access hospital.

6. Cherry County Hospital is licensed for 21 Medicare/Medicaid beds.

7. Cherry County Hospital's current average daily census is 6.66

8. Cherry County Hospital currently receives 23% Medicare funding and 9% Medicaid funding of total reimbursements.

9. Cherry County Hospital provides patient care including, but not limited to, primary care, emergency care, obstetrics with C-sections, dialysis, physical therapy, home health, orthopedics, podiatry, cardiology, imaging and laboratory services, general surgery, urology, pain management, neurology, etc. Cherry County Hospital performs and employs our own billing/coding services, dietary/environmental/maintenance personnel to support our clinical teams. Although this is a portion of our team, it is certainly not all-inclusive or a full representation of the services provided to our community and beyond.

10. Cherry County Hospital serves a patient population made up of a primary and secondary services area base of twenty-one thousand people throughout nineteen different zip codes.

11. Cherry County Hospital employs 159 total staff, including 4 providers, 116 clinical staff, and 39 non-clinical staff.

12. Cherry County Hospital is currently experiencing a workforce shortage of health care staff with, at minimum, 18 position vacancies; however, with the difficulties in recruitment, we hire nursing and ambulance staff as we are able regardless of an open vacancy. These positions include the following areas: nursing (3+), laboratory (2), radiology (1), clinic (3), environmental services (2), dietary (1), pharmacy (1), dialysis (1), nursing leadership (1), ambulance (2+), and provider (1). Being in a remote area is very challenging for recruitment. As an example, we have had a laboratory manager position open for over one year, nursing positions open for multiple years due to the shortage of the nursing field, and a family practice physician opening for greater than two years.

13. Amongst Cherry County Hospital's employees, 66 are known to have not or are reasonably believed to have not received a COVID-19 vaccine. This comes from the

following departments:

a. Primary Care Clinic – 8
b. Nursing – 23 staff
c. Surgery – 5 staff
d. Radiology – 3 staff
e. Dialysis – 3 staff
f. Pharmacy – 1
g. Laboratory – 2
h. Maintenance – 1
i. Medical Records/Coding/Billing/Registration – 7
j. Environmental Services – 2
k. Ambulance – 10
l. Therapy – 1

14. Cherry County Hospital stands to lose 50 employees from all areas of the organization, including 8 additional who are currently undecided. As a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case, Cherry County Hospital stands to lose 39 clinical employees (RN's, radiology and lab techs, providers, etc.) and 11 non-clinical employees (environmental services, billing, coding, and other support areas).

15. The patients served by Cherry County Hospital will have the following negative consequences on their healthcare or the services provided by the Hospital and Clinic as a result of the additional loss of Hospital employees:

a. Loss of the only employed physician in the primary care clinic
b. Loss of all but two clinical staff in the primary care clinic
c. Loss of billing and coding staff in the primary care clinic (with these losses combined, patient access to care would decrease from 25 days for a new appointment to greater than 45 days for a new appointment and risks

closure)

d. Reduction in available laboratory services due to minimal staff
e. Reduction in radiology services due to minimal staff
f. Reduction in physical therapy services due to minimal staff
g. Loss of highly skilled charge nurses, RN's, LPN's, CNA's on the floor decreasing the ability to staff beds
h. Loss of medical records staff which ensure safe transport of medical records for patients needing a higher level of care
i. Loss of billing staff therefore revenue is not able to be collected timely and leads to denials in payment from timely filing requirements
j. Loss of two environmental services staff, which makes keeping a clean and safe environment for our patients impossible and puts the burden of cleaning rooms for new patients on the one remaining staff member as well as on the nursing team. As an organization, we also do all laundry in-house as there are not contracted services in our small community to be able to take this on. This results in an inability to keep up with proper PPE methods and reduces the number of services we can provide as an organization.
k. With the loss of providers and skilled RN's, the community and beyond suffers from the loss of OB and both planned and emergency C-section delivery. We deliver over 110 babies per year and are the closest hospital in our area for such services. This will, without a doubt, result in poor outcomes for mom and newborn.
l. Loss of Home Health as this team would be pulled to help assist on the med/surg area as well as the emergency room.
m. Loss of Dialysis department. This is a critical need in our community and any remaining staff would be pulled to assist on med/surg area as well as the emergency department.
n. Loss of surgery personnel leading to a dramatically limited ability to perform the needed surgical (both elective and emergent) surgeries on patients.
o. Loss of ambulance volunteers/staff. This results in an inability to respond

to calls due to an already thin number of skilled personnel.

p. Loss of emergency department providers.

q. Loss of the chemotherapy department as this team would be pulled to help assist on the med/surg area as well as the emergency room.

r. Loss of cardiac rehabilitation as this team would be pulled to help assist on the med/surg area as well as the emergency room.

s. Loss of many of the remaining staff members who have already voiced they will seek employment elsewhere due to no relief and a heavy workload they would entail.

t. All of this combined, may lead to a closure of Cherry County Hospital as we will not have the staff to care for the patients, the staff to bill for the services, and the staff to keep a sanitary environment.

16. As the CEO of the organization, I cannot express the extent of what is about to happen. Healthcare in this community and beyond (we service the largest county in the State of Nebraska and into South Dakota) will never look the same. Patients will not have the primary care services needed to stay healthy, will not have the staff to care for them in an emergency, and will not have an ambulance service to respond to calls in an emergent manner. Cherry County Hospital is a leader of employment for our county; residents will be forced to move away to support their families resulting in a dramatic impact to the local economy. Very highly skilled providers, nurses, ancillary, and support personnel will walk away from healthcare for good; this is not a maybe, this is an absolute. Patients needing life saving measures such chemotherapy, cardiac rehabilitation, and dialysis (to name a few), will need to drive a minimum of two and three hours to receive the same services they are receiving locally today. This, however, is assuming the overburdened healthcare system in those organizations two and three hours away have the capacity to accept them as patients; which they will not be able to do so. I simply cannot put into words what this mandate will do to our community and

our healthcare system. As the CEO, I am proud of our organization; I see the good and necessary work happening every day and night. This is not a matter of if all of the above will occur should this mandate go through; this is a matter of it will begin occurring in December and increase exponentially by January 4th, 2022.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12 day of November, 2021.

Kyle Kellum, CEO
Cherry County Hospital

EXHIBIT

Q

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF LARRY KAHL

1. My name is Larry Kahl, and I am the Chief Operating Officer for the Nebraska Department of Health and Human Services ("the Department"). I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. According to licensure data maintained by the Department's Division of Public Health, there are a total of 702 federally certified providers and suppliers within the state of Nebraska that are directly regulated by the CMS Interim Final Rule with Comment Period ("IFC") challenged by Plaintiff States in this case. These providers and suppliers are comprised of: fifty Ambulatory Surgical Centers, 35 hospices, five Psychiatric residential treatment facilities (PRTFs), one Program of All-Inclusive Care for the Elderly (PACE), 42 hospitals, 196 long-term care facilities, 13 intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), 67 home health agencies (HHAs), 63 critical access hospitals (CAHs),

six outpatient physical therapy and speech-language pathology clinics, 145 rural health clinics (RHCs), 39 federally qualified health centers (FQHCs), and 40 end-stage renal disease (ESRD) facilities.

4. According to licensure data maintained by the Department's Division of Public Health, nine assisted living facilities and 20 nursing homes in rural Nebraska have closed since January 1, 2019. Therefore, the infrastructure for services at nursing homes is currently reduced within the State.

5. According to the Department's Division of Medicaid and Long-Term Care, the State of Nebraska receives approximately $223,000,000 to $228,000,000 in Federal Financial Participation per state fiscal year for Nebraska's approximately 200 nursing facilities for long term care non-acute stays. The State of Nebraska reimbursed Nebraska hospitals approximately $346,798,356.00 Medicaid funds for State Fiscal Year 2021. These funds are used to reimburse the above facility types for Medicaid covered care and services.

6. According to publicly available data reported by nursing homes to the CDC's National Healthcare Safety Network COVID-19 Long Term Care Facility Module maintained by the Centers for Medicare and Medicaid at https://data.cms.gov/covid-19/covid-19-nursing-home-data, as of October 24, 2021, 101 of the 196 nursing homes in Nebraska (51.8%) had staff vaccination rates under 75%. 24 of the nursing homes (12.3%) had staff vaccination rates under 50%, and 77 of the nursing homes (39.4%) had staff vaccination rates between 50% and 75%.

7. According to the Nebraska Center for Nursing, a Department-supported entity created by Nebraska statute to alleviate the state's nursing shortage, the current nursing shortage in the State of Nebraska is 4,192 and is projected to increase to 5,436 by 2025. This

shortage is particularly acute in rural areas, with eleven rural Nebraska counties having no Registered Nurses and nine rural Nebraska counties having no Licensed Practical Nurses. The Nebraska Center for Nursing's 2020 biennial report is found at https://center4nursing.nebraska.gov/data.

8. The State of Nebraska operates various state-run healthcare providers and suppliers such as a state psychiatric hospital and state ICFs-IID, as well as numerous state employees that will be directly affected by the IFC that Plaintiff States have challenged in this case.

9. The Department operates a psychiatric hospital, Lincoln Regional Center in Lincoln, Nebraska which expended $1,435,482.00 in federal Medicaid and Medicare funding in state fiscal year 2021. The Department has calculated and expects a similar federal Medicaid and Medicare reimbursement for state fiscal year 2022. The vaccination rate of Lincoln Regional Center staff is 70% as of November 8, 2021.

10. The Department operates Beatrice State Developmental Center ("BSDC") in Beatrice, Nebraska, a community of approximately 13,000 people. BSDC is a 24-hour state and federally funded residential treatment facility dedicated to the provision of specialized psychological, medical, and developmental supports to approximately ninety adults with intellectual and developmental disabilities requiring comprehensive, specialized support. The BSDC campus contains several nationally accredited Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID). BSDC's total federal Medicaid and Medicare expenditure for State fiscal year 2021 was $16,813,708. Its total expenditures for State fiscal year 2021 was $26,926,596. Federal Medicaid and Medicare expenditure represented 62.44% of the total expended. The vaccination rate of BSDC staff is 62% as

of November 8, 2021.

11. The Department's Division of Public Health employs 89 individuals who work on programs funded by Medicare and Medicaid. Amongst these 89 employees are 61 surveyors who are responsible for conducting inspections and assessing compliance with state and federal regulations, including the CMS vaccine mandate should it become effective.

12. When the surveyors conduct inspections, they assess compliance with both federal and state regulations at the same time. As to federal regulations, if a facility is determined to be deficient, the Department sends the facility a "2567" form (violation report). The enforcement letter that accompanies the 2567 form, sent by DPH Staff, serves as notice of the facility's deficiencies and gives the facility a set period of time to correct the deficiencies. These surveys must be completed in order for facilities to continue to be certified for participation in Medicare and Medicaid.

13. Beginning on or about August 2021 the State of Nebraska attempted to hire unvaccinated health care workers to help staff its state-run facilities specifically relying upon prior CMS rules allowing this practice.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12 day of November, 2021.

Larry Kahl, Chief Operating Officer
Nebraska Department of Health and Human Services

EXHIBIT

R

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al.,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR., et al.,

Defendants.

No. _____

DECLARATION OF LORI MAZANEC

1. My name is Lori Mazanec, and I am the Chief Executive Officer of Box Butte General Hospital in Alliance, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Box Butte General Hospital will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Box Butte General Hospital is a small rural hospital.

5. Box Butte General Hospital is a critical access hospital.

6. Box Butte General Hospital is licensed for twenty-five Medicare/Medicaid beds.

7. Box Butte General Hospital's average daily census is currently 9.94 for the period July-October 2021 compared to 7.76 for the period July-October 2020; Fiscal Year

ending June 30, 2021 average daily census is 8.78.

8. Box Butte General Hospital provides patient care for all patient types - acute, surgical, observation, swing, intensive care and obstetrics and a variety of outpatient services, including: staffed 24-hour Emergency Department, complete Laboratory and Diagnostic Imaging (X-ray, CT, MRI, Nuclear Medicine, Mammography, Advanced Ultrasound Imaging, Bone Density/DEXA Scan); Diabetic Education, Dialysis, Oncology, Rehabilitation (including Cardiac Rehab, Occupational Therapy, Physical Therapy, Sports Medicine and Speech Therapy); Orthopedic Surgery (large joint, foot and ankle, spine, and hand and wrist), Gastroenterology, Urology, Respiratory Therapy, Electro Diagnostics, Surgery, Wound Care, and Behavioral Health. Additional services as part of a Multi-Specialty Clinic include Cardiology, ENT, General Surgery, Oral Surgery, and Podiatry. The hospital also has three Rural Health Clinics located in Alliance, Hemingford, and Hyannis.

9. Box Butte General Hospital serves a patient population base of over 78,000 people (26,800 primary service, 51,800 secondary service), all within a geographic area covering 10 panhandle counties (six counties primary service and four counties secondary service).

10. Box Butte General Hospital employs 289 staff, including 165 number of health care / clinical / practitioner staff.

11. Box Butte General Hospital is currently experiencing a workforce shortage of health care staff with 43 vacancies, including 29 of which are health care / clinical / practitioner staff positions, ranging from more recent openings to others that have been open since 2019 with no applications received. Current health care / clinical / practitioner openings include Hospitalist, Physician Assistant or Nurse Practitioner and Two Family Practice/OB

Physicians; 16 Nursing positions including Registered Nurses, LPNs, Nurse Assistants, Informatics Registered Nurse, Clinical Practice Education Nurse, Quality Data Registered Nurse, and Clinical Inpatient Nurse Manager; Two Phlebotomists; Two Physical Therapists and Therapy Technologist; Radiologic Technologist; Registered Respiratory Therapist; and Certified Occupational Therapy Assistant. Also, the Chief Financial Officer position has been vacant for five months with two rounds of separate candidates interviewed and not filled. Current barriers include the low unemployment rate in Nebraska, existing health care worker shortages prior to the COVID pandemic, role burnout, and challenges of the rural location. For the value level positions in dietary and environmental services, the ease of obtaining unemployment benefits outweighs the benefits of accepting job offers.

12. Amongst Box Butte General Hospital's employees, 42 percent are known to have not or are reasonably believed to have not received a COVID-19 vaccine with a wide range of positions including several health care / clinical / practitioner level. Known physicians, registered nurses, licensed practical nurses, laboratory technologists, senior leadership, nursing leadership among others across the organization are included in this percentage.

13. Box Butte General Hospital stands to lose 15 percent of its total employees from all across the organization, unfortunately. This mandate will not hit one single department, and includes key leadership positions in physicians, nursing, and even executive roles along with registered nurses, laboratory technologists, therapists, radiologic technologists, and many other non-clinical positions. This impacts nearly all Hospital departments including the Emergency Department, Infusion, Laboratory, Patient Care Unit, Ultrasound, Occupational Therapy, Operating Room, Environmental Services, Dietary

Services, Plant Services, Information Technology, Behavioral Health, Dialysis, Wellness Center, and Clinic Services as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

14. The patients served by Box Butte General Hospital will have the following negative consequences on their healthcare or the services provided by the Hospital as a result of the additional loss of Hospital employees: closure of departments, reduction of services, inability to accept patients and/or staff beds, increased wait times for services, need to access care possibly outside of state lines, dramatic increase in our inability to transfer to alternative hospitals, or even loss of services altogether.

15. The effects of this mandate will have ongoing ripple effects on the Hospital, its patients, remaining employees, and community for some time in the future. With anticipated limited service offerings, remaining employees will experience an even greater amount of burnout, ultimately risking their own health and likelihood, they, too, will leave health care. They will be forced to work extended hours, take significant call hours and shifts, resulting in a risk in patient safety. Not to mention the burden of ensuring all those individuals the hospital contracts with are vaccinated before entering the facility. The ultimate goal of the vaccine mandate, per CMS, is to keep patients safe. Patients are and will continue to be safe in our hospital whether our team is vaccinated or not vaccinated. The current rate of eligible individuals vaccinated in the Nebraska Panhandle is 40 percent. Patients are not coming to the hospital for services and becoming ill with COVID. Patients seek care when sick with COVID and our teams provide the highest level of care and excellence with or without vaccinations. The authority for the COVID pandemic guidelines has been left with the states to govern. It should and needs to continue to remain at the state level.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11th day of November, 2021.

Lori Mazanec

Lori Mazanec
Box Butte General Hospital

EXHIBIT S

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF MEL McNEA

1. My name is Mel McNea, and I am the Chief Executive Officer of Great Plains Health in North Platte, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction

3. Great Plains Health will be directly affected by the CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Great Plains Health is a general acute hospital that serves a patient population base of 136,000 lives and approximately 67,832 square miles, about the size of the state of Pennsylvania. With nearly 100 physicians representing 30 medical specialties, the Great Plains Health system offers advanced medical services, including heart and vascular, cancer, orthopedic services, women's services, a level III trauma center, a level II neonatal intensive

care unit, and one of just two behavioral health units in western Nebraska.

5. Great Plains Health is licensed for 116 Medicare/Medicaid beds.

6. Great Plains Health's average daily census is 56.3

7. Great Plains Health receives 62% funding from Medicare and/or Medicaid reimbursements.

8. Great Plains Health employs 1197 total staff, including 772 clinical staff.

9. Great Plains Health is currently experiencing a workforce shortage of health care staff with 231 vacancies consisting of: 88 vacancies for Registered Nurses and Licensed Practical Nurses, nine vacancies for Advanced Practice Providers, three vacancies for respiratory therapists, 13 diagnostic imaging vacancies, and seven lab vacancies. In attempting to fill these types of vacancies we relied upon prior CMS rules that did not mandate vaccination.

10. Great Plains Health has a 75% compliance rate for staff vaccinations to COVID-19, however, 311 are known to have not be vaccinated. Based on direct conversations with staff or their supervisors it is my reasonable belief that Great Plains Health stands to lose a high percentage of these unvaccinated employees as a result of the CMS vaccine mandate.

11. As a result of the likely loss of a significant number of staff because of the vaccine mandate, including the loss of the only remaining employed anesthesiologist, the patients served by Great Plains Health will experience a number of negative effects on their ability to receive health care including a dangerously reduced number of staffed ICU beds, a reduced ability to obtain timely surgeries or surgery all together due to loss of an anesthesiologist and nursing staff, reduced ability of Great Plains Health to provide cardiac stenting, and an inability to receive forensic sexual assault exams due to loss of SANE-

qualified nurses.

12. Great Plains Health's behavioral health unit which maintains the ability to treat nineteen patients will prospectively need to close or reduce services as most of the clinical staff within this unit is currently not vaccinated. This will leave only nine available behavioral health beds available at Regional West Medical Center in Scottsbluff, Nebraska which is nearly three hours away and itself facing staffing concerns.

13. Great Plains Health maintains that the CMS rule should better align with the OSHA ETS that allows for unvaccinated individuals to produce a negative test weekly. With our enhanced precautions we have in place currently, allowing this alternative to a vaccine mandate would not sacrifice patient or staff safety.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Mel McNea

Mel McNea, MHA, Chief Executive Officer
Great Plains Health

EXHIBIT

T

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF MARK SROCZYNSKI

1. My name is Mark Sroczynski, and I am the Vice President of Operations for Emerald Health Care. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. The four facilities operated by Emerald Health Care in Nebraska will be directly affected by the CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Emerald Health Care operates Emerald Nursing and Rehab in Columbus, Nebraska, a rural municipality of less than 25,000 people. This facility provides skilled nursing, long-term care, occupational and speech therapy, and hospice care amongst other services. This facility currently has a vacancy rate of approximately 35% for Registered Nurses and Licensed Practical Nurses and a vacancy rate of approximately 37% for Certified Nursing Assistants and Medication Aides. The applicant pool of qualified staff applying to

fill these vacancies is at an historic low. Based on conversations with this facility's staff, it is estimated that an additional loss of at least 10% of the Certified Nursing Assistants currently employed at this facility will occur as a result of the CMS vaccine mandate.

5. Emerald Health Care operates Emerald Nursing and Rehab in Cozad, Nebraska, a rural town of less than 4,000 people. This facility provides skilled nursing, physical, occupational and speech therapy, and cardiac rehabilitation care, amongst other services. This facility has a vacancy rate of approximately 26% for Registered Nurses and Licensed Practical Nurses, a vacancy rate of approximately 49% for Certified Nursing Assistants and Medication Aides, and a vacancy rate of approximately 80% for housekeeping and dietary services. This facility is in dire straits in terms of staffing and stands to lose an additional 25% of its employees as a result of the CMS vaccine mandate based on conversations with this facility's staff. This facility has received at least one qualified application from a former employee of a recently closed facility in a nearby facility who applied to the Emerald Nursing and Rehab Cozad facility because it was not mandating vaccination.

6. Emerald Health Care operates Emerald Nursing and Rehab in Omaha, Nebraska, the state's largest city. This facility provides, skilled nursing, long-term care, rehabilitative services, and amongst other services. This facility has a vacancy rate of approximately 42% for Registered Nurses and Licensed Practical Nurses, a vacancy rate of approximately 32% for Certified Nursing Assistants and Medication Aides, and a vacancy rate of approximately 38% for housekeeping and dietary services. This facility serves a substantial number of minority residents amongst whom the vaccination rate is approximately 50%. Based on conversations with this facility's staff, this facility anticipates an additional loss of approximately 18% of its current employees as a result of the CMS vaccine mandate.

7. Emerald Health Care operates Emerald Nursing and Rehab Lakeview in Grand Island, Nebraska, a city of approximately 50,000 people. This facility provides skilled nursing, assisted living and dementia care, physical, occupational and speech therapy, and stroke and neurological care, amongst other services. This facility has a vacancy rate of approximately 45% for Registered Nurses and Licensed Practical Nurses, a vacancy rate of approximately 27% for Certified Nursing Assistants and Medication Aides. Based on conversations with this facility's staff, this facility anticipates an additional loss of approximately 13% of its current employees as a result of the CMS vaccine mandate.

8. The CMS vaccine mandate will undoubtedly add to the vacancy rate of each of Emerald Health Care's four Nebraska facilities. Such decreases in available staff will result in each facility turning away patients in their respective communities. It is further expected that other long-term care or assisted living facilities in rural areas will likely close due to less patient population density and a limited pool of qualified staff. Closures of other facilities will only compound the inability of Emerald Health Care's to care for patients in rural areas.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11 day of November, 2021.

Mark Sroczynski, Vice President of Operations
Emerald Health Care

EXHIBIT

U

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF NANCY GLAUBKE

1. My name is Nancy Glaubke, and I am the Chief Executive Officer of Valley County Health System in Ord, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Valley County Health System will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Valley County Health System is a small rural hospital.

5. Valley County Health System is a critical access hospital.

6. Valley County Health System is licensed for 16 Medicare/Medicaid beds.

7. Valley County Health System's average daily census is 3.5 patients.

8. Valley County Health System provides patient care services for emergencies, inpatient, swing bed, observation, laboratory, radiology, operating room, rehabilitation

services, respiratory therapy, behavioral health and visiting specialists.

9. Valley County Health System serves a patient population base of 4,200 people within a geographic area of four counties.

10. Valley County Health System employs 210 staff; approximately 65% are clinical and practitioner staff.

11. Valley County Health System is currently experiencing a workforce shortage of health care staff with 14 vacancies, or 6.5% of our total workforce. Of these vacancies 6 are RNs, 2 are CNA/Unit Secretary, 2 Clerical, 2 Housekeepers, 1 Cook, and 1 Certified Nurse Assistant. The nursing positions have been open for over 365 days due to the nationwide shortage of Registered Nurses. Prior to 2020 Valley County Health System didn't have to use outside agency staff. Today, we have contracted with 4 RNs and 1 Lab Tech even though we've doubled our recruiting efforts.

12. Amongst Valley County Health System's employees, 60 (30%) are known to have not or are reasonably believed to have not received a COVID-19 vaccine.

13. Valley County Health System stands to lose all 60 of these employees. That's 30% of our total labor force. We stand to lose 80% of our Imaging Department as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

14. The patients served by Valley County Health System will suffer from the potential closure of some departments as a result of the additional loss of Hospital employees. If we lose our imaging department we will have to divert many of our emergency patients to other facilities; the closest one is 45 miles away.

15. This has created undue stress on our employees and our community.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 10th day of November, 2021.

Nancy Glaubke, CEO
Valley County Health System

EXHIBIT

V

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF SHANNON MONHEISER

1. My name is Shannon Monheiser, and I am the Administrator of Kimball County Manor and Assisted Living in Kimball, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Kimball County Manor and Assisted Living will be directly affected by the CMS vaccine mandate that Plaintiff States have challenged in this case.

4. Kimball County Manor and Assisted Living is comprised of a skilled nursing facility and an assisted living facility. 75% of the patients served in the skilled nursing facility are funded by Medicare or Medicaid and 56% of the assisted living residents are funded by Medicaid.

5. Kimball County Manor and Assisted Living employs 55 full time staff and as such is one of the largest employers in Kimball County, a rural county located in Nebraska's western panhandle.

6. Kimball County Manor and Assisted Living currently has six nursing vacancies and utilizes agency provided nursing that includes foreign nurses. Utilization of agency provided nurses costs Kimball County Manor in excess of $20,000 per week.

7. Kimball County Manor's skilled nursing facility is licensed for forty-nine skilled nursing beds, however, the current census is 45 patients. Kimball County Manor is placing a hold on admitting new patients in anticipation of a loss of staff due to the CMS vaccine mandate, thus already sustaining a loss of at least $36,000 in revenue per month by not filling available beds for which there is an existing demand.

8. Of Kimball County Manor and Assisted Living's 55 employees, 31 are known to be unvaccinated, at least 27 have informed management that they will resign or be terminated rather than be vaccinated. Unvaccinated employees are comprised of various types of personnel, however, 48% of our unvaccinated workforce are nurses.

9. Losing potentially 48% of our workforce, including a substantial percentage of our already depleted nursing staff will force Kimball County Manor and Assisted Living to further reduce skilled nursing services and force current patients to seek long-term care in

facilities that are more than an hour away from our community and place significant financial pressure on our facility as a result, thereby unnecessarily jeopardizing the very existence of Kimball County Manor and Assisted Living.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11th day of November, 2021.

Shannon Monheiser
Kimball County Manor and Assisted Living

EXHIBIT

W

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF TROY BRUNTZ

1. My name is Troy Bruntz, and I am the President and Chief Executive Officer of Community Hospital in McCook, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Community Hospital will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Community Hospital is a small rural hospital.

5. Community Hospital is a critical access hospital.

6. Community Hospital is licensed for 25 Medicare/Medicaid beds.

7. Community Hospital's average daily census has been approximately 8 to 10 patients.

8. Community Hospital receives 56% of its $51 million annual patient service

revenue from Medicare and/or Medicaid reimbursements.

9. Community Hospital provides patient care such as general and specialty surgical services, medical and surgical acute patient services, phase 2 and 3 cardiopulmonary rehabilitation, physical, occupational, and speech therapy, home health and hospice services, radiology tests such as ultrasound, MRI, and CT Scans, and full laboratory testing on a 24 hour a day, 7 day per week basis. Many of these services such as home health and hospice are only available in our entire 7 to 10 county region by our hospital. The next closest facility providing all of these services on a 24 hour per day and 7 day per week basis is 70 miles away.

10. Community Hospital serves a patient population base of 30 thousand people in 7 to 10 counties of Southwest Nebraska and Northwest Kansas.

11. Community Hospital employs 330 total staff. 190 are classified as clinical or clinical support personnel.

12. Community Hospital is currently experiencing a workforce shortage of health care staff with 18 vacancies including 5 registered nurses, 2 licensed practical nurses, a radiology technician, and an ultrasound technician. Many of these positions, including registered nurses, licensed practical nurse, radiology and ultrasound technicians, have been posted for many months without adequate, if any, response.

13. Amongst Community Hospital's employees, 24% (78 out of 330) are known to have not or are reasonably believed to have not received a COVID-19 vaccine. Of the 78, 76 have indicated they will not or are seriously considering not receiving the vaccination. This includes 23 of 63 registered nurses serving our medical surgical inpatient services, emergency department, and labor and delivery services, 4 of 11 radiology and ultrasound technicians, 4 of 18 surgical services staff, 7 of 20 home health and hospice services staff, and 5 of 10 plant

engineering staff. Our physical therapy department labor is contracted but we believe from inquiry for compliance with the first COVID 19 OSHA ETS that currently 11 of 15 staff are not vaccinated.

14. Community Hospital stands to lose well more than 10% of its staffing in nursing services, home health and hospice, physical therapy, radiology, and plant engineering as a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case.

15. The patients served by Community Hospital will be harmed. Ultrasound services will not be available for our emergency room as they were before. To maintain our emergency room and inpatient services, which are essential, we will be forced to limit or close services such as cardiopulmonary rehabilitation and home health and hospice services. This will be necessary in order to retrain and transfer registered nurses from these services to the emergency room and inpatient care departments. Ultrasound coverage will only be available during normal business hours and radiology services will be delayed. Maintaining our plant assets will be difficult if not nearly impossible for any extended period of time. Staffing of 25 beds, our licensed amount, is already not possible which has created a need for additional transfers. As a result of this ITS, these transfers will be needed much more frequently and to communities hours away at best.

16. We have had discussions with our unvaccinated staff and, at their discretion, they have been honest with us in all cases about their intentions and therefore we have strong evidence of the potential impact on our services. It needs to be understood that even if we can technically staff services with extra shift and call, we are already doing that, have been doing that for more than a year, and our vaccinated staff will not be capable of doing it for much

longer. At that point, considering it is nearly impossible to recruit clinical staff today, more will resign due to the stress and burn out that will inevitably exist.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 10th day of November, 2021.

Troy Bruntz, President & CEO

Community Hospital

EXHIBIT

X

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al.,

Plaintiffs,

v.

JOSEPH R. BIDEN, JR., et al.,

Defendants.

No. 4:21-cv-01329

DECLARATION OF TANYA SHARP

1. My name is Tanya Sharp, and I am the Chief Executive Officer of Boone County Health Center in Albion, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Boone County Health Center will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Boone County Health Center is a small rural hospital.

5. Boone County Health Center is a critical access hospital.

6. Boone County Health Center is licensed for 25 Medicare/Medicaid beds.

7. Boone County Health Center's average daily census is 9.2

8. Boone County Health Center receives 60% of our funding for inpatient and outpatient visits has a payor source of Medicare or Medicaid. Boone County Health Center

has a 50 Million Dollar annual revenue budget.

9. Boone County Health Center provides patient care in a 25 private bed hospital with two family obstetrical suites. The health center is a hub for five medical clinics in the towns of Albion, Spalding, Newman Grove, Fullerton and Elgin. The health center performs 60,000 procedures annually including lab, imaging, screenings, surgeries, in-patient stays, obstetrics, outpatient procedures, cardiac and pulmonary rehab and wellness management.

10. Boone County Health Center serves a patient population base of 10,000 rural residents that are residents of Boone, Antelope, Greeley, Madison, Nance, Platte and Wheeler counties in north central Nebraska.

11. Boone County Health Center employs 300 staff members with 17 providers (9 MD's and 8 Mid-levels)

12. Boone County Health Center is currently experiencing a workforce shortage of health care staff with 9 current open nursing positions that have been open for over 3 months, without a single application, in addition, positions multiple openings in Housekeeping, Lab and Reception Areas. We have relied on prior CMS rules that did not require vaccination in attempting to fill existing vacancies.

13. Amongst Boone County Health Center's employees, 28 percent are known to have not or are reasonably believed to have not received a COVID-19 vaccine. With the majority of these positions being in clinical roles or provider roles within the organization.

14. Boone County Health Center stands to lose a significant number of staff members as a result of implementation of the CMS vaccine mandate. This projection accounts for potential religious or medical exemptions provided under federal law.

15. The patients served by Boone County Health Center will have the following

negative consequences on their healthcare or the services provided by the Hospital as a result of the additional loss of Hospital employees. This could range from reduction of services, closure of satellite clinic locations, increased availability for clinic visits, increased wait time in the ER, inability to staff hospital beds safely but also the ability to transfer when needed since we are all having the same issues.

16. Boone County Health Center is under a large construction renovation, it has been costly and taxing with the lack of goods and workers. Now with this mandate we are at risk of losing even more construction staff members with contractors requiring proof of vaccination and it is my understanding the burden of proof is on the hospital. This would be almost an unreasonable ask since multiple individuals will be in this space and some here for a day or two. Please consider this being on the contractors not the hospitals responsibility to enforce and provide documentation.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11th day of November, 2021.

Tanya Sharp, CEO
Boone County Health Center

EXHIBIT

Y

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. _____

DECLARATION OF TYLER TOLINE

1. My name is Tyler Toline, and I am the Chief Executive Officer of Franciscan Care Services in West Point, Nebraska. I am also a resident of the State of Nebraska and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. Franciscan Care Services will be directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

4. Franciscan Care Services is a small rural hospital.

5. Franciscan Care Services is a critical access hospital.

6. Franciscan Care Services is licensed for 25 Medicare/Medicaid beds.

7. Franciscan Care Services's average daily census is 8.

8. Franciscan Care Services receives 57 percent / $34,800,000 of its annual revenue / funding from Medicare and/or Medicaid reimbursements.

9. Franciscan Care Services provides patient care in a rural community in Northeast Nebraska. Services we provide include acute care inpatient and observation services, infusion services, obstetric labor and delivery, surgery with specialties such as orthopedic/urology/general/OB, level IV trauma emergency room services serving approximately 250 patients per month, outpatient specialty clinic with 10-30 patients per day, radiology, laboratory, cardiac rehab, physical therapy, occupational therapy, speech therapy, home health and hospice services. We also have five rural health clinics that see approximately 80-120 patients a day. At the end of June 2021, the critical access hospital located in Oakland, Nebraska, approximately 15 miles from us, closed. This has resulted in increased volumes in almost every department for our facility.

10. Franciscan Care Services serves a patient population base of 16,000 people within a geographic area of 6 counties.

11. Franciscan Care Services employs 292 people, including 15 medical staff members.

12. Franciscan Care Services is currently experiencing a workforce shortage of health care staff with 15 vacancies which include 10 clinical positions causing stress to existing staff to cover. RN vacant positions have been open since before the start of the pandemic.

13. Amongst Franciscan Care Services's employees, 23% or 67 employees are known to have not or are reasonably believed to have not received a COVID-19 vaccine

14. Franciscan Care Services stands to lose 23% or 67 of its employees. Departments with most risk include 75% of employees in radiology, 57% in acute patient care, 47% in dietary, 40% in scheduling, 38% in surgery, and 33% in home health care as a result of the implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states

in this case.

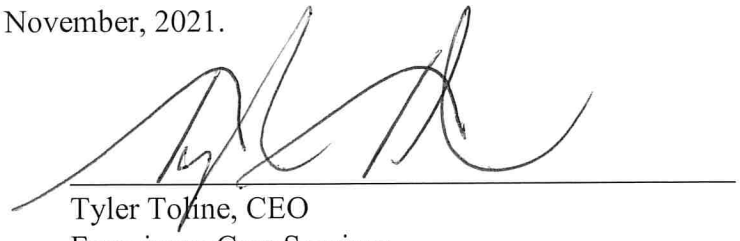
15. The patients served by Franciscan Care Services will experience many negative consequences if the CMS vaccine mandate goes through and we lose 23% of our workforce. We will have to reduce services in the clinic, in outpatient services and in surgery to utilize clinical staff to provide care for acute inpatient, observation, and emergency patients. Emergency room patient volumes and acuity will increase due to inability to care for them in the clinic setting. At this time only 43% of our Med/Surg staff are vaccinated. Of the 35 Med/Surg employees that we have, we may have to terminate 20 of them if the CMS vaccine mandate goes through. Who is going to care for our patients? Also, only 2 of our 8 Radiology employees are vaccinated. We cannot have a fully functioning Radiology department if we only have a staff of 2. We may have to divert emergency patients if we do not have Radiology capabilities. Patients that need long term care (LTC) placement upon discharge will have longer length of stay due to lack of beds in LTC leading to decreased acute care bed availability due to staffing shortages. Wait times to transfer critical care patients will become even longer than what we are currently experiencing due to lack of staffed beds in tertiary care centers. When we have a patient needing an ICU level of care we can call up to 15 facilities and are put on a waiting list or told to call back at a later time. We have had to keep intubated patients and patients requiring 1:1 care in our facility making nursing ratios unsafe for the rest of the acute care patients. Nursing and provider staff are already working longer hours and extra shifts due to increased emergency department volumes and acute care census.

16. These potential staffing loses do not include the related nursing home in West Point that will also have a similar expected percentage loss and will most likely need to discharge residents because of the lack of staffing necessary to take care of them. This will in

turn fill up the hospital beds with residents that should reside in a nursing home.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 11th day of November, 2021.



Tyler Tolne, CEO
Franciscan Care Services

EXHIBIT

Z

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No. 4:21-cv-01329

DECLARATION OF DEBRA SHACKETT

1. My name is Debra Shackett. I am the County Administrator for the Belknap County, New Hampshire. I am also a resident of New Hampshire and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. The Belknap County Commissioners collectively administer the business of Belknap County, New Hampshire. I have been appointed by the Belknap County Commissioners to be the administrative head of the county and, in that capacity, I am responsible for the efficient and effective administration of various departments within the county.

4. Belknap County Nursing Home is a 94 bed skilled nursing facility that provides long-term care and rehabilitative services to its residents. I, along with the Commission, and a professional nursing home administrator, help oversee the operations of the Belknap County

Nursing Home.

5. The Belknap County Nursing Home is presently experiencing a severe employment crisis that has limited the county's ability to provide needed residence and eldercare to Belknap County's most needy elderly.

6. The Belknap County Nursing Home has halted admissions due to staffing issues which has created problems for the nursing home and has created a long waitlist for admission. The Belknap County Nursing Home already had 20 full-time and 4 part-time nursing position vacancies prior to the imposition of the CMS vaccine mandate. Additionally, there are 2 part-time vacancies in Housekeeping. The staff have been under stress and increased duties throughout the pandemic, and the shortage of positions for this rural facility has increased the pressure on those remaining staff.

7. The recent CMS vaccine mandate will only exacerbate this existing problem.

8. At the Belknap County Nursing Home, we have approximately 36 staff members who have chosen not to participate in vaccination. We have worked to educate and encourage staff that are experiencing vaccine hesitancy. We have also offered them a financial incentive to get vaccinated. Since the timeline for the CMS vaccine mandate has been revealed, we have had only a few staff members indicate that they intend to get vaccinated. Belknap County Nursing Home has also received three healthcare worker resignations and one support staff resignation since that time.

9. Belknap County Nursing Home is already operating at approximately 75% of its 94 bed-capacity. As a result of the CMS vaccine mandate, this problem will worsen. Belknap County Nursing Home will have to decrease its bed capacity to approximately 50%, meaning that only approximately 46 beds will be able to be staffed. This decrease has required

Belknap County Nursing Home to plan to move approximately 19 vulnerable, elderly residents to other nursing home facilities outside of the county.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Debra Shackett
County Administrator
Belknap County, New Hampshire

EXHIBIT

AA

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI,
STATE OF NEBRASKA,
STATE OF ARKANSAS,
STATE OF KANSAS,
STATE OF IOWA,
STATE OF WYOMING,
STATE OF ALASKA,
STATE OF SOUTH DAKOTA,
STATE OF NORTH DAKOTA, and STATE OF NEW HAMPSHIRE,

Plaintiffs,

vs.

JOSEPH R. BIDEN, JR.,
in his official capacity as the President of the United States of America;

THE UNITED STATES OF AMERICA;

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

XAVIER BECERRA in his official capacity as Secretary of the United States Department of Health and Human Services;

CENTERS FOR MEDICARE AND MEDICAID SERVICES;

CHIQUITA BROOKS-LASURE in her official capacity as Administrator for the Centers for Medicare and Medicaid Services;

MEENA SESHAMANI in her official capacity as Deputy Administrator and Director of Center for Medicare;

DANIEL TSAI in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services;

Defendants.

Case No. 4:21-cv-01329

DECLARATION OF CHRISTOPHER D. JONES

STATE OF NORTH DAKOTA)
) ss.
COUNTY OF BURLEIGH)

Christopher D. Jones states as follows:

1. I am the Executive Director of the North Dakota Department of Human Services. I am also a resident of North Dakota and over the age of majority. I believe the facts in this declaration are true and correct to the best of my knowledge.

2. I submit this declaration to provide documentation for Plaintiffs' Motion for Preliminary Injunction.

3. The North Dakota Department of Human Services (NDDHS) operates three facilities that fall under the Centers for Medicare & Medicaid Services (CMS) Interim Final Rule (IFR).

a. North Dakota State Hospital (NDSH) is located in Stutsman County, and it provides short-term acute psychiatric and substance use treatment, intermediate psycho-social rehabilitation services, forensic services, and safety net services for adults. NDSH also provides residential addiction treatment services for adult male and female clients referred to the Tompkins Rehabilitation Center and provides inpatient evaluation and treatment services for sexually dangerous individuals.

b. Life Skills and Transition Center (LSTC) is in Walsh County and is a comprehensive support agency serving people with intellectual and developmental disabilities. LSTC serves as a crisis and stabilization center, as well as a safety net for people whose needs exceed community resources. People supported by the LSTC may reside in an intermediate care facility setting on campus, in residential habilitation homes in the Grafton community, or in communities across the state.

c. Ruth Meiers Adolescent Treatment Center (RMAC) is in Grand Forks County and is licensed as a ten-bed psychiatric residential treatment facility serving children with serious emotional disturbance using a holistic approach emphasizing behavioral and cognitive change and recognizing needs related to family, community, school, social skills, and therapy (individual, family, and group therapy).

4. NDSH employs approximately three hundred thirty staff, ranging from full-time equivalent positions and temporary hires that work part-time to full time. NDSH contracts with approximately thirty individuals and has approximately seventeen to twenty-five volunteers and four hundred students that would be considered staff under CMS' IFR. LSTC employs approximately three hundred eighteen staff, ranging from part-time to full time. LSTC contracts with one individual and has approximately one hundred volunteers and two students that would be considered staff under CMS' IFR. RMAC employs approximately sixteen staff, ranging from part-time to full time.

5. The critical staff shortages for NDSH exist for registered nurses, licensed practical nurses, and certified nursing assistants and are currently between the vacancy rate of 28% to 38%. The overall staff vacancy rate for NDSH is 28%. The critical staff shortages for LSTC exist for direct care and food service staff and are currently between the rate of 13% to19%. The overall staff vacancy for LSTC ranges from 20% to 26%. The critical staff shortage for RMAC exists for direct care associates and is currently at 48%.

6. As of November 7, 2021, the North Dakota State Department of Health's COVID-19 Vaccine Dashboard indicates that the COVID-19 primary series complete vaccine rate for the three counties in which NDDHS facilities are located are 56.4% for Stutsman County, 61.4% for Walsh County, and 56.6% for Grand Forks County. The approximation vaccination rate for the approximately three hundred thirty full-time equivalent filled positions at NDSH is 76%, three hundred eighteen full-time and temporary filled positions at LSTC is 67%, and RMAC is unknown.

7. In North Dakota, the public and private entities that are deemed subject to the Conditions of Participation process by CMS and fall under the IFR's vaccination requirements

employ tens of thousands of individuals who work in professions ranging from direct caregiving to building maintenance to medicine. Health and human service providers are facing workforce challenges that jeopardize their ability to continue providing quality care and services to the men, women, and children who rely on them for various caregiving and healthcare related supports. Anything that threatens their ability to minimize staff turnover and maximize staff retention threatens the health and safety of the individuals they serve. The imposition of a vaccine mandate presents a risk to health and human services providers' ability to adequately staff their facilities.

8. The approximate amount of federal Medicaid funds received by the NDDHS for NDSH is $2,300,000, LSTC is $29,200,000, and RMAC is $1,700,000 during the 2019-2021 biennium. These amounts do not include any federal Medicaid expansion funding, Medicare funding, or state Medicaid match funding. In accordance with the Schedule of Federal Expenditures included in the State's 2021 Financial Statements, the NDDHS reported federal Medicaid grant expenditures of approximately $913,300,000. This amount does not include any Medicare funding or state Medicaid match funding.

9. NDSH expects there will be loss of eight to twelve current staff that have clearly stated they will quit. NDSH is aware of other staff who are expressing concern or reluctance to receive the vaccination. The exact staffing impact to NDSH is unknown as these numbers are based on polling staff. NDSH is required by law to accept admissions. Therefore, any further shortages of staff will result in mandatory overtime of existing staff or the hiring of travel nursing staff, or both. The staffing impact of a mandatory vaccination policy on LSTC is unknown at this time. What is known, however is that without adequate staffing, LSTC will not be able to provide statewide safety services for its most vulnerable population, both in terms of on-site placements and the crisis services provided statewide. The staffing impact on RMAC is unknown currently if

it must implement mandatory vaccinations. If RMAC faces additional staff losses or additional struggles to hire staff, it will have to limit admissions for adolescent clients.

I declare, under penalty of perjury under the law of North Dakota, that the foregoing is true and correct to the best of my knowledge and belief.

Signed on this 12th day of November, 2021 at Bismarck, North Dakota, United States.

Christopher D. Jones, Executive Director
North Dakota Department of Human Services

EXHIBIT

BB

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI

STATE OF MISSOURI,
STATE OF NEBRASKA,
STATE OF ARKANSAS,
STATE OF KANSAS,
STATE OF IOWA,
STATE OF WYOMING,
STATE OF ALASKA,
STATE OF SOUTH DAKOTA,
STATE OF NORTH DAKOTA, and STATE OF NEW HAMPSHIRE,

Plaintiffs,

vs.

JOSEPH R. BIDEN, JR.,
in his official capacity as the President of the United States of America;

THE UNITED STATES OF AMERICA;

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

XAVIER BECERRA in his official capacity as Secretary of the United States Department of Health and Human Services;

CENTERS FOR MEDICARE AND MEDICAID SERVICES;

CHIQUITA BROOKS-LASURE in her official capacity as Administrator for the Centers for Medicare and Medicaid Services;

MEENA SESHAMANI in her official capacity as Deputy Administrator and Director of Center for Medicare;

DANIEL TSAI in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services;

Defendants.

Case No. 4:21-cv-01329

DECLARATION OF DR. NIZAR WEHBI

STATE OF NORTH DAKOTA)
) ss.
COUNTY OF BURLEIGH)

Dr. Nizar Wehbi states as follows:

1. I am the North Dakota State Health Officer, which is the administrative officer of the North Dakota State Department of Health ("Department"). I was appointed to such position by Governor Doug Burgum, effective May 1, 2021.

2. The Department reports thirty-three (33) surveyors to the Centers for Medicare & Medicaid Services ("CMS") as a part of our annual budget process.

3. Of these surveyors, twenty-nine (29) surveyors complete on-site surveys of healthcare facilities to determine compliance with CMS standards. Two (2) surveyors complete on-site construction visits for compliance with North Dakota regulatory requirements. Two (2) surveyors are reported as temporary staff who can also be used for CMS survey purposes.

4. All thirty-three (33) surveyors are employees of the state of North Dakota.

5. As a part of their job duties, surveyors determine healthcare facilities' compliance with federal and state regulations by conducting on-site surveys and evaluating the programs, services, staff, buildings, and equipment of inpatient care facilities and outpatient programs to ensure that they meet applicable standards and provide services consistent with generally accepted practices.

6. I declare, under penalty of perjury under the law of North Dakota, that the foregoing is true and correct to the best of my knowledge and belief.

Signed on this 12 day of November, 2021 at Bismarck, North Dakota, United States.

Nizar Wehbi
Dr. Nizar Wehbi

EXHIBIT

CC

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No.

DECLARATION OF LAURA RINGLING

1. My name is Laura Ringling, and I am Chief of Behavioral Health for the South Dakota Department of Social Services. I am also a resident of South Dakota and over the age of majority. I have personal knowledge of the facts in this declaration, and those facts are true and correct to the best of my knowledge.

2. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

3. The Human Services Center (HSC) in Yankton is the only state-operated inpatient psychiatric hospital in South Dakota. It is overseen by the South Dakota Department of Social Services.

4. HSC had 207 operating beds in SFY21.

5. HSC receives just under $8 million annually from Medicaid or Medicare, which accounts for approximately 15% of its budget.

6. As of August 2021, HSC's vacancy rate was 22.6%. Nursing and health care

workers in general are in high demand and filling positions has been challenging. Nearly 90% of the vacant positions are for direct care providers.

7. HSC currently has 120 employees whose vaccination status is unknown. However, we expect there will be some staff who leave employment at HSC due to the mandate.

8. Any loss of employees would impact services at HSC as our facility is already experiencing workforce shortages that have taken units offline, most recently an adolescent treatment unit. An inability to adequately staff HSC treatment units would require HSC to reduce the patient population, limit admissions, and potentially take an additional treatment unit offline. This would adversely impact inpatient psychiatric hospital capacity in South Dakota. Additionally, it could require that individuals needing emergency inpatient psychiatric treatment be held in jail settings or emergency rooms until capacity is available.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this the 12th day of November, 2021.

Laura Ringling

Laura Ringling
Chief of Behavioral Health

KRISTEN CAMPBELL
SEAL NOTARY PUBLIC SOUTH DAKOTA SEAL

Kristen Campbell

Commission expires on 8/31/2027

EXHIBIT

DD

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

STATE OF MISSOURI, et al., *Plaintiffs*, v. JOSEPH R. BIDEN, JR., et al., *Defendants*.	No.

DECLARATION OF STEFAN JOHANSSON

Pursuant to 28 U.S.C. § 1746, I hereby declare that the foregoing is true and correct:

1. I am the interim director for the Wyoming Department of Health. In that capacity, I am responsible for the management and oversight of the entire Department, which includes Medicaid, public health, aging services, behavioral health services, healthcare licensing and survey, and five state-run healthcare facilities. I am a resident of Wyoming and am over the age of majority. I have personal knowledge of all facts stated in this declaration.

2. Healthcare staffing shortages are a significant problem throughout Wyoming. During the COVID-19 pandemic, numerous healthcare facilities in Wyoming have had to rely extensively on contracted labor to cover shortages in healthcare workers, including state-run safety net facilities that serve individuals with mental illnesses, those with intellectual and developmental disabilities, and the elderly. In particular, the Wyoming State Hospital (a state-run psychiatric hospital) has had to fill between 6-11 full time equivalent employees with contracted workers (traveling nurses) over the past several months. Additionally, the Wyoming Retirement Center (a state-run skilled nursing facility) has had to fill between 12-14 full time equivalent employees with contracted

workers over the past several months. Soldiers from the National Guard were recently deployed to support the Wyoming Retirement Center during a major COVID-19 outbreak because of critically low staffing levels.

3. There are currently 97 soldiers from the National Guard supporting Wyoming hospitals, long term care facilities, and public health departments statewide.

4. The Wyoming Department of Health has allocated over $50 million since late 2020 to Wyoming hospitals and long-term care facilities. That money supports procurement of contract labor (e.g., agency/traveling nurses caused by staffing shortages) and supports retention funding for current facility staff that have worked through the pandemic. The $50 million also supports healthcare facilities at risk of losing workers who may terminate for a variety of reasons (exhaustion and burnout, better pay in other sectors, vaccine mandates, etc.). The money also supports continued recruitment of critical workforce (nurses, certified nursing assistants, etc.).

5. Moreover, there are currently two hospitals in Wyoming operating in crisis standards of care or near crisis standards due to critically low staffing levels and increased demand for care. The Wyoming Department of Health is supporting these hospitals with medical equipment and with soldiers from the National Guard.

6. The State of Wyoming itself runs three safety net healthcare facilities that receive funding from Medicaid and Medicare – the Wyoming State Hospital, the Wyoming Retirement Center, and the Wyoming Life Resource Center. The State Hospital has approximately 360 employees and an average daily census (number of patients) of 80 - 90 as of the date of this declaration. The Life Resource Center has approximately 250 employees and an average census of 50 - 60 as of the date of this declaration. The Retirement Center has approximately 75 employees and an average census of 70 as of the date of this declaration.

7. The workforce shortages that exist at the Wyoming healthcare facilities are significant. At our state-run facilities, current vacancy rates range from 20-38%. Other public and private healthcare facilities continually report critical levels of staffing due to shortages. In addition to factors that have led to current staffing shortages (exhaustion, burnout, better pay in other sectors), it is likely that vaccine mandates would cause additional loss of staff in the healthcare facilities throughout Wyoming, many of which operate in rural and frontier areas with small or limited labor markets.

8. There are significant numbers of staff at state-run healthcare facilities in Wyoming who have not received a COVID-19 vaccine at this time.

9. Currently in Wyoming there are 12 state surveyors – who perform duties related to assessing compliance with Medicare and Medicaid conditions of participation – all of whom are employed by the State of Wyoming.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 10th day of November 2021.

Stefan Johansson
Interim Director – Wyoming Department of Health