No. 21-3725

United States Court of Appeals for the Eighth Circuit

STATE OF MISSOURI, STATE OF NEBRASKA, *et al.*,
Plaintiffs-Appellees,

v.

JOSEPH R. BIDEN, JR., in his official capacity as the President of the United States of America, *et al.*,
Defendants-Appellants.

Reliant Care Management Company, L.L.C.,
Amicus Curiae,
American Academy of Family Physicians, *et al.*,
Amici on Behalf of Appellant(s).

Appeal from the United States District Court
for the Eastern District of Missouri, Eastern Division
The Honorable Matthew T. Schelp, United States District Judge

APPELLEES' UNOPPOSED MOTION TO EXPEDITE APPEAL

Counsel Listed on Inside Cover

ERIC S. SCHMITT
Attorney General of Missouri

D. John Sauer
Solicitor General
John.Sauer@ago.mo.gov

Jesus A. Osete
Deputy Attorney General
Jesus.Osete@ago.mo.gov

Maddie McMillian Green
Assistant Attorney General
Maddie.Green@ago.mo.gov

Office of the Attorney General
Supreme Court Building
207 W. High St.
P.O. Box 899
Jefferson City, Missouri 65102
Tel.: (573) 751-8870
Fax: (573) 751-0774

*Counsel for Appellees**

DOUGLAS J. PETERSON
Attorney General of Nebraska

James A. Campbell
Solicitor General
Jim.Campbell@nebraska.gov

Office of the Attorney General
2115 State Capitol
Lincoln, Nebraska 68509
Tel.: (402) 471-2682

*Additional counsel listed
on signature page

STATES' UNOPPOSED MOTION TO EXPEDITE APPEAL

Plaintiffs-Appellees States of Missouri, Nebraska, Arkansas, Kansas, Iowa, Wyoming, Alaska, South Dakota, North Dakota, and New Hampshire (the "States") face a crisis in rural healthcare, caused by the Center for Medicaid and Medicare's vaccine mandate for healthcare workers, 86 Fed. Reg. 61,555-61,627 ("Mandate"). One of the States' declarants aptly summarized this imminent crisis:

> I cannot express the extent of what is about to happen. Healthcare in this community and beyond … 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…. 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 as 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. I simply cannot put into words what this mandate will do to our community and our healthcare system.

App. 160-161, R. Doc. 9-16, at 6-7. This crisis is unfolding now. The district court's preliminary injunction is stayed pending the outcome of this appeal. *Biden v. Missouri*, 142 S. Ct. 647, 654-55 (2022). Rural healthcare facilities are already closing and cutting services as they feel the Mandate's effect.

Because of this imminent crisis, the States respectfully request expedited consideration of this appeal by whatever method the Court prefers, to obtain a

decision on the merits as quickly as possible. The States respectfully request that the Government file its Reply brief, without extension, by the current deadline of March 22, 2022. The Government has waived oral argument. Appellants' Br. i. The States agree to waive oral argument, or else they request expedited oral argument during the April 11-15, 2022 argument setting, and they respectfully request an expedited decision on the merits.[1]

FACTUAL AND PROCEDURAL BACKGROUND

On November 5, 2021, breaking with 50 years of consistent policy of not requiring vaccination of healthcare workers, CMS imposed its Mandate requiring COVID-19 vaccination for the vast majority of healthcare workers in America, comprising over 10 million workers. 86 Fed. Reg. 61,555-61,627. The States contain large rural areas where healthcare is provided, not by massive healthcare systems with tens of thousands of employees, but by small rural hospitals, community health centers, long-term care facilities, and similar facilities, which are staffed by a small numbers of employees drawn from the local rural community. States' Br. Statement of the Case, Part E.1; *see also* App. 89-224, R. Docs. 9-1 to 9-

[1] The States consulted with the federal Government about the relief requested in this Motion, and the Government stated its position as follows: "The federal government defers to the Court as to whether oral argument is necessary and the scheduling of argument. Government counsel will be unavailable on Friday, April 15 and between April 21-27 because of previously scheduled travel, and asks that the case not be heard on those days."

30 (thirty declarations from rural and state-run healthcare providers). Many of those facilities treat high-risk, vulnerable patients who have nowhere else to go, such as psychiatric patients and mentally disabled individuals. States' Br., Part E.2.

Before the Mandate, such rural facilities were already facing critical staffing shortages due to the pandemic's toll on the healthcare profession. *Id.* Part E.3. Without exception, these facilities hired and retained significant numbers of unvaccinated workers to address their staffing shortages, in direct reliance on CMS's longstanding policy of *not* mandating vaccines for healthcare workers. *Id.* Part E.4. The facilities were already observing COVID-19 precautions for unvaccinated workers that CMS admits are "highly effective," and as a result, they have not experienced significant issues of staff-to-patient COVID-19 transmission in their facilities. *Id.* Part E.5. Based on direct conversations with their employees, these facilities predicted that the Mandate would cause many qualified workers to quit, resulting in intolerable staffing losses on top of their preexisting critical staffing shortages. *Id.* Part E.6.

Based on these harsh realities, the States' declarants anticipated that the Mandate would have a devastating impact on rural healthcare in the States. *Id.* Part E.7. They predicted facility closures, closure of departments, cancellation of critical services, loss of emergency-response capability, long wait times, long travel distances to obtain basic life-saving services, and similar devastation. *See id.* These

problems threatened rural and state-run facilities in the ten Plaintiff States and, by extension, across rural America. *Id.*[2]

Rural facilities predicted across-the-board service reductions. One facility stated: "Emergency room patient volumes and acuity will increase due to inability to care for them in the clinic setting.… Of the 35 Med/Surg staff that we have, we may have to terminate 20 of them …. Who is going to care for our patients?" App. 202, R. Doc. 9-25, at 4; *see also id.* (predicting the need "to reduce services in the clinic, in outpatient services and in surgery," "to divert emergency patients," and to increase "[w]ait times for critical care patients," thus "making nursing ratios unsafe for the rest of the acute care patients"). Similarly, another rural hospital predicted, "[p]atients 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…. Patients needing life saving measures such as 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." App. 160, R. Doc. 9-16, at 6. Many other facilities predicted a wide variety of devastating impacts—such as reduced availability of

[2] Notwithstanding the Supreme Court's stay opinion, 26 States with substantial rural areas are continuing to challenge the Mandate in federal court—ten States in this coalition, 14 States in the Louisiana-led coalition in the U.S. District Court for the Western District of Louisiana (Case No. 3:21-cv-03970), and two States that have recently sought to join the Louisiana coalition.

emergency services, the inability to perform emergency C-sections, the inability to provide SAFE exams to rape victims, and the need to house people experiencing psychiatric emergencies in local jails. States' Br., Statement of the Case, Part E.7.

Facing an imminent crisis in the provision of rural healthcare, the States sued to block the Mandate, and the district court entered a preliminary injunction against the Mandate in the States. Add. 1-28; R. Doc. 28. The Government sought an emergency stay of the injunction from the Supreme Court, contending that patients in healthcare facilities faced an immediate and intolerable threat of transmission of COVID-19 from unvaccinated staff. On January 13, 2022, the Supreme Court stayed the district court's injunction pending appeal. *Biden v. Missouri*, 142 S. Ct. 647 (2022). The Supreme Court's stay remains in effect "pending disposition of the Government's appeal in the United States Court of Appeals for the Eighth Circuit and the disposition of the Government's petition for a writ of certiorari." *Id.* at 654.

The Government insisted to the Supreme Court that immediate relief was necessary to protect vulnerable patients from imminent death by COVID-19, and it obtained a stay on that basis on January 13, 2022. Then, on the very next day, the Government delayed full implementation of the Mandate for another 90 days. On January 14, 2022, CMS issued its Memorandum QSO-22-09-ALL, which provided a three-month, multi-stage timeframe for facilities to comply with the Mandate. *See* Department of Health & Human Services, Centers for Medicare and Medicaid

Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Mem. QSO-22-09-ALL, *Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination* 3-4 (Jan. 14, 2022) (attached as Exhibit A).

Under QSO-22-09-ALL, facilities must adopt a policy to require vaccination and have all workers obtain the first shot by February 14, 2022, to avoid technical non-compliance, but there are no penalties if a facility achieves 80 percent compliance by February 14. *Id.* at 3. After 60 days—*i.e.*, by March 15, 2022—covered workers must be fully vaccinated, and a facility must achieve 90 percent compliance to avoid repercussions. *Id.* at 4. Facilities that do not achieve 100 percent compliance within 90 days—*i.e.*, by April 14, 2022—then face enforcement actions. *Id.* at 5. In other words, facilities must achieve 80 percent compliance by February 14, 90 percent compliance by March 15, and 100 percent compliance by April 14, 2022. *Id.* QSO-22-09-ALL admits that achieving only partial compliance with the Mandate typically will *not* pose "a threat to patient health and safety": "States should work with their CMS location for cases that exceed these thresholds, *yet pose a threat to patient health and safety*." *Id.* at 3, 4 (emphasis added).

The Government's prolonged schedule for implementing the Mandate was perhaps driven by fear of fomenting the very crisis in rural healthcare that CMS ignored in its rulemaking. But the Government's slow-walking of the Mandate has

only slow-walked the unfolding of that crisis; it has not prevented it. The States are already facing the closure of rural facilities and reduction of services due to the Mandate.

For example, Missouri is already experiencing closures of much-needed skilled nursing facilities and other care facilities in rural areas. Anticipating a wave of facility closures from the Mandate, Missouri's Department of Health and Senior Services adopted an emergency regulation on November 10, 2021, permitting skilled nursing and intermediate care facilities to "temporarily close for up to two years to due to staffing shortages as a result of [the] COVID-19 vaccine mandate" issued by CMS on November 5, 2021. Bollin Decl. ¶¶ 4-5 (attached as Exhibit B). After the Supreme Court stayed the preliminary injunction and CMS reinstated its enforcement plans for the Mandate on January 14, 2022, "DHSS has received closure plans from eight (8) facilities so far." *Id.* ¶ 8. Three facilities have closed completely, two are in the process of closing, and three "will begin implementing their closure plan soon." *Id.*

Likewise, one private health system of skilled nursing facilities in Missouri reports that, "[a]s a result of implementation of the CMS vaccine mandate … 5 [of its] skilled nursing facilities[3] have closed or are in the process of closing since

[3] These five skilled nursing facilities are included in the eight facility closures discussed in the Bollin Declaration, *supra*.

February 2, 2022. If the mandate remains in place, *more will close*." McClain Decl., ¶ 12 (attached as Exhibit C) (emphasis added). In addition, "[m]any of the facilities" that remain open "are unable to admit residents due to lack of staff," and "[s]ome have been forced to reduce their patient census in order to provide proper care." *Id.*

A now-shuttered nursing home in rural Missouri describes the Mandate's devastating effect on small communities. The Scotland County Care Center in Memphis, Missouri was forced to shut down permanently, shortly after the Mandate was imposed. "Because we were forced to close our doors, we have had to displace the residents … who desire to live in the community where they have lived their entire lives." Schrage Decl., ¶ 11 (attached as Exhibit D). "It was extremely difficult and heart wrenching to relocate our residents. Most nearby nursing homes could not accept new residents because they did not have enough staffing themselves to take on new clients," which "forced families to look further away for placement options." *Id.* "The impact on our community was devastating as the nursing home has been a large source of employment in Scotland County." *Id.* "Community members have strong ties to the nursing home and remember this as the place where their parents and grandparents lived, were cared for, and died amongst familiar caring staff." *Id.*

Many small healthcare facilities report critical staffing losses due to the Mandate, and are desperately hanging on by filling shortfalls with expensive,

financially unsustainable travel staff. The experience of Stevens County Hospital in Hugoton, Kansas, is typical. In the Mandate's wake, that small rural hospital "has had to implement crisis staffing standards," thus "causing us to pay exorbitant agency costs to cover open shifts." Stalcup Decl. ¶¶ 12, 14 (attached as Exhibit E). "The current path we are on is not financially sustainable." *Id.* ¶ 14. "Our staff is already exhausted and overworked," and "it is difficult for us to find beds for critically ill patients entering our doors, causing our nursing staff to perform patient care above their scope and experience." *Id.* ¶ 15.

Similarly, the overseer of 13 skilled nursing facilities in Kansas reports: "Because of the heavy burden imposed by the [Mandate], we are barely able to staff our Facilities. We have had to limit admissions because it would be unsafe to try and care for additional residents. … [W]e cannot find people to hire regardless of pay increases and bonuses we offer. Imposition of the Mandate is exasperating [*sic*] our already desperate situation." Ribordy Decl., ¶ 13 (attached as Exhibit F).

In other words, the crisis in rural healthcare that the States' declarants predicted is already unfolding, and it will undoubtedly worsen as the next two deadlines approach—90 percent compliance in mid-March, and full enforcement of the Mandate in mid-April. Though the Mandate is striking with speed of an anaconda rather than a pit viper, its effect is just as deadly. To address these harms

as quickly as possible, the States respectfully request an expedited disposition of this appeal.

The Fifth Circuit's recent decision in *Texas v. Biden* provides a recent example of such expeditious consideration. In that case, Missouri and Texas obtained an injunction preventing the Department of Homeland Security from terminating the "Migrant Protection Protocols" program. *Texas v. Biden*, No. 2:21-CV-067-Z, 2021 WL 3603341, at *27 (N.D. Tex. Aug. 13, 2021). The Government sought stays of the injunction from the Fifth Circuit and the Supreme Court, which were denied. *Texas v. Biden*, 10 F.4th 538 (5th Cir. 2021); *Biden v. Texas*, 210 L. Ed. 2d 1014 (U.S. Aug. 24, 2021). The Fifth Circuit expedited the Government's appeal "for consideration before the next available oral argument panel." *Texas*, 10 F.4th at 560-61. The Fifth Circuit imposed an accelerated briefing schedule, held oral argument on that expedited basis, and issued its decision on the merits within four months of the district court's decision. *Texas v. Biden*, 20 F.4th 928, 1004 (5th Cir. Dec. 13, 2021).

The States respectfully request similar expedited consideration here. The Government's opening brief in this Court was accepted for filing on February 3, 2022. The States filed their Brief of Appellees seven days early, and it was accepted for filing on March 1, 2022. The States propose that the Government should file its Reply brief within the 21-day period allotted by the Federal Rules of Appellate

Procedure, without extension, by March 22, 2022. The States request that this Court issue its decision on an expedited basis as soon as reasonably possible as briefing is concluded. To that end, the States either agree to waive oral argument, or else request that oral argument be scheduled at the soonest possible opportunity after briefing is concluded, such as during the Court's sitting scheduled for April 11-15, 2022.

CONCLUSION

For the reasons stated, Appellees respectfully request that this Court grant expedite consideration of this appeal, and to that end order: (1) that the Government should file its Reply brief on the current due date of March 22, 2022, without extensions, and (2) that the Court should either waive oral argument or conduct oral argument during its April 11-15, 2022, setting, for the purpose of providing a disposition on the merits as soon as reasonably possible after the case is submitted.

Respectfully submitted,

ERIC S. SCHMITT
Attorney General of Missouri

/s/ D. John Sauer

D. JOHN SAUER, 58721 MO
Solicitor General

JESUS A. OSETE
Deputy Attorney General
MADDIE MCMILLIAN GREEN
Assistant Attorney General

Office of the Attorney General
Supreme Court Building
207 W. High St.
P.O. Box 899
Jefferson City, Missouri 65102
Tel.: (573) 751-8870
Fax: (573) 751-0774
John.Sauer@ago.mo.gov

Counsel for Appellees

DOUGLAS J. PETERSON
Attorney General of Nebraska

JAMES A. CAMPBELL
Solicitor General

Office of the Attorney General
2115 State Capitol
Lincoln, Nebraska 68509
Tel.: (402) 471-2682

*Additional counsel listed on following pages

Additional counsel:

LESLIE RUTLEDGE
Attorney General of Arkansas
Dylan L. Jacobs
Deputy Solicitor General
Dylan.Jacobs@arkansasag.gov
Office of the Attorney General
323 Center St., Suite 200
Little Rock, Arkansas 72201
Tel.: (501) 682-2007

DEREK SCHMIDT
Attorney General of Kansas
Kurtis Wiard
Assistant Solicitor General
Kurtis.Wiard@ag.ks.gov
Office of the Attorney General
120 SW 10th Avenue, 2nd Floor
Topeka, Kansas 66612
Tel.: (785) 296-2215
Fax: (785) 296-6296

JEFFREY S. THOMPSON
Solicitor General of Iowa
Samuel P. Langholz
Assistant Solicitor General
Sam.Langholz@ag.iowa.gov
Office of the Attorney General
1305 E. Walnut Street
Des Moines, Iowa 50319
Tel.: (515) 281-5164

BRIDGET HILL
Attorney General of Wyoming
Ryan Schelhaas
Chief Deputy Attorney General
Ryan.Schelhaas@wyo.gov
Office of the Attorney General
109 State Capitol
Cheyenne, Wyoming 82002
Tel.: (307) 777-5786

TREG R. TAYLOR
Attorney General of Alaska
Cori M. Mills
Deputy Attorney General
Cori.Mills@alaska.gov
Alaska Department of Law
1031 W. 4th Avenue, Suite 200
Anchorage, Alaska 99502
Tel.: (907) 269-5100

JASON R. RAVNSBORG
South Dakota Attorney General
David M. McVey
Assistant Attorney General
David.McVey@state.sd.us
Office of the Attorney General
1302 E. Highway 14, Suite 1
Pierre, South Dakota 57501-8501
Tel.: (605) 773-3215

DREW H. WRIGLEY
North Dakota Attorney General
Matthew A. Sagsveen
Solicitor General
Masagsve@nd.gov
Office of Attorney General
500 North 9th Street
Bismarck, ND 58501-4509
Tel.: (701) 328-3640
Fax: (701) 328-4300

JOHN M. FORMELLA
New Hampshire Attorney General
Anthony J. Galdieri
Solicitor General
Anthony.J.Galdieri@doj.nh.gov
New Hampshire Department of Justice
33 Capitol Street
Concord, NH 03301
Tel.: (603) 271-3658

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this Motion complies with the typeface and formatting requirements of Fed. R. App. P. 32, that it is written in Times New Roman 14-point font, and that it contains 2,674 words as determined by the word-count feature of Microsoft Word. Both the Motion and its attachments have been scanned for viruses and are virus-free.

/s/ D. John Sauer

CERTIFICATE OF SERVICE

I hereby certify that on March 2, 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ D. John Sauer

EXHIBIT

A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-09-ALL

DATE: **January 14, 2022**

TO: State Survey Agency Directors

FROM: Directors
Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination

Memorandum Summary

- CMS is committed to ensuring America's healthcare facilities respond effectively in an evidence-based way to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On November 05, 2021, CMS published an interim final rule with comment period (IFC). This rule establishes requirements regarding COVID-19 vaccine immunization of staff among Medicare- and Medicaid-certified providers and suppliers.
- CMS is providing guidance and survey procedures for assessing and maintaining compliance with these regulatory requirements.
- The guidance in this memorandum specifically applies to the following states: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia and Wyoming.
- The guidance in this memorandum does not apply to the following state at this time: Texas. **Surveyors in Texas should not undertake any efforts to implement or enforce the IFC.**
- States that are not identified above are expected to continue under the timeframes and parameters identified in the December 28, 2021 memorandum (QSO-22-07-ALL).

Background

Since the beginning of the Public Health Emergency, CMS and the Centers for Disease Control and Prevention (CDC) data show as of mid-October, over 44 million COVID-19 cases, 3 million COVID-19 related hospitalization, and 720,000 COVID-19 deaths have been reported. The CDC has reported that COVID-19 vaccines are safe and effective at preventing severe illness from COVID-19 and limiting the spread of the virus that causes it. On December 11, 2020, the Advisory Committee in Immunization Practices (ACIP) recommended, as interim guidance, that both 1) health care personnel, and 2) residents of long-term care (LTC) facilities be offered COVID-19 vaccine in the initial phase of the vaccination program. To support this

recommendation, on May 13, 2021, CMS published an interim final rule with comment period (IFC), entitled "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 FR 26306). Also, CMS released guidance for surveyors and LTC facilities in the CMS memo, QSO-21-19-NH, Interim Final Rule - COVID-19 Vaccine Immunization Requirements for Residents and Staff. This rule required all certified LTC facilities (i.e., nursing homes) to educate all residents and staff on the benefits and potential side effects associated with the COVID-19 vaccine, and offer the vaccine.

The regulation was intended to help increase vaccination rates among nursing home residents and staff to reduce the risk of infection and disease associated with COVID-19. Approximately two months after the publication of the rule, about 80 percent of nursing home residents were vaccinated. However, during that same time, roughly 60% of nursing home staff were vaccinated.[1] Therefore, more actions are warranted to increase vaccination rates among staff.

On August 18, 2021, CMS announced that it would be issuing a regulation that all nursing home staff would have to be vaccinated against COVID-19 as a requirement for LTC facilities participating with the Medicare and Medicaid programs. Subsequently, on September 9, 2021, CMS announced that this requirement would be extended to nearly all Medicare and Medicaid-certified providers and suppliers. These actions aim to support increasing vaccination rates among staff working in all facilities, providers, and certified suppliers that participate in Medicare and Medicaid.

Discussion

On November 5, 2021, CMS published an IFC with comment period (86 FR 61555), entitled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," revising the infection control requirements that most Medicare- and Medicaid-certified providers and suppliers must meet to participate in the Medicare and Medicaid programs. These changes are necessary to protect the health and safety of patients and staff during the COVID-19 public health emergency. The COVID-19 vaccination requirements and policies and procedures required by this IFC must comply with applicable federal non-discrimination and civil rights laws and protections, including providing reasonable accommodations to individuals who are legally entitled to them because they have a disability or sincerely held religious beliefs, practices, or observations that conflict with the vaccination requirement. More information on federal non-discrimination and civil rights laws is available here: https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws.

Vaccination Enforcement– Surveying for Compliance

Medicare and Medicaid-certified facilities are expected to comply with all regulatory requirements, and CMS has a variety of established enforcement remedies. For nursing homes, home health agencies, and hospice (beginning in 2022), this includes civil monetary penalties, denial of payments, and—as a final measure—termination of participation from the Medicare and Medicaid programs. The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination; however, CMS's primary goal is to bring health care facilities into compliance. Termination would generally occur only after providing a facility with an opportunity to make corrections and come into compliance.

[1] COVID-19 Nursing Home Data - Centers for Medicare & Medicaid Services Data (cms.gov)

CMS expects all providers' and suppliers' staff to have received the appropriate number of doses by the timeframes specified in the QSO-22-07 unless exempted as required by law, or delayed as recommended by CDC. **Facility staff vaccination rates under 100% constitute non-compliance under the rule.** Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance. Consistent with CMS's existing enforcement processes, this guidance will help surveyors determine the severity of a noncompliance deficiency finding at a facility when assigning a citation level. These enforcement action thresholds are as follows:

Within 30 days after issuance of this memorandum[2], if a facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[3] of their non-compliance with the 100% standard. A facility that is above 80% **and** has a plan to achieve a 100% staff vaccination rate within 60 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 60 days after the issuance of this memorandum[4], if the facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-**

[2] If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
[3] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) federal tag.
[4] If 60 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.

compliant under the rule. The facility will receive notice[5] of their non-compliance with the 100% standard. A facility that is above 90% **and** has a plan to achieve a 100% staff vaccination rate within 30 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action.

Federal, state, Accreditation Organization, and CMS-contracted surveyors will begin surveying for compliance with these requirements as part of initial certification, standard recertification or reaccreditation, and complaint surveys 30 days following the issuance of this memorandum. Additional information and expectations for compliance can be found at the provider-specific guidance attached to this memorandum.

Provider-Specific Guidance:

Guidance specific to provider types and certified suppliers is provided in the following attachments. The provider-specific guidance should be used in conjunction with the information in this memo.

- Attachment A: LTC Facilities (nursing homes)
- Attachment B: ASC
- Attachment C: Hospice
- Attachment D: Hospitals
- Attachment E: PRTF
- Attachment F: ICF/IID
- Attachment G: Home Health Agencies
- Attachment H: CORF
- Attachment I: CAH
- Attachment J: OPT
- Attachment K: CMHC
- Attachment L: HIT
- Attachment M: RHC/FQHC
- Attachment N: ESRD Facilities

Enforcement Actions

CMS will follow current enforcement procedures based on the level of deficiency cited during a survey.

Contact:
DNH_TriageTeam@cms.hhs.gov for questions related to nursing homes;

[5] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) tag.

QSOG_Emergencyprep@cms.hhs.gov for question related to acute and continuing care providers.

Effective Date: This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Location training coordinators immediately. The effective dates of the specific actions are specified above.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Attachments: A through N

EXHIBIT

B

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

STATE OF MISSOURI, et al., *Appellees*, v. JOSEPH R. BIDEN, JR., et al., *Appellants*.	No. 21-3725

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 regulates a variety of entities including intermediate care and skilled nursing facilities.

4. DHSS filed emergency and proposed amendments to 19 CSR 30-82.010 General Licensure Requirements with the Missouri Secretary of State and the Joint Committee on Administrative Rules on November 10, 2021. The

emergency amendment to 19 CSR 30-82.010 General Licensure Requirements became effective on November 29, 2021. Attached hereto as Exhibit 1 is a true and correct copy of the emergency and proposed amendments to 19 CSR 30-82.010, which is publicly available in the December 15, 2021, online edition of the Missouri Register on the Missouri Secretary of State's website at www.sos.mo.gov/default.aspx?PageID-10129.

5. The emergency and proposed amendments to 19 CSR 30-82.010 General Licensure Requirements added an option for skilled nursing and intermediate care facilities to temporarily close for up to two years due to staffing shortages as a result of a COVID-19 vaccine mandate first issued in emergency regulation by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") on November 4, 2021, effective on November 5, 2021.

6. Temporary closures allow the skilled nursing and intermediate care facilities to not have to voluntarily relinquish their license. If skilled nursing facilities or intermediate care facilities close, then they have to give up their Medicare and Medicaid provider agreement with CMS. It can take up to six (6) months to apply for and get approved to be a Medicare and Medicaid provider again. Additionally, if skilled nursing facilities and intermediate care facilities close, then these facilities must comply with all new requirements since these facilities will be considered to be new facilities and not existing facilities. This can be very expensive for facilities to meet new requirements that they did not

have to meet as existing facilities. By allowing skilled nursing and intermediate care facilities to temporarily close and not have to relinquish their license, then facilities can reopen quicker under less onerous requirements.

7. Following the lifting of all injunctions against this COVID-19 vaccine mandate by the United States Supreme Court, CMS issued a memo to all state survey agencies on January 14, 2022, setting forth actions that skilled nursing and intermediate care facilities must have completed by thirty (30) days, sixty (60) days and ninety (90) days from the date of the memo (January 14, 2022). Attached hereto as Exhibit 2 is a true and correct copy of Guidance for the Interim Final Rule – Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, QSO-22-09-ALL, which is publicly available on CMS's website at https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-1.

8. DHSS has received closure plans from eight (8) facilities so far since the memo in Exhibit 2 was issued on January 14, 2022. Three (3) of those facilities have temporarily closed. Two (2) of those facilities are actively implementing their closure plans. Three (3) of those facilities have been approved by DHSS and these facilities will begin implementing their closure plan soon.

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

Executed on this 28 day of February, 2022.

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

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 82—General Licensure Requirements

EMERGENCY AMENDMENT

19 CSR 30-82.010 General Licensure Requirements. The department is amending section (3).

PURPOSE: This emergency amendment creates a temporary closure procedure for those Medicare and Medicaid federally certified facilities (skilled nursing facilities and intermediate care facilities) licensed in Missouri which experience staffing shortages from the COVID-19 vaccine mandate issued by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services emergency regulation 42 CFR part 483 for long term care facilities and intermediate care facilities on November 4, 2021, with an effective date of November 5, 2021.

*EMERGENCY STATEMENT: The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") issued an emergency regulation on November 4, 2021, with an effective date of November 5, 2021, which amended 42 CFR part 483. The emergency amendments made to 42 CFR part 483 affect long term care facilities in Missouri, which are federally certified by CMS as skilled nursing facilities and intermediate care facilities. These emergency amendments made to 42 CFR part 483 require, among other things, that current staff as well as any new staff who provide any care, treatment, or other services for the facility and/or its patients must receive the COVID-19 vaccine. However, there is an exemption procedure outlined in the emergency regulation. Facilities covered by this regulation are required to establish a policy ensuring all eligible staff have received the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine prior to providing any care, treatment, or other services by December 5, 2021. All eligible staff must have received the necessary shots to be fully vaccinated – either two doses of Pfizer or Moderna or one dose of Johnson & Johnson – by January 4, 2022. The Missouri Department of Health and Senior Services anticipates most eligible staff at these long term care facilities (skilled nursing facilities and intermediate care facilities) will be required to get an approved COVID-19 vaccination as most of these eligible staff will not meet the requirements for the exemption procedure as set forth in emergency regulation 42 CFR part 483. Currently, approximately forty-four percent (44%) of staff working at Missouri long term care facilities are not fully vaccinated for COVID-19. The Missouri Department of Health and Senior Services anticipates many of the forty-four percent (44%) of unvaccinated staff working at these long term care facilities will not choose to get vaccinated, even with this vaccine mandate from CMS. Therefore, there may be some long term care facilities (skilled nursing facilities and intermediate care facilities) that will not have enough staff to care for the residents in its facilities and be in compliance with federal and state law. These facilities may be forced to temporarily close or consolidate until the staffing issues get rectified in such a manner as these facilities will be able to comply with federal and state law. Currently, the Missouri Department of Health and Senior Services does not have a procedure in its regulations which would allow for the temporary closure of skilled nursing facilities and intermediate care facilities licensed in Missouri by the Missouri Department of Health and Senior Services. This emergency amendment will allow skilled nursing facilities and intermediate care facilities to temporarily close due to staffing shortages as a result of the vaccine mandate contained in 42 CFR part 483. Temporary closures allow the skilled nursing facilities and intermediate care facilities to not have to voluntarily relinquish their license. If skilled nursing facilities or intermediate care facilities close, then they have to give up their Medicare and Medicaid provider agreement with CMS. It can take up to six (6) months to apply for and get approved to be a Medicare and Medicaid provider again. Additionally, if skilled nursing facilities and intermediate care facilities close, then these facilities must comply with all new requirements since these facilities will be considered to be new facilities and not existing facilities. This can be very expensive for facilities to meet new requirements that they did not have to meet as existing facilities. This amendment is an emergency as facilities, which anticipate additional staffing shortages, will be needing to make plans to begin discharging residents and pursuing temporary closures before the December 5, 2021 and January 4, 2022, deadlines mandated by 42 CFR part 483. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 10, 2021, becomes effective November 29, 2021, and expires May 27, 2022.*

(3) **Licensed Facility Closures.**

(A) If a licensed facility discontinues operation as evidenced by the fact that no residents are in care or at any time the department is unable to freely gain entry into the facility to conduct an inspection,

the facility shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

(B) If any licensed skilled nursing facility or intermediate care facility is required to temporarily close for two (2) years or less from the effective date of the temporary closure due to staffing shortages as a result of a COVID-19 vaccine mandate first issued in emergency regulation by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") on November 4, 2021, effective on November 5, 2021, or any amendment changes or amendments thereafter, then the skilled nursing and intermediate care facilities shall do the following:

1. The facility operator shall submit a closure plan to the department which is in compliance with state and federal law, including 42 CFR part 483.15(c) (detailed in federal deficiency F623 in the State Operations Manual appendix PP), 42 CFR part 483.70(l) (detailed in federal deficiency F845 in the State Operations Manual appendix PP), and 42 CFR 483.70(m) (detailed in federal deficiency F846 in the State Operations Manual appendix PP). The State Operations Manual appendix PP revised November 22, 2017, which is incorporated by reference in this rule, as published by the Centers for Medicare and Medicaid Services and is available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf or the United States Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244. This rule does not incorporate any subsequent amendments or additions. After review of the temporary closure plan, the department shall either approve or disapprove the plan;

2. Facilities with approved closure plans by the department shall ensure that all residents residing at the facility are provided discharge notices in accordance with federal and state law and the facility shall assist all residents with discharge planning in accordance with federal and state law;

3. Facilities with approved closure plans by the department shall enter into a consent agreement with the department for a probationary license. These facilities shall agree to discharge all residents by the effective date of the temporary closure and to admit no residents while the facility is temporarily closed;

4. Temporary closure of facilities shall not be allowed past two (2) years from the effective date of the temporary closure. The effective date of the temporary closure is the date the last resident left the facility;

5. Facilities shall be reopened within two (2) years of the effective date of the temporary closure. Prior to reopening, the department shall conduct a full survey/inspection and the facility may be approved by the department to reopen after this survey or inspection. Facilities shall not reopen until approved by the department;

6. Facilities shall be reopened by the facility operator which initiated the temporary closure and a change of operator may not occur during this period of temporary closure;

7. Facilities shall submit plans of corrections, applications, licensure and certification fees in accordance with state law regardless of temporary closure status;

8. Facilities approved by the department to be temporarily closed will be noted as temporarily closed on state directories. The department will communicate temporary closure status of these facilities approved for temporary closure to CMS; and

9. Facilities not approved for temporary closure by the department which have closed or those facilities which stayed closed longer than two (2) years from the effective date of the temporary closure shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

*AUTHORITY: Executive Order 77-9 of the Governor filed Jan. 31, 1979, effective Sept. 28, 1979, and sections 198.018, 198.073, 198.076, and 198.079, RSMo [Supp. 2007] **2016**. This rule was originally filed as 13 CSR 15-10.010. Emergency rule filed Aug. 13, 1979, effective Oct. 1, 1979, expired Jan. 25, 1980. Original rule filed Aug. 13, 1979, effective Dec. 13, 1979. Emergency amendment filed Nov. 10, 2021, effective Nov. 29, 2021, expires May 27, 2022. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

EXECUTIVE ORDER
21-12

WHEREAS, Section 105.454(5), RSMo, requires the Governor to designate those members of his staff who have supervisory authority over each department, division, or agency of state government for purposes of the application of such subdivision.

NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby designate the following members of my staff as having supervisory authority over the following departments, divisions, or agencies of state government for the purposes of Section 105.454(5), RSMo:

Office of Administration	Andrew Bailey
Department of Agriculture	Kayla Hahn
Department of Conservation	Kayla Hahn
Department of Corrections	Alex Tuttle
Department of Economic Development	Aaron Willard
Department of Elementary and Secondary Education	Kayla Hahn
Department of Health and Senior Services	Alex Tuttle
Department of Higher Education and Workforce Development	Aaron Willard
Department of Commerce and Insurance	Alex Tuttle
Department of Labor and Industrial Relations	Alex Tuttle
Department of Mental Health	Alex Tuttle
Department of Natural Resources	Andrew Bailey
Department of Public Safety	Andrew Bailey
Department of Revenue	Alex Tuttle
Department of Social Services	Alex Tuttle
Department of Transportation	Aaron Willard
Missouri Housing Development Commission	Kayla Hahn
Boards Assigned to the Governor	Kyle Aubuchon
Unassigned Boards and Commissions	Kyle Aubuchon

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 5th day of November, 2021.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 82—General Licensure Requirements

PROPOSED AMENDMENT

19 CSR 30-82.010 General Licensure Requirements. The department is amending section (3).

PURPOSE: This amendment creates a temporary closure procedure for those Medicare and Medicaid federally certified facilities (skilled nursing facilities and intermediate care facilities) licensed in Missouri which experience staffing shortages from the COVID-19 vaccine mandate issued by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services emergency regulation 42 CFR part 483 for long term care facilities and intermediate care facilities on November 4, 2021, with an effective date of November 5, 2021.

(3) **Licensed Facility Closures.**

(A) If a licensed facility discontinues operation as evidenced by the fact that no residents are in care or at any time the department is unable to freely gain entry into the facility to conduct an inspection, the facility shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

(B) If any licensed skilled nursing facility or intermediate care facility is required to temporarily close for two (2) years or less from the effective date of the temporary closure due to staffing shortages as a result of a COVID-19 vaccine mandate first issued in emergency regulation by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on November 4, 2021, effective on November 5, 2021, or any amendment changes or amendments thereafter, then the skilled nursing and intermediate care facilities shall do the following:

1. The facility operator shall submit a closure plan to the department which is in compliance with state and federal law, including 42 CFR part 483.15(c) (detailed in federal deficiency F623 in the *State Operations Manual* appendix PP), 42 CFR part 483.70(l) (detailed in federal deficiency F845 in the *State Operations Manual* appendix PP), and 42 CFR 483.70(m) (detailed in federal deficiency F846 in the *State Operations Manual* appendix PP). The *State Operations Manual* appendix PP revised November 22, 2017, which is incorporated by reference in this rule, as published by the Centers for Medicare and Medicaid Services and is available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf or the United States Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244. This rule does not incorporate any subsequent amendments or additions. After review of the temporary closure plan, the department shall either approve or disapprove the plan;

2. Facilities with approved closure plans by the department shall ensure that all residents residing at the facility are provided discharge notices in accordance with federal and state law and the facility shall assist all residents with discharge planning in accordance with federal and state law;

3. Facilities with approved closure plans by the department shall enter into a consent agreement with the department for a probationary license. These facilities shall agree to discharge all residents by the effective date of the temporary closure and to admit no residents while the facility is temporarily closed;

4. Temporary closure of facilities shall not be allowed past two (2) years from the effective date of the temporary closure. The effective date of the temporary closure is the date the last resident left the facility;

5. Facilities shall be reopened within two (2) years of the effective date of the temporary closure. Prior to reopening, the department shall conduct a full survey/inspection and the facility may be approved by the department to reopen after this survey or inspection. Facilities shall not reopen until approved by the department;

6. Facilities shall be reopened by the facility operator which initiated the temporary closure and a change of operator may not occur during this period of temporary closure;

7. Facilities shall submit plans of corrections, applications, licensure and certification fees in accordance with state law regardless of temporary closure status;

8. Facilities approved by the department to be temporarily closed will be noted as temporarily closed on state directories. The department will communicate temporary closure status of these facilities approved for temporary closure to CMS; and

9. Facilities not approved for temporary closure by the department which have closed or those facilities which stayed closed longer than two (2) years from the effective date of the temporary closure shall be considered closed. The department shall notify the operator in writing requesting the voluntary surrender of the license. If the department does not receive the license within thirty (30) days, it shall be void. If the operator should choose to again license the facility, the operator shall submit a complete application. The provisions of section (1) shall apply.

AUTHORITY: Executive Order 77-9 of the Governor filed Jan. 31, 1979, effective Sept. 28, 1979, and sections 198.018, 198.073, 198.076, and 198.079, RSMo [Supp. 2007] 2016. This rule was originally filed as 13 CSR 15-10.010. Emergency rule filed Aug. 13, 1979, effective Oct. 1, 1979, expired Jan. 25, 1980. Original rule filed Aug. 13, 1979, effective Dec. 13, 1979. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Nov. 10, 2021, effective Nov. 29, 2021, expires May 27, 2022. Amended: Filed Nov. 10, 2021.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Carmen Grover-Slattery, Regulation Unit Manager, Section for Long-Term Care Regulation, PO Box 570, Jefferson City, MO 65102-0570 or at RegulationUnit@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 500—Property and Casualty
Chapter 1—Property and Casualty Insurance in General

PROPOSED AMENDMENT

20 CSR 500-1.100 Standard Fire Policies. The department is amending paragraph (2)(A)3.

PURPOSE: This amendment implements changes required as a result of section 379.150, RSMo, as amended by HB 604 (2021).

(2) Mandated Changes to Standard Fire Policy.

(A) These provisions shall apply to all fire insurance policies issued or renewed pursuant to sections 375.001–375.008, 379.160, and 379.810–379.880, RSMo, after August 7, 1964*[:]*.

1. That portion of the 1943 Standard Fire Insurance Policy for New York which gives "the insured five (5) days' written notice of cancellation" on line 62 of the policy form shall be given no effect where contained within a policy designated as the "Standard Fire Insurance Policy for Missouri" insuring property located in this state, except as stated in paragraph (2)(A)2. of this regulation.

2. The language in the 1943 Standard Fire Insurance Policy for New York contained in lines 60–67 shall be superseded with the following language printed anywhere on this policy or amendatory endorsement: "This policy may be canceled, not renewed, reduced in amount or adversely modified at any time by the company by giving to the insured thirty (30) days' written notice of such action with or without tender of the excess of paid premium above the *pro rata* premium for the expired time, which excess, if not tendered, shall be refunded on demand. Only ten (10) days notice is required where such action is based upon non-payment of premium or evidence of incendiarism by the insured."

3. The language in lines 141–147 of the 1943 Standard Fire Insurance Policy for New York relating to "company's options" shall be superseded by *[the following or equivalent language: "Upon partial destruction or damage to insured property, this company shall pay the insured a sum of money equal to the damage done or repair the same to the extent of such damage, not exceeding the amount written in the policy, so that said property shall be in as good condition as before the fire, at the option of the insured, pursuant to section 379.150, RSMo (1986)."]* **the language quoted in section 379.150, RSMo, or by other language that provides coverage for a partial loss caused by fire in a policy form determined and approved by the director to be at least as favorable to the insured as the standard fire insurance policy for Missouri.**

4. The language in lines 123–140 of the 1943 Standard Fire Insurance Policy of New York relating to "appraisal" shall be superseded by the following or equivalent language: "In case the insured and this company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty (20) days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen (15) days to agree upon such umpire, then, on request of the insured or this company, such umpire shall be selected by a judge of a court of record in the state and county (or city if the city is not within a county) in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. The umpire shall make the award within thirty (30) days after the umpire receives the appraisers' submissions of their differences. An award in writing, so itemized, of any two (2) when filed with this company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting such appraiser and the expenses of appraisal and umpire shall be paid by the parties equally."

AUTHORITY: sections 374.045[, 379.150, 379.160] and 379.840, RSMo [2000] 2016, and sections 379.150 and 379.160, RSMo Supp. 2021. This rule was previously filed as 4 CSR 190-16.060. This version of ***the*** *rule filed July 27, 1964, effective Aug. 7, 1964. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Nov. 10, 2021.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Commerce and Insurance, Attention: Josh Wille, PO Box 690, Jefferson City, Missouri 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 10:00 a.m. on January 19, 2022, at the Missouri Department of Commerce and Insurance, Room 530, 301 West High Street, Jefferson City, Missouri 65101.*

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-09-ALL

DATE: **January 14, 2022**

TO: State Survey Agency Directors

FROM: Directors
Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination

Memorandum Summary

- CMS is committed to ensuring America's healthcare facilities respond effectively in an evidence-based way to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- On November 05, 2021, CMS published an interim final rule with comment period (IFC). This rule establishes requirements regarding COVID-19 vaccine immunization of staff among Medicare- and Medicaid-certified providers and suppliers.
- CMS is providing guidance and survey procedures for assessing and maintaining compliance with these regulatory requirements.
- The guidance in this memorandum specifically applies to the following states: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia and Wyoming.
- The guidance in this memorandum does not apply to the following state at this time: Texas. **Surveyors in Texas should not undertake any efforts to implement or enforce the IFC.**
- States that are not identified above are expected to continue under the timeframes and parameters identified in the December 28, 2021 memorandum (QSO-22-07-ALL).

Background

Since the beginning of the Public Health Emergency, CMS and the Centers for Disease Control and Prevention (CDC) data show as of mid-October, over 44 million COVID-19 cases, 3 million COVID-19 related hospitalization, and 720,000 COVID-19 deaths have been reported. The CDC has reported that COVID-19 vaccines are safe and effective at preventing severe illness from COVID-19 and limiting the spread of the virus that causes it. On December 11, 2020, the Advisory Committee in Immunization Practices (ACIP) recommended, as interim guidance, that both 1) health care personnel, and 2) residents of long-term care (LTC) facilities be offered COVID-19 vaccine in the initial phase of the vaccination program. To support this

recommendation, on May 13, 2021, CMS published an interim final rule with comment period (IFC), entitled "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 FR 26306). Also, CMS released guidance for surveyors and LTC facilities in the CMS memo, QSO-21-19-NH, Interim Final Rule - COVID-19 Vaccine Immunization Requirements for Residents and Staff. This rule required all certified LTC facilities (i.e., nursing homes) to educate all residents and staff on the benefits and potential side effects associated with the COVID-19 vaccine, and offer the vaccine.

The regulation was intended to help increase vaccination rates among nursing home residents and staff to reduce the risk of infection and disease associated with COVID-19. Approximately two months after the publication of the rule, about 80 percent of nursing home residents were vaccinated. However, during that same time, roughly 60% of nursing home staff were vaccinated.[1] Therefore, more actions are warranted to increase vaccination rates among staff.

On August 18, 2021, CMS announced that it would be issuing a regulation that all nursing home staff would have to be vaccinated against COVID-19 as a requirement for LTC facilities participating with the Medicare and Medicaid programs. Subsequently, on September 9, 2021, CMS announced that this requirement would be extended to nearly all Medicare and Medicaid-certified providers and suppliers. These actions aim to support increasing vaccination rates among staff working in all facilities, providers, and certified suppliers that participate in Medicare and Medicaid.

Discussion

On November 5, 2021, CMS published an IFC with comment period (86 FR 61555), entitled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," revising the infection control requirements that most Medicare- and Medicaid-certified providers and suppliers must meet to participate in the Medicare and Medicaid programs. These changes are necessary to protect the health and safety of patients and staff during the COVID-19 public health emergency. The COVID-19 vaccination requirements and policies and procedures required by this IFC must comply with applicable federal non-discrimination and civil rights laws and protections, including providing reasonable accommodations to individuals who are legally entitled to them because they have a disability or sincerely held religious beliefs, practices, or observations that conflict with the vaccination requirement. More information on federal non-discrimination and civil rights laws is available here: https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws.

Vaccination Enforcement– Surveying for Compliance

Medicare and Medicaid-certified facilities are expected to comply with all regulatory requirements, and CMS has a variety of established enforcement remedies. For nursing homes, home health agencies, and hospice (beginning in 2022), this includes civil monetary penalties, denial of payments, and—as a final measure—termination of participation from the Medicare and Medicaid programs. The sole enforcement remedy for non-compliance for hospitals and certain other acute and continuing care providers is termination; however, CMS's primary goal is to bring health care facilities into compliance. Termination would generally occur only after providing a facility with an opportunity to make corrections and come into compliance.

[1] COVID-19 Nursing Home Data - Centers for Medicare & Medicaid Services Data (cms.gov)

CMS expects all providers' and suppliers' staff to have received the appropriate number of doses by the timeframes specified in the QSO-22-07 unless exempted as required by law, or delayed as recommended by CDC. **Facility staff vaccination rates under 100% constitute non-compliance under the rule.** Non-compliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance. Consistent with CMS's existing enforcement processes, this guidance will help surveyors determine the severity of a noncompliance deficiency finding at a facility when assigning a citation level. These enforcement action thresholds are as follows:

Within 30 days after issuance of this memorandum[2], if a facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-compliant under the rule.** The facility will receive notice[3] of their non-compliance with the 100% standard. A facility that is above 80% **and** has a plan to achieve a 100% staff vaccination rate within 60 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 60 days after the issuance of this memorandum[4], if the facility demonstrates that:

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; **and**
- 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is compliant under the rule; or**
- Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the **facility is non-**

[2] If 30 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.
[3] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) federal tag.
[4] If 60 days falls on a weekend or designated federal holiday, CMS will use enforcement discretion to initiate compliance assessments the next business day.

compliant under the rule. The facility will receive notice[5] of their non-compliance with the 100% standard. A facility that is above 90% **and** has a plan to achieve a 100% staff vaccination rate within 30 days would not be subject to additional enforcement action. States should work with their CMS location for cases that exceed these thresholds, yet pose a threat to patient health and safety. Facilities that do not meet these parameters could be subject to additional enforcement actions depending on the severity of the deficiency and the type of facility (e.g., plans of correction, civil monetary penalties, denial of payment, termination, etc.).

Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action.

Federal, state, Accreditation Organization, and CMS-contracted surveyors will begin surveying for compliance with these requirements as part of initial certification, standard recertification or reaccreditation, and complaint surveys 30 days following the issuance of this memorandum. Additional information and expectations for compliance can be found at the provider-specific guidance attached to this memorandum.

Provider-Specific Guidance:

Guidance specific to provider types and certified suppliers is provided in the following attachments. The provider-specific guidance should be used in conjunction with the information in this memo.

- Attachment A: LTC Facilities (nursing homes)
- Attachment B: ASC
- Attachment C: Hospice
- Attachment D: Hospitals
- Attachment E: PRTF
- Attachment F: ICF/IID
- Attachment G: Home Health Agencies
- Attachment H: CORF
- Attachment I: CAH
- Attachment J: OPT
- Attachment K: CMHC
- Attachment L: HIT
- Attachment M: RHC/FQHC
- Attachment N: ESRD Facilities

Enforcement Actions

CMS will follow current enforcement procedures based on the level of deficiency cited during a survey.

Contact:
DNH_TriageTeam@cms.hhs.gov for questions related to nursing homes;

[5] This information will be communicated through the CMS Form-2567, using the applicable Automated Survey Process Environment (ASPEN) tag.

QSOG_Emergencyprep@cms.hhs.gov for question related to acute and continuing care providers.

Effective Date: This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Location training coordinators immediately. The effective dates of the specific actions are specified above.

/s/

Karen L. Tritz
Director, Survey & Operations Group

David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Attachments: A through N

EXHIBIT

C

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 SHANE MCCLAIN

1. My name is Shane McClain and I am the President of Health Systems, Inc., (HSI) a consulting group for 76 Skilled Nursing Facilities in Missouri. 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. The facilities consulted by HSI have been directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

3. The facilities consulted by HSI are skilled nursing facilities.

4. These facilities are licensed for 7492 Medicare/Medicaid beds.

5. These facilities' combined average daily census is 4055 patients.

6. These facilities receive over 70% percent / $190,000,000 of their annual revenue from Medicare and Medicaid reimbursements.

7. These facilities provide 24 hour nursing care, custodial care, therapy services, and behavioral health services.

8. These facilities serves a patient population base of 3,863,360 people who reside in the counties where these facilities are.

9. These facilities employ 4114 total staff, including 3000 health care staff.

10. These facilities are currently experiencing a workforce shortage of health care staff with many vacancies. Since January 1, 2021, these facilities have lost 714 staff. Since the vaccine mandate was announced, these facilities lost 194 employees. Most of these facilities have shortages in every position class.

11. Amongst the employees of these facilities, approximately 27% or 1100 are known to have not or are reasonably believed to have not received a COVID-19 vaccine. Over 30% of agency staff are not or are reasonably believed to have received a vaccine.

12. As a result of implementation of the CMS vaccine mandate in the IFC challenged by Plaintiff states in this case, 5 skilled nursing facilities have closed or are in the process of closing since February 2, 2022. If the mandate remains in place, more will close. Many of the facilities are unable to admit residents due to the lack of staff. Some have been forced to reduce their patient census in order to provide proper care.

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

Executed on this the 1st day of March, 2022.

SHANE McC

Shane McClain, President
Health Systems Inc.

EXHIBIT

D

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

STATE OF MISSOURI, et al., *Appellees*, v. JOSEPH R. BIDEN, JR., et al., *Appellants*.	No. 21-3725

DECLARATION OF TIM SCHRAGE

1. My name is Tim Schrage and I am the Administrator of Scotland County Care Center ("SCCC") in Memphis, Missouri. 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. Scotland County Care Center has been directly affected by the interim final rule with comment period (IFC) that Plaintiff States have challenged in this case.

3. Scotland County Care Center is a 96-bed, non-for-profit nursing home that has been in operation since 1969. SCCC is considered local government, a political subdivision of the state of Missouri 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 Skills Nursing Home benefit, and a Residential Care Facility holding an additional 28 beds.

4. Scotland County Care Center serves a patient population base of approximately 5,000 persons within the county of Scotland located in the State of Missouri.

5. Scotland County Care Center is licensed for 96 Medicare/Medicaid beds. It was previously licensed for 125 beds.

6. Scotland County Care Center's average daily census is approximately 40 residents.

7. Centers for Medicare and Medicaid Services ("CMS") provides reimbursement to SCCC for treatment of patients through the federal Medicare and Medicaid programs, providing some of the funding needed to meet SCCC's expenses. SCCC receives approximately 50% of its total operational revenues from CMS, which is a huge portion of SCCC's income.

8. Like many rural nursing home districts, Scotland County Care Center is one of the largest employers in Scotland County, second only to the school system. SCCC has approximately 65 employees ranging from a licensed administrator, accountants, RN Director of Nurses, registered nurses, licensed practical nurses, certified nurses, dietary staff, med techs, and a host of other staff who are necessary and essential in caring for our residents.

9. 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 on "agency staffing." Contracting with agency staffing means instead of paying an aide $15/hour, we pay $40-50/hour for a Certified Nurses Aide. We have to pay licensed nursed $65 dollars/hour compared to about $22/hour. In the past fiscal year, we have paid out nearly $380,000 in agency staffing fees because we have not been able to hire enough of our own staff. Furthermore, agency staffing does not have enough staffing for the absence of nurses who are not willing to be vaccinated. 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 must smaller than the non-rural areas. We face immense difficulties filling "key," "essential" positions.

10. The previous vaccination mandate deadline of December 4, 2021 caused extreme concerns in our having enough staff to continue operations. As we neared this deadline (even after education and encouragement for staff to become vaccinated), we were going to lose about 25% of our workforce. I was facing a complete and total loss in my housekeeping and laundry departments, director of nursing, supervisory staff in maintenance, and in the business office. Employees in all departments and those with higher levels of education were refusing to become vaccinated. The enforcement of this mandate was putting providers in an extremely difficult position of either taking a liberal approach in accepting exemptions based on religious beliefs or not having the staff to stay in business. This was a very unethical position for employers to be in. Was it more unethical or perhaps illegal to question an employee's religious conviction or to close your doors and force residents to relocate? Prior to the announcement of the successful injunction against the vaccination mandate, I had multiple resignations of three registered nurses along with other key personnel. Ultimately, I was unable to recover from losing these personnel. Beginning

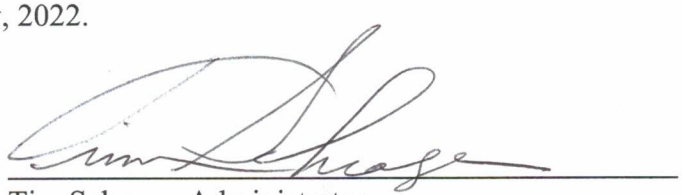
December 21, 2021 I had gaping holes in my licensed nurse schedule whereas I had 12 shifts without a licensed nurse. I made exhaustive efforts to fill those shifts. I called area nursing homes, hospitals, 8 staffing agencies, the regional Medical Reserve Corps, and the Missouri Department of Health and Senior Services. Missouri State Emergency Management Agency ("SEMA") sent an urgent message to 77 licensed nursing in surrounding counties. I contacted and posted to websites of nursing programs hoping to reach out to their alumni, posted to social media and recruiting websites, called former licensed nurses, followed up with names board members gave me, and more. Ultimately, I was unable to get the staffing I needed and on December 13, 2022 our board of directors was forced to make the difficult decision to close our nursing home and residential care facilities.

11. On November 4, 2021, I received an emergency update notice from the Missouri Department of Health and Human Services. The 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 Medicaid programs. The impact of this emergency regulation has had dramatic and devastating consequences. I believe that the staffing crisis in this country is so severe that the result of our government requiring a mandatory vaccine in order to work in health care will cause other homes to close. While the intent of this emergency regulation may be to protect our elderly nursing home residents, the result has actually created more harm. Because we were forced to close our doors, we have had to displace the residents who enjoy residing in Scotland County Care Center and who desire to live in the community where they have lived their entire lives. It was extremely difficult and heart wrenching to relocate our

residents. Most nearby nursing homes could not accept new residents because they did not have enough staffing themselves to take on new clients. This forced families to look further away for placement options. Approximately 65 employees had to find a new job. For many this meant traveling further and earning less. The impact on our community was devastating as the nursing home has been a large source of employment in Scotland County. Citizens were "irate" upon hearing the news of our closing. Community members have strong ties with the nursing home and remember this as the place where their parents or grandparents lived, were cared for, and died amongst familiar caring staff. Now, we are faced with the questions of what to do with our vacant buildings and property. This is a monumental task for a small rural community. Certainly, there were other contributing factors behind our closing. However, I do believe that the federal government's enforcement of a vaccine mandate is adding additional burdens upon health care providers who are already struggling to hire enough staff.

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

Executed on this 8th day of February, 2022.



Tim Schrage, Administrator
Scotland County Care Center

EXHIBIT

E

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. 4:21-cv-01329

DECLARATION OF LINDA STALCUP

1. My name is Linda Stalcup, and I am the Chief Executive Officer of Stevens County Hospital located in Hugoton, Kansas. I am also a resident of the State of Kansas 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' case.

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

4. Stevens County Hospital is a small rural hospital.

5. Stevens County Hospital is a critical access hospital.

6. Stevens County Hospital is licensed for 102 Medicare/Medicaid beds, which are comprised of 25 hospital beds and 77 nursing home beds (long-term care beds in a separate building).

7. Stevens County Hospital receives 52.7 percent or $7,929,151.34 of its annual net revenue/funding from Medicare and Medicaid reimbursements.

8. Stevens County Hospital serves a patient population base located in five Kansas counties, two Oklahoma counties, and one Texas county.

9. Stevens County Hospital employs 161 total staff, including 98 clinical staff.

10. Stevens County Hospital's average daily census is 3.93 (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 3.06 days and our average length of stay for swing bed patients is 8.67 days.

11. Of Stevens County Hospital's staff, approximately 38 percent are reasonably believed to have not received a COVID-19 vaccine.

12. Stevens County Hospital has had to implement crisis staffing standards.

13. Stevens County Hospital is the second largest employer in the county, so closing would devastate the local community.

14. Because of the IFC, staffing shortages have worsened, causing us to pay exorbitant agency costs to cover open shifts. We have also had to pay a premium to keep staff employed. The current path we are on is not financially sustainable.

15. Our staff is already exhausted and overworked, which has reduced the quality of care that we can provide our patients. Due to staff shortages in larger, urban hospitals, it is difficult for us to find beds for critically ill patients entering our doors, causing our nursing staff to perform patient care above their scope and experience.

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

Executed on this the 11th day of February, 2022.

Linda Stalcup, Chief Executive Officer
Stevens County Hospital

EXHIBIT

F

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. 4:21-cv-01329

DECLARATION OF DELLA RIBORDY

1. My name is Della Ribordy, and I am the Regional Director of Operations for Kansas, Skilled Nursing Division of Americare Senior Living. I am also a resident of the State of Kansas 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' case.

3. I oversee and manage 13 freestanding Skilled Nursing Facilities (Facilities) in the State of Kansas, which are:

i. Wheatland Nursing Center located in Russell;

ii. Grand Plains Nursing and Rehabilitation Center located in Pratt;

iii. Hilltop Manor located in Cunningham;

iv. Eureka Nursing Center located in Eureka;

v. Galena Nursing Center located in Galena;

vi. Heritage Healthcare located in Chanute;

vii. Montgomery Place located in Independence;

viii. Moran Manor located in Moran;

ix. North Point located in Paola;

x. Osage Nursing Center located in Osage City;

xi. Pleasant Valley Manor located in Sedan;

xii. Quaker Hill Nursing Center located in Baxter Springs; and

xiii. Sabetha Manor located in Sabetha.

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

5. All Facilities except North Point are located in rural areas of Kansas.

6. All Facilities are licensed for a total of 623 Medicare/Medicaid beds.

7. All Facilities receive the majority of their annual net revenue from Medicaid.

8. All Facilities receive 69.7 percent or $27.2 million of their annual net revenue/funding from Medicare and/or Medicaid reimbursements.

9. All Facilities serve their local communities within a geographic area of twenty-five counties.

10. All Facilities employ 665 total employees.

11. The average daily census per each facility 36.23 (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 28 days.

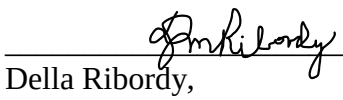
12. Of the Facilities' employees, approximately 138 are reasonably believed to be unvaccinated.

13. Because of the heavy burden imposed by the IFC, we are barely able to staff our Facilities. We have had to limit our admissions because it would be unsafe to try and care for additional residents. With the loss of our permanent staff, our Facilities have been forced (when

possible) to use staffing agencies to hire necessary staff. The loss of our permanent staff has rendered us unable to provide the required quality of care that is important to serving our residents. For instance, the loss of permanent has resulted in the social isolation of our residents. Our Facilitates were stretched thin before the pandemic, but now we cannot find people to hire regardless of pay increases and bonuses we offer. Imposition of the IFC is exasperating our already desperate situation.

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

Executed on this the 14th day of February, 2022.



Della Ribordy,
Regional Director of Operations for Kansas
Skilled Nursing Division
Americare Senior Living