No. _____

In the Supreme Court of the United States

STATES OF MISSOURI, NEBRASKA, ALASKA, ARKANSAS, IOWA, KANSAS, NEW HAMPSHIRE, NORTH DAKOTA, SOUTH DAKOTA, AND WYOMING,

Petitioners,

v.

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

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

On November 5, 2021, the Centers for Medicare & Medicaid Services (CMS) issued its vaccine mandate for workers in most federally funded healthcare facilities. 86 Fed. Reg. 61,555-61,627 ("Mandate"). On January 13, 2022, this Court stayed the district court's preliminary injunction against the Mandate, *Biden* v. *Missouri*, 142 S. Ct. 647 (2022) (per curiam), and thus necessarily determined that there is "a reasonable probability that four Justices will consider the issue sufficiently meritorious to grant certiorari." *Hollingsworth* v. *Perry*, 558 U.S. 183, 190 (2010). Indeed, four Justices in *Missouri* noted that "there is no real dispute that this case merits our review." *Missouri*, 142 S. Ct. at 655 (Thomas, J., dissenting). After the agency imposed a 90-day delay, the Mandate went into full effect on April 15, 2022, and the Petitioner States are now experiencing its devastating consequences—especially on their small, rural, and community-based healthcare systems.

The Questions Presented are:

1. Whether the Mandate violates the Administrative Procedure Act (APA) because it is arbitrary, capricious, and unlawful?

2. Whether the Mandate is unconstitutional under the Spending Clause, the anti-commandeering doctrine, and the Tenth Amendment?

3. Whether the Mandate violates the APA because it was issued without notice and comment?

4. Whether the Mandate exceeds CMS's statutory authority?

PARTIES TO THE PROCEEDING

Petitioners are the States of Missouri, Nebraska, Alaska, Arkansas, Iowa, Kansas, New Hampshire, North Dakota, South Dakota, and Wyoming.

Respondents are President Joseph R. Biden, Jr., in his official capacity as the President of the United States of America; United States of America; United States Department of Health and Human Services; Xavier Becerra, in his official capacity as Secretary of the United States Department of Health and Human Services; Centers for Medicare and Medicaid Services; Chiquita Brooks-LaSure, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; Meena Seshamani, in her official capacity as Deputy Administrator and Director of Center for Medicare; and Daniel Tsai, in his official capacity as Deputy Administrator and Director of Center for Medicaid and CHIP Services.

STATEMENT OF RELATED PROCEEDINGS

This case arises from the following proceedings:

- *State of Missouri, et al.* v. *Joseph Biden, Jr., et al.*, No. 21-3725 (8th Cir.) (order vacating the preliminary injunction and remanding to the district court entered on April 11, 2022); and
- *State of Missouri, et al.* v. *Joseph R. Biden, Jr., et al.*, No. 4:21-cv-01329-MTS (E.D. Mo.) (order granting a preliminary injunction entered on November 29, 2021).

There are no other proceedings in state or federal court or this Court directly related to this case within the meaning of this Court's Rule 14.1(b)(iii).

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PETITION FOR WRIT OF CERTIORARI

CMS's vaccine mandate is now devastating small, rural, and community-based healthcare facilities and systems throughout the States. Last November, echoing many similar concerns, the administrator of one rural hospital predicted:

> 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 … 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.

Mo. Stay App. 90a-91a.[1] These dire predictions are now coming true. Even before the Mandate went into

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[1] "Mo. Stay App." refers to the "Respondents' Appendix" that then-Respondents (now Petitioners) Missouri et al. filed in the stay proceedings in this Court on Dec. 30, 2021, in No. 21A240. It contains the States' 30 declarations at 35a-139a.

full effect on April 15, 2022, the States were already facing facility closures and cutbacks, especially at much-needed long-term care facilities in rural areas. The Court should grant certiorari and grant expedited review to hear this case at its first sitting in the October 2022 Term.

OPINIONS BELOW

The district court's opinion granting a preliminary injunction is not yet reported in the Federal Supplement. It is available at -- F. Supp. 3d --, 2021 WL 5564501 (E.D. Mo. Nov. 29, 2021), and reprinted at pages 6a-50a of the Appendix.

The Eighth Circuit's order vacating the preliminary injunction and remanding to the district court is not reported in the Federal Reporter. It is reprinted at pages 1a-3a of the Appendix. The Eighth Circuit's judgment is not reported in the Federal Reporter. It is available at 2022 WL 1093036 (8th Cir. April 11, 2022), and reprinted at pages 4a-5a of the Appendix.

JURISDICTION

The Court of Appeals issued its judgment on April 11, 2022. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

The Spending Clause provides that "[t]he Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States…." U.S. CONST. art. I, § 8.

The Tenth Amendment provides that "[t]he powers not delegated to the United States by the

Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X.

The judicial-review provisions of the Administrative Procedure Act, 5 U.S.C. § 706, are reproduced at pages 51a-52a of the Appendix.

The Department of Health and Human Services, Centers for Medicare & Medicaid Services' interim final rule, *Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination*, 86 Fed. Reg. 61,555 *et seq*., is reproduced at pages 53a-357a of the Appendix.

STATEMENT OF THE CASE

A. Mandating Vaccines Is "Not the Role of the Federal Government."

From its founding in 1965 until 2021, CMS never mandated vaccines: "We have not previously required any vaccinations." 86 Fed. Reg. 61,567. "[W]e have not, until now, required any health care staff vaccinations." *Id.* at 61,568. Even during the COVID-19 pandemic, CMS deliberately "chose … to encourage rather than mandate vaccination…." *Id.* at 61,583.

Until September 9, 2021, this Administration agreed. "In December of 2020, the President was quoted as saying, 'No I don't think [vaccines] should be mandatory.'" *BST Holdings, LLC* v. *Occupational Safety & Health Admin*., 17 F.4th 604, 614 n.17 (5th Cir. 2021). On May 13, 2021, CMS published an IFC related to COVID-19, 86 Fed. Reg. 26,306, which "required offering vaccination to residents and staff, but did not mandate vaccination." 86 Fed. Reg. 61,601; *see also id*. 61,583. On July 23, 2021, the White House Press Secretary stated that vaccine mandates are "not

the role of the federal government." The White House, *Press Briefing by Press Secretary Jen Psaki, July 23, 2021*, *at* https://www.whitehouse.gov/briefing-room/press-briefings/2021/07/23/press-briefing-by-press-secretary-jen-psaki-july-23-2021/.

B. The President Imposes Vaccine Mandates To Cover as Many Americans as Possible.

On September 9, 2021, in a major shift of policy, the President announced multiple vaccine mandates designed to increase the number of vaccinated Americans using any federal power available. The White House, *Remarks by President Biden on Fighting the COVID-19 Pandemic* (Sept. 9, 2021), *at* https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/ ("Speech"). At the outset of the Speech, the President announced that his goal was to "raise our vaccination rate." *Id.* He said, "I'm announcing tonight a new plan to require more Americans to be vaccinated…." *Id.* He asserted that federal mandates would "reduce the number of unvaccinated Americans," and "we must increase vaccinations among the unvaccinated with new vaccination requirements." *Id.*

To this end, the President announced several new federal vaccine mandates, including a mandate for private employers, a mandate for federal employees, a mandate for federal contractors, and a mandate for "those who work in hospitals, home healthcare facilities, or other medical facilities." *Id.* The explicit purpose of these mandates was to compel vaccination in as many Americans as possible. The President stated that "vaccine requirements in my plan will

affect about 100 million Americans – two thirds of all workers." *Id.*

The same day, September 9, 2021, the White House unveiled its "COVID-19 Action Plan." The White House, *Path Out of the Pandemic: President Biden's COVID-19 Action Plan*, *at* https://www.whitehouse.gov/covidplan/ ("Plan"). Like the Speech, the Plan stated that its purpose was to compel vaccination was widely as possible. *See id.* The first point of the six-point Plan was "Vaccinating the Unvaccinated." *Id.* Like the Speech, the Plan announced that it would "reduce the number of unvaccinated Americans by using regulatory powers … to substantially increase the number of Americans covered by vaccination requirements." *Id.* The Plan intended that "these requirements will become dominant in the workplace." *Id.* The Plan emphasized that "[t]hese requirements will apply to approximately 50,000 providers and cover a majority of health care workers across the country." *Id.*

Two days later, on September 11, 2021, the White House Chief of Staff retweeted a description of the vaccine mandates as "the ultimate work-around for the Federal govt to require vaccinations." *BST Holdings*, 17 F.4th at 612 n.13.

C. CMS Imposes a Nationwide Vaccine Mandate on Healthcare Workers.

On November 5, 2021, CMS published its vaccine Mandate for healthcare workers at nearly all healthcare facilities that receive Medicare or Medicaid funds. 86 Fed. Reg. 61,555-61,627. As noted above, CMS admitted that the Mandate is unprecedented and represented a major shift in policy for the agency: "We have not previously required any

vaccinations." *Id.* at 61,567. "[W]e have not, until now, required any health care staff vaccinations." *Id.* at 61,568; *see also id.* at 61,583.

The Mandate requires vaccination against COVID-19 for nearly all workers in 15 kinds of federally funded healthcare facilities. *Id.* at 61,567. It mandates vaccination for all "facility staff, regardless of clinical responsibility or patient contact," including "[f]acility employees; licensed practitioners; students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its patients, under contract or other arrangement." *Id.* at 61,570. Even "a crew working on a construction project whose members use shared facilities … would be subject to these requirements." *Id.* at 61,571. CMS estimated that the Mandate covers 10.3 million workers. *Id.* at 61,603.

For statutory authority, CMS provided 51 overlapping citations of definitional and ancillary provisions applicable to 15 different facility types, and two provisions providing general administrative authority. *Id.* at 61,567 tbl.1. CMS did not specify what language in which specific statutory provisions purportedly authorized its vaccine mandate. *Id.*

To enforce the Mandate, CMS relied exclusively on state surveyors in state health departments. *Id.* at 61,574. CMS announced that it will "advise and train State surveyors on how to assess compliance with the new requirements among providers and suppliers." *Id.* The Mandate requires state surveyors to probe individual healthcare decisions: "The guidelines will also instruct surveyors to conduct interviews [of] staff to verify their vaccination status." *Id.*

CMS possessed scant evidence of present risks of staff-to-patient transmission of COVID-19 in most facilities. To find a risk of transmission, it relied heavily on two sources. First, the Mandate noted that "[a] retrospective analysis from England found up to 1 in 6 SARS-CoV-2 infections among hospitalized patients with COVID-19 in England *during the first 6 months* of the pandemic could be attributed to healthcare-associated transmission." *Id.* at 61,557 (emphasis added). Second, CMS relied on evidence of patient infections in long-term care facilities (LTCs), and "extrapolated" to conclude that patients faced an infection risk from staff at 14 other kinds of facilities. *Id.* at 61,585. CMS admitted that "similarly comprehensive data" on staff-to-patient transmission "are not available for all Medicare- and Medicaid-certified provider and supplier types," but it concluded, without further evidence, that the "LTC facilities[] experience may generally be extrapolated to other settings." *Id.* at 61,585.

CMS's other evidence, however, indicated that the risk of staff-to-patient transmission was minimal in the vast majority of facilities, especially in the second year of the pandemic. CMS admitted that source-control measures other than vaccines—such as physical distancing, use of PPE, periodic testing, ventilation, and patient isolation—"have been highly effective" in preventing transmission of COVID-19 in healthcare facilities. *Id.* at 61,557. And CMS noted that "the most effective precautions other than vaccination … have been essentially universal in the health care sector during all of 2021." *Id.* at 61,612.

By contrast, CMS had little evidence of vaccination's efficacy as a source-control measure. CMS admitted that "the effectiveness of the vaccine to

prevent disease transmission by those vaccinated" is "*not currently known*." *Id.* at 61,615 (emphasis added).

CMS acknowledged that "endemic" staffing shortages were already afflicting every sector of the healthcare industry. It noted that "1 in 5 hospitals report that they are currently experiencing a critical staffing shortage." *Id.* at 61,559. "[A]pproximately 23 percent of LTC facilities reported a shortage in nursing aides; 21 percent reported a shortage of nurses; and 10 to 12 percent reported shortages in other clinical and non-clinical staff categories." *Id.* "Over half (58 percent) of nursing homes … indicated that they are limiting new admissions due to staffing shortages." *Id.* According to CMS, "currently there are endemic staff shortages for almost all categories of employees at almost all kinds of health care providers and suppliers and these may be made worse if any substantial number of unvaccinated employees leave health care employment altogether." *Id.* at 61,607.

Nevertheless, CMS paradoxically concluded that the Mandate presents a low risk of exacerbating existing staffing shortages. CMS admitted that it was basically guessing on this point; it conceded that "there might be a certain number of health care workers who choose to do so," but claimed that "there is insufficient evidence to quantify … temporary staffing losses due to mandates." *Id.* at 61,569. CMS also stated that "it is possible there may be disruptions in cases where substantial numbers of health care staff refuse vaccination," but "there are so many variables and unknowns" that CMS could not predict them. *Id.* at 61,608.

In the end, CMS relied solely on the experience of massive private health-care systems based principally in heavily populated areas that had imposed employee vaccine mandates—such as "a health care system that is the largest private employer in Delaware with more than 14,000 employees, a health care system and academic medical center with over 26,000 employees in Texas, and an integrated health system in North Carolina with more than 35,000 employees." *Id.* at 61,566; *see also id.* at 61,569 ("a large hospital system in Texas," "[a] Detroit-based health system" with "33,000 workers," and "a LTC parent corporation" with "250 LTC facilities"). No small rural healthcare systems were included in this analysis. *Id.*

CMS was fully aware that America contains many small, rural, community-based healthcare systems and facilities, with staff drawn from less vaccinated local communities. *See id.* at 61,613. Further, CMS acknowledged that "[e]ven a small fraction of recalcitrant unvaccinated employees could disrupt facility operations." *Id.* at 61,612. CMS also admitted that staffing shortages raised particularly pressing concerns for small, rural facilities, noting that "early indications are that rural hospitals are having greater problems with employee vaccination refusals than urban hospitals." *Id.* at 61,613. But CMS did not consider their plight, and it collected and cited no evidence relating to them. Instead, CMS indicated that it would *not* consider the issue now, and instead deferred consideration of this issue until after the Mandate's implementation, stating that "we welcome comments on ways to ameliorate this problem." *Id.*

D. The Mandate Disrupts Reliance Interests.

In the district court, the States submitted thirty declarations, including 27 declarations from administrators of public and private healthcare facilities, and three from state agencies employing state surveyors. Mo. Stay App. 35a-139a. These declarations addressed small healthcare providers' extensive reliance on CMS's previous policy of *not* mandating vaccines.

1. Small, rural facilities in remote locations.

Unlike the massive private healthcare systems in Detroit and Houston that CMS considered, the States' declarants operate small facilities in rural and underserved locations. *See, e.g.,* Mo. Stay App. at 42a (Arkadelphia, Arkansas); *id.* at 44a (Carroll, Iowa); *id.* at 53a (Memphis, Missouri); *id.* at 86a (Valentine, Nebraska); *id.* at 105a (Cozad, Nebraska); *id.* at 125a (Belknap County, New Hampshire); *id.* at 129a (Stutsman County, North Dakota); *id.* at 135a (Yankton, South Dakota).

Most of these facilities are tiny compared to those cited by CMS, often with workforces of a few dozen employees. *See, e.g., id.* at 47a (60 employees); *id.* at 61a (65 employees); *id.* at 71a (103 employees); *id.* at 75a (65 employees); *id.* at 78a (134 employees); *id.* at 111a (55 employees).

These tiny facilities serve enormous geographic areas. *See, e.g, id.* at 81a (2,500 square miles); *id.* at 84a (8,100 square miles); *id.* at 87a ("twenty-one thousand people in nineteen different zip codes"); *id.* at 97a ("10 panhandle counties" in Nebraska); *id.* at 101a ("67,832 square miles, about the size of the state of Pennsylvania"); *id.* at 115a ("7 to 10 counties"); *id.*

at 119a (seven counties); *id.* at 135a ("the only state-run inpatient psychiatric hospital in South Dakota").

These facilities draw their workforces from local communities, where qualified healthcare workers are scarce, and the labor pool is less vaccinated than in urban centers. *See, e.g., id.* at 63a ("In our rural areas, the pool of qualified workers for specific skills and knowledge is much smaller than the [n]on-rural areas. We face immense difficulties filling 'key,' 'essential' positions."); *id.* at 87a, 99a, 117a, 130a; *id.* at 139a (Wyoming facilities "operate in rural and frontier areas with small or limited labor markets").

2. Patients with few or no other options.

Many such facilities treat patients who lack other treatment options, such as psychiatric patients, intellectually disabled individuals, and the elderly. *See id.* at 39a-40a; *id.* at 42a ("some of Arkansas' most vulnerable populations including the elderly, children, intellectually disabled individuals, and the mentally ill"); *id.* at 65a-69a (Missouri's 12 state-run psychiatric facilities serving adults and children with severe psychiatric problems, and children with developmental disabilities); *id.* at 94a ("adults with intellectual and developmental disabilities requiring comprehensive, specialized support"); *id.* at 126a-127a (the "most needy elderly" and "vulnerable, elderly residents"); *id.* at 129a ("sexually dangerous individuals," "people with intellectual and developmental disabilities … whose needs exceed community resources," and "children with serious emotional disturbance"); *id.* at 136a. Small rural systems are often the network of last resort for such patients.

3. Already facing critical staffing shortages.

Without exception, these facilities were already facing critical staffing shortages before CMS announced its vaccine mandate. *See, e.g., id.* at 43a (Arkansas' state-run facilities had "over 1,000 positions—representing over 40% of total positions—classified as being 'open' or unfilled"); *id.* at 45a (134 open positions out of 750 staff); *id.* at 50a-51a ("Nearly all" of 350 nursing homes in Missouri "are currently facing a staffing crisis and barely able to meet minimum staffing levels to keep their doors open."); *id.* at 62a, 69a; *id.* at 71a-72a ("[P]ositions are extremely difficult to fill…. We are already functioning in crisis mode."); *id.* at 97a-98a, 102a; *id.* at 105a ("This facility is in dire straits in terms of staffing…"); *id.* at 126a ("experiencing a severe employment crisis"); *id.* at 130a.

4. Reliance on CMS's previous longstanding policy of not mandating vaccines.

To address such critical staffing shortages, these facilities specifically relied on CMS's previous policy of *not* mandating vaccines, by hiring unvaccinated workers to fill much-needed positions. For example, "[b]eginning on or about August 2021 the State of Nebraska attempted to hire unvaccinated health care workers to help staff its state-run facilities *specifically relying upon prior CMS rules allowing this practice*." *Id.* at 95a (emphasis added). This led to significant proportions of unvaccinated staff. *Id*. at 95a-96a.

Likewise, the Butler County Health Center in rural Nebraska "has relied upon prior CMS rules that did not require COVID-19 vaccination for hiring staff" to fill critical staffing shortages. *Id.* at 78a. This reliance resulted in 43 percent of the "active medical

staff" unvaccinated, including "sixty six percent (66%) of physicians that provide obstetric services." *Id.*

Similarly, Boone County Health Center in rural Nebraska "relied on prior CMS rules that did not require vaccination in attempting to fill existing vacancies." *Id.* at 119a. This has resulted in 24 percent of staff unvaccinated. *Id.*

These experiences were univeral. Every other facility similarly relied on CMS's prior policies by hiring significant numbers of unvaccinated staff to address their critical staffing shortages. *See, e.g., id.* at 48a ("The vaccination rate of [the facility's] employees is under 50%"); *id.* at 66a-68a (describing Missouri state-run psychiatric facilities' staff vaccination rates); *id.* at 72a (49 of 103 employees are unvaccinated); *id.* at 85a (44 percent of employees unvaccinated); *id.* at 87a (66 of 159 employees are unvaccinated); *id.* at 93a (101 of the 196 nursing homes in Nebraska had staff vaccination rates under 75%); *id.* at 98a (42 percent of staff unvaccinated); *id.* at 101a ("311 [staff] are known to have not been vaccinated"); *id.* at 111a (among "55 employees, 31 are known to be unvaccinated"); *id.* at 115a ("78 out of 330" staff unvaccinated).

Not just facilities, but healthcare *workers* also relied on CMS's prior policy by taking jobs that CMS would later forbid. *See, e.g., id.* at 105a (noting that the facility received a job application specifically "because it was not mandating vaccination"). Such workers face the daunting prospect of a mid-career change. *See, e.g., id.* at 90a. Moreover, even vaccinated staff relied on CMS's prior policy—they relied on their unvaccinated coworkers to prevent understaffing, overscheduling shifts, and burnout:

"With anticipated limited service offerings, remaining employees … will be forced to work extended hours, take significant call hours and shifts, resulting in a risk in patient safety." *Id.* at 99a; *see also, e.g.*, *id.* at 108a (expected losses of unvaccinated workers put "undue stress on our employees"); *id.* at 116a-117a ("[E]ven if we can technically staff services with extra shift and call, we are already doing that, have been doing that for more than a year, and our vaccinated staff will not be capable of doing it for much longer.…").

5. No greater risk of COVID-19 transmission.

In these facilities, there is no evidence that the mix of vaccinated and unvaccinated staff presented any heightened risk to patients of COVID-19 transmission. None of the States' 30 declarants attested to any such risk, and the Government submitted no evidence of it. *See id.* at 35a-139a. On the contrary, these facilities have taken common precautions, which CMS admits "have been highly effective" in preventing transmission, 86 Fed. Reg. 61,557, and "have been essentially universal in the health care sector during all of 2021," *id.* at 61,612.

For example, an Iowa hospital "instituted a policy that requires employees declining the vaccine to wear an N95 mask and in some cases be tested prior to working each shift. This policy … has resulted in no infections occurring within our workplace." Mo. Stay App. 45a. A Nebraska hospital explained that, due to precautions, "[p]atients are not coming to the hospital for services and becoming ill with COVID." *Id.* at 99a. Another facility noted, "[w]ith our enhanced precautions we have in place currently, allowing [an]

alternative to a vaccine mandate would not sacrifice patient or staff safety." *Id.* at 103a.

6. Critical staffing losses from the Mandate.

Virtually all declarants anticipated painful staffing losses from the Mandate. For example, the leader of a 350-facility association of Missouri nursing facilities reported that "[a] significant number facilities across [Missouri] … could lose up to 25% of their employees or more if CMS were to issue a vaccine mandate," when they "cannot afford to lose even 1% of their employees." *Id.* at 51a. Another facility reported that it "does not have enough staffing for the absence of nurses who are not willing to be vaccinated. We will be facing a huge problem!" *Id.* at 62a. Another Nebraska hospital "stands to lose 15 percent of its total employees from all across the organization," including "key leadership positions in physicians, nursing…." *Id.* at 98a.

These administrators gauged their risk of staffing losses by actually talking to unvaccinated healthcare workers—something CMS never did. *See, e.g., id.* at 45a; *id.* at 48a (facility surveyed all 60 employees, and "a majority of these unvaccinated staff stated they would chose to leave healthcare completely"); *id.* at 54a; *id.* at 63a ("Out of about 65 employees, about 20 employees tell me they are vehemently opposed to taking the vaccine … and will quit working at [the facility]."); *id.* at 72a, 79a, 102a, 105a, 117a, 131a.

7. Loss of critical healthcare services.

As a result of these additional staffing shortages, the facilities universally predict that they will be forced to cut critical healthcare services for vulnerable and underserved populations, or (in some cases) close

facilities entirely. One facility stated: "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?" *Id.* at 123a. This facility "will have 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." *Id.*

At Cherry County Hospital in Valentine, Nebraska, "[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." *Id.* at 90a. That facility also forecasts "the loss of OB and both planned and emergency C-section delivery…. This will, without a doubt, result in poor outcomes for mom and newborn." *Id.* at 89a.

Box Butte General Hospital, serving Nebraska's panhandle, anticipates "closure of departments, reduction of services, inability to accept patients and/or staff beds, increased wait times for services, need to access care possibly outside state lines, dramatic increase in our inability to transfer to alternative hospitals, or even loss of services altogether." *Id.* at 99a.

The only state-run inpatient psychiatric hospital in South Dakota will likely "reduce the patient population, limit admissions, and potentially take

additional treatment unit offline," which "could require that individuals needing emergency inpatient psychiatric treatment be held in jail settings or emergency rooms until capacity is available." *Id.* at 136a. North Dakota, too, anticipates that, without adequate staffing, it "will not be able to provide statewide safety services for its most vulnerable population." *Id.* at 131a.

Scotland County Care Center in Memphis, Missouri predicts that the "emergency regulation will have dramatic and devastating consequences…. [T]here is no way we can continue to operate…. We will be forced to close our doors and displace the residents." *Id.* 63a-64a. (This facility did, in fact, close after the Mandate issued.) Great Plains Health in North Platte, Nebraska predicts "a dangerously reduced number of staffed ICU beds, a reduced ability to obtain timely surgeries or surgery altogether due to loss of an anesthesiologist and nursing staff, reduced ability … to provide cardiac stenting, and an inability to receive forensic sexual assault exams due to loss of SANE-qualified nurses." *Id.* at 102a-103a.

Many other facilities in the States made similarly dire predictions of loss of services, closing departments, or shuttering healthcare facilities. *See, e.g., id.* at 48a ("The loss of … employees will cause significant difficulty in the continued operation of MCMCC."); *id.* at 51a ("Without a sufficient number of staff, skilled nursing care facilities cannot stay open and will be forced to close."); *id.* at 54a (the Mandate "will cause significant difficulty in the continued quality and safe operations of SCH"); *id.* at 72a ("[I]f we lose even one nurse … our 24/7 nursing floor and emergency room services could collapse."); *id.* at 76a ("The projected loss of approximately 30% of our staff

… will almost certainly lead to closure of our facility"); *id.* at 79a (the Mandate would "make it very difficult to continue operations," and require cutting "emergency department services, obstetric services, laboratory services, and acute nursing care"); *id.* at 81a (anticipating potential "closure of departments, reduction of services, inability to accept patients, increased wait times for services, [and] inability to staff beds"); *id.* at 85a (the medical center "will be put in an almost impossible position to provide the same level and quality of services"); *id.* at 108a (predicting "potential closure of some departments" and the need to "divert many of our emergency patients to other facilities; the closest one is 45 miles away"); *id.* at 112a (the Mandate "jeopardiz[es] the very existence" of the facility); *id.* at 116a ("we will be forced to limit or close services such as cardiopulmonary rehabilitation and home health and hospice services"); *id.* at 120a (predicting potential "reduction of services, closure of satellite clinic locations, … increased wait time in the ER, [and] inability to staff hospital beds safely").

The closures and service cuts, moreover, will be compounded across rural America. As one facility stated, because all rural facilities face the same problems, "the CMS vaccine mandate threatens rural healthcare infrastructure not only in Custer County but throughout Nebraska." *Id.* at 76a. Another facility explained, "[i]f someone is having a heart attack or a stroke, they may not make it to the other critical access hospital down the road 30 miles. This is assuming the critical access hospital 30 miles away is going to be able to keep their services going. During these surges of COVID we have also struggled terribly getting bed acceptance at larger facilities." *Id.* at 72a. "Closures of other facilities will only compound the

inability of [the facilities] to care for patients in rural areas." *Id.* at 106a. *See also, e.g.*, *id.* at 81a (the facility "is already experiencing an inability to transfer patients to alternative hospitals facing similar staffing challenges"); *id.* at 99a (predicting a "dramatic increase in our inability to transfer to alternative hospitals" that have "ongoing ripple effects"); *id.* at 119a (predicting the loss of "the ability to transfer when needed since we are all having the same issues").

E. The States Challenge the Mandate.

On November 10, 2021, Petitioners (the "States") challenged the Mandate. C.A. App. 1-58. Their Complaint raised ten claims, including that the Mandate is unconstitutional under the Spending Clause, the anti-commandeering doctrine, and the Tenth Amendment. *Id.* at 52-55. The Complaint also alleged that CMS arbitrarily and capriciously failed to consider reliance interests. *Id.* at 44.

On November 29, 2021, the district court granted a preliminary injunction against the Mandate. App. 6a-50a. Among other things, the district court held that the Mandate was likely pretextual, *id.* at 33a-34a n.24, and that "CMS did not properly consider *all* necessary reliance interests of facilities, healthcare workers, and patients." *Id.* at 35a. The district court declined to reach the States' constitutional claims. *Id.* at 15a-16a n.8.

The Government sought a stay of the injunction from the Eighth Circuit, which was denied. The Government then sought a stay from this Court, which was granted on January 13, 2021. *Missouri*, 142 S. Ct. 647. In the stay opinion, the Court did not address the States' constitutional claims, whether the

Mandate is impermissibly pretextual, or whether CMS adequately considered legitimate reliance interests. *Id.*

The day after this Court stayed the injunction, CMS delayed full implementation of the Mandate for another 90 days, with 30-day and 60-day benchmarks to achieve partial compliance. *See* Department of Health & Human Services, 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). The memo admitted that partial compliance with the Mandate typically does *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.

On March 2, 2022, the States moved for expedited hearing in the Eighth Circuit, submitting evidence that they were already suffering healthcare-facility closures and cutbacks in rural areas. Before the Eighth Circuit, the States contended that the Mandate was arbitrary and capricious for failing to consider reliance interests, was pretextual, and violated constitutional limitations on CMS's authority. By contrast, the Government's *sole* argument on appeal was that this Court's stay opinion had "decided the merits" of the case.

On April 11, 2022, the Eighth Circuit disposed of the appeal by issuing a two-page order. App. 1a-2a. The order stated: "Based on the Supreme Court's opinion [in *Missouri*], this court vacates the preliminary injunction and remands to the district court for a determination of the merits of the State of Missouri's claim for permanent injunctive relief. *See*

Fed. R. Civ. P. 65(a)(2)." *Id.* at 2a. No further analysis was provided.

The States filed this timely petition for writ of certiorari.

REASONS FOR GRANTING THE PETITION

I. The Case Warrants This Court's Review.

In granting the Government's stay motion, *Missouri*, 142 S. Ct. 647, this Court necessarily determined that this case likely merits its review. When addressing a stay motion, the first factor the Court considers is whether the applicant has shown "a reasonable probability that four Justices will consider the issue sufficiently meritorious to grant certiorari." *Hollingsworth* v. *Perry*, 558 U.S. 183, 190 (2010). By granting a stay, the *Missouri* majority necessarily determined that a grant of certiorari was reasonably probable. *Id.* And the four dissenting Justices agreed that "there is no real dispute that this case merits our review." *Missouri*, 142 S. Ct. at 655 (Thomas, J., dissenting). The Court's view of the case's certworthiness was therefore unanimous.

The Government should not be heard to contend otherwise. When the preliminary injunction was in place, the Government urgently contended that the case warrants the Court's review. Gov. Stay App. in No. 21A240, at 15-17. The Government argued that the case presents "an issue of exceptional national importance that would warrant this Court's review if the Eighth Circuit allowed the injunction to stand," *id.* at 16, and that "the likelihood of certiorari is especially clear because the district court's order … contradicts a thorough published decision by the Eleventh Circuit rejecting a parallel challenge to the

same rule," *id.* Having "succeeded in persuading" the Court "to accept [its] earlier position" that the case is certworthy, *New Hampshire* v. *Maine*, 532 U.S. 742, 750 (2001), the Government should not be allowed to advocate the opposite position now.

Nor does the fact that the Government prevailed in its stay application change the analysis. This Court's "stay order is not a ruling on the merits, but instead simply stays the District Court's injunction *pending a ruling on the merits*." *Merrill* v. *Milligan*, 142 S. Ct. 879, 879 (2022) (Kavanaugh, J., concurring). "To reiterate: The Court's stay order is not a decision on the merits." *Id.* The "historic office" of a stay pending appeal "is to hold the matter under review in abeyance because the appellate court lacks sufficient time to decide the merits." *Nken* v. *Holder*, 556 U.S. 418, 432 (2009).

Likewise, to obtain a stay, the Government needed only show a "fair prospect" that the district court's injunction would be reversed—not a certainty. *Hollingsworth*, 558 U.S. at 190; *see also, e.g., Merrill*, 142 S. Ct. at 879 (Kavanaugh, J., concurring); *Little* v. *Reclaim Idaho*, 140 S. Ct. 2616 (2020) (Roberts, C.J., concurring). Thus, the stay "ruling means only that the Federal Government is likely to be able to show that this departure is lawful, not that it actually is so." *Missouri*, 142 S. Ct. at 659 (Alito, J., dissenting).

By granting the stay in this case, the Court "h[e]ld the matter under review in abeyance" to allow it "sufficient time to decide the merits." *Nken*, 556 U.S. at 432. The Court should now grant this petition to "decide the merits." *Id.*

Indeed, nothing in the past three months has diminished the case's importance. The Mandate's

validity is "an important question of federal law that has not been, but should be, settled by this Court." S. Ct. R. 10(c). And the harms that the States are currently experiencing provide further "compelling reasons" to review this case. S. Ct. R. 10. The States are already facing closures and service cuts at healthcare facilities, especially in rural and underserved areas, as a result of the Mandate.

For example, six weeks before the Mandate went into full effect, Missouri was already experiencing closures of much-needed skilled nursing facilities and other facilities in rural areas. Missouri's Department of Health and Senior Services adopted an emergency regulation 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." C.A. Mot. to Expedite,[2] Ex. B (Bollin Decl. ¶¶ 4-5). As of February 28, 2022, "DHSS ha[d] received closure plans from eight (8) facilities so far," three of which had already closed outright. *Id.* ¶ 8. Likewise, on March 1, 2022, a private health system of skilled nursing facilities in Missouri reported that, "[a]s a result of implementation of the CMS vaccine mandate … 5 [of its] 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*." *Id.* Ex. C (McClain Decl., ¶ 12) (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

[2] "C.A. Mot. to Expedite" refers to the States' Unopposed Motion to Expedite the appeal, filed in the Eighth Circuit on March 2, 2022, and the Exhibits thereto.

have been forced to reduce their patient census in order to provide proper care." *Id.*

On March 15, 2022, Nebraska's Governor issued Executive Order No. 22-02, extending Nebraska's state of emergency with respect to hospital capacity in Nebraska. The Governor found that "just when hospitals, clinics, and other health care facilities began experiencing staffing relief, the Biden Administration implemented a vaccine mandate for all hospitals, clinics and other health care facilities that receive funding from the Center for Medicare & Medicaid Services," and that "the Biden Administration's forced termination of non-vaccinated employees at hospitals, clinics and other health care facilities will likely lead to staffing emergencies at many hospitals, clinics and other health care facilities in Nebraska." Neb. E.O. 22-02 (March 15, 2022).

Indeed, many small healthcare facilities continue to 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, it "has had to implement crisis staffing standards," thus "causing us to pay exorbitant agency costs to cover open shifts." C.A. Mot. to Expedite, Ex. E (Stalcup Decl. ¶¶ 12, 14). "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." C.A. Mot. to Expedite, Ex. F (Ribordy Decl., ¶ 13). Such experiences are being replicated across rural America. The Court should grant review and hold the Mandate invalid.

II. The Mandate Is Unlawful, Arbitrary and Capricious, and Unconstitutional.

The Court should also grant certiorari because there are compelling reasons to conclude that the Mandate is invalid, including multiple grounds not considered or addressed in the Court's stay opinion.

A. CMS failed to consider reliance interests.

Before the Mandate, CMS had a longstanding policy—going back to the agency's very beginning—of *not* mandating vaccines for healthcare workers: "We have not previously required any vaccinations." 86 Fed. Reg. 61,567, 61,568. Before September 9, 2021, CMS considered the issue anew and affirmatively "chose … to encourage rather than mandate vaccination" for COVID-19. *Id.* at 61,583. CMS's no-mandate policy, therefore, was explicit, longstanding, and recently reaffirmed.

After September 9, 2021, CMS abruptly changed course, under the President's instructions. But "[w]hen an agency changes course, as [CMS] did here, it must be cognizant that longstanding policies may

have engendered serious reliance interests that must be taken into account." *Dep't of Homeland Sec.* v. *Regents of the Univ. of California*, 140 S. Ct. 1891, 1913 (2020) (quotation marks omitted) (quoting *Encino Motorcars, LLC* v. *Navarro*, 136 S. Ct. 2117, 2126 (2016)). Yet CMS "failed to address whether there was 'legitimate reliance' on the" prior policy. *Id.* (quoting *Smiley* v. *Citibank (South Dakota), N.A.*, 517 U.S. 735, 742 (1996)). There is literally no discussion of reliance interests in the Mandate. Though the Mandate spans 73 pages of the Federal Register, a text search reveals that it does not contain the words "reliance," "rely," or "relied." 86 Fed. Reg. 61,555-61,627. (Its sole use of "relying," App.264a, does not refer to reliance interests.)

Yet there were extensive reliance interests to consider. Small healthcare facilities, whose staff were already thinly stretched by the pandemic, consciously relied on CMS's prior policy in hiring and retaining unvaccinated workers to fill critical staffing shortfalls. *Supra*, Statement of the Case, Part D. Virtually every small rural facility acted thus in reliance on the prior policy, and several of the States' declarants specifically attested to this fact. For example, "[b]eginning on or about August 2021 the State of Nebraska attempted to hire unvaccinated health care workers to help staff its state-run facilities *specifically relying upon prior CMS rules allowing this practice*." Mo. Stay App. 95a (emphasis added); *see also id.* at 78a, 119a. Every facility relied on the previous policy by hiring and retaining substantial numbers of unvaccinated staff to meet staffing shortfalls. *Supra*, Statement of the Case, Part D.

Healthcare workers, too, relied on CMS's prior policy of not mandating vaccines. *Id.* Unvaccinated

workers took jobs in reliance on the policy—sometimes transferring from facilities with private vaccine mandates. *Id.* Those individuals took jobs and "embarked on careers" in reliance on CMS's prior policy. *Regents*, 140 S. Ct. at 1914. Now they stand to lose those jobs because of CMS's mandate. The consequences of those job losses—with attendant service reductions and facility closures—"radiate outward" to injure not only those workers' families, but also patients, facilities, and local economies. *Id.* Vaccinated workers, likewise, relied on their unvaccinated coworkers to fill up critical staffing shortfalls to avoid excessive shifts and burnout. *Id.*

CMS gave no consideration to these reliance interests. The Mandate does not mention them. Accordingly, the district court correctly held that "CMS did not properly consider *all* necessary reliance interests of facilities, healthcare workers, and patients." App. 35a. The Court did not address this issue in its stay opinion. *See Missouri*, 142 S. Ct. 647. It provides a compelling reason to grant certiorari and reverse here.

B. The Mandate is a pretext and *post hoc* rationalization for the President's vaccine-maximizing policy.

The Mandate is also overtly pretextual. It is a *post hoc* rationalization for a new policy that the President dictated to the agency after the agency had previously rejected it. But the President's policy was not imposed to protect patients; it was imposed as part of an overarching plan to mandate vaccination for as many Americans as possible, all in one stroke.

The President's Speech and Plan were explicit about the Mandate's purpose: To require as many

Americans as possible to be vaccinated, using whatever coercive powers were available to the federal government. The Speech announced "a new plan to require more Americans to be vaccinated," emphasizing that its purpose was to "increase vaccinations among the unvaccinated with new vaccination requirements." Speech, *supra*. The Plan's purpose was to "reduce the number of unvaccinated Americans by using regulatory powers and other actions to substantially increase the number of Americans covered by vaccination requirements." Plan, *supra*.

CMS produced an elaborate justification for the Mandate, spanning 73 pages of the Federal Register. 86 Fed. Reg. 61,555-61,627. But these 73 pages do not mention the Mandate's actual motivation—*i.e.*, the Administration's professed goal of requiring as many Americans as possible to be vaccinated. The reason for this omission is not hard to fathom: CMS lacks authority to mandate vaccination for its own sake. Instead, CMS claimed to be adopting the Mandate to protect *patients* from becoming infected by unvaccinated healthcare workers. This patient-protection rationale, however, was barely mentioned in the Speech and the Plan, and it never moved CMS to adopt such any such mandate in the many months of pandemic before September 9, 2021.

Thus, the entire Mandate is an "impermissible '*post hoc* rationalization.'" *Regents*, 140 S. Ct. at 1896 (quoting *Citizens to Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 420 (1971)). CMS did not identify a danger to patients from COVID-19 and then fashion a standard to protect them. Instead, the White House dictated the standard to CMS in advance, and CMS reverse-engineered an elaborate justification for that

standard. Such "*post hoc* rationalizations ... cannot serve as a sufficient predicate for agency action." *Id.* at 1909 (quoting *American Textile Mfrs. Institute, Inc.* v. *Donovan*, 452 U.S. 490, 539 (1981)).

For the same reasons, the Mandate is impermissibly "pretextual." *Dep't of Commerce*, 139 S. Ct. at 2573. Just as with the OSHA mandate, CMS "pursued its regulatory initiative only as a legislative 'work-around.'" *NFIB* v. *OSHA*, 142 S. Ct. 661, 668 (2022) (Gorsuch, J., concurring) (quoting *BST Holdings*, 17 F.4th at 612). "After the President voiced his displeasure with the country's vaccination rate in September," CMS "pored over the U.S. Code in search of authority, or a 'work-around,' for imposing a national vaccine mandate." *BST Holdings*, 17 F.4th 612. It settled on "a constellation of statutory provisions that each concern one of the 15 types of medical facilities that the rule covers." *Missouri*, 142 S. Ct. at 656 (Thomas, J., dissenting). But this was pretextual. "In reviewing agency pronouncements, courts need not turn a blind eye to the statements of those issuing such pronouncements," *BST Holdings*, 17 F.4th at 614, and this Court is "not required to exhibit a naiveté from which ordinary citizens are free." *Dep't of Commerce* v. *New York*, 139 S. Ct. 2551, 2575 (2019) (quoting *United States* v. *Stanchich*, 550 F.2d 1294, 1300 (2d Cir. 1977) (Friendly, J.)).

As in *Department of Commerce*, the Speech and the Plan "reveal a significant mismatch between the decision the Secretary made and the rationale he provided." 139 S. Ct. at 2575. "The reasoned explanation requirement of administrative law, after all, is meant to ensure that agencies offer genuine justifications for important decisions." *Id.* at 2575-76. "In order to permit meaningful judicial review, an

agency must "disclose the basis" of its action." *Dep't of Commerce*, 139 S. Ct. at 2573 (quoting *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156, 167–69 (1962)). The Mandate runs afoul of this principle.

C. The Mandate is unconstitutional.

In addition, the Mandate is unconstitutional under the Spending Clause, the anti-commandeering doctrine, and the Tenth Amendment. The States raised these constitutional claims before the district court, but it declined to reach them, App. 15a-16a n.8, and this Court's stay opinion did not address them. *Missouri*, 142 S. Ct. at 653-54.

First, the Mandate violates the Spending Clause because the dozens of scattered statutory provisions cited by CMS do not provide clear notice that the federal government could impose a vaccine mandate. "[I]f Congress desires to condition the States' receipt of federal funds, it must do so unambiguously, enabling the States to exercise their choice knowingly, cognizant of the consequences of their participation." *South Dakota* v. *Dole*, 483 U.S. 203, 207 (1987) (cleaned up) (quoting *Pennhurst State School and Hospital* v. *Halderman*, 451 U.S. 1, 17 (1981)).

The Mandate's rule of compulsory vaccination is a surprising and unprecedented requirement that an informed reader of the relevant statutes would not have anticipated—including, evidently, CMS itself, which had never imposed a vaccine mandate for healthcare workers. "Previous Medicaid [regulations] simply do not fall into the same category as the one at stake here." *NFIB* v. *Sebelius*, 567 U.S. 519, 585 (2012) (plurality opinion). This Court has held for over a century that compulsory-vaccination policies "are matters that do not ordinarily concern the national

government." *Jacobson* v. *Commonwealth of Massachusetts*, 197 U.S. 11, 38 (1905). "Vaccine mandates … fall squarely within a State's police power, … and, until now, only rarely have been a tool of the Federal Government." *Missouri*, 142 S. Ct. at 658 (Thomas, J., dissenting)) (citing *Zucht* v. *King*, 260 U.S. 174, 176 (1922)).

CMS asserted statutory authority for the Mandate by a blunderbuss citation of dozens of statutory provisions in definitional and ancillary provisions. 86 Fed. Reg. 61,567. In the face of a century of contrary understanding, this "hodgepodge of provisions," *Missouri*, 142 S. Ct. at 656 (Thomas, J., dissenting), falls far short of the constitutionally required "clear notice" that the Spending Clause requires for such funding conditions. *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). The Spending Clause "does not include surprising participating States with post-acceptance or 'retroactive' conditions." *NFIB*, 567 U.S. at 584.

Further, as in *NFIB*, the Mandate "accomplishes a shift in kind, not merely degree." 567 U.S. at 583. Under the Mandate, Medicare is "no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal" vaccination of Americans. *Id.* at 583. "A State could hardly anticipate that" the statutes cited by CMS "included the power to transform [Medicare and Medicaid] so dramatically." *Id*. at 584.

Second, the Mandate is unconstitutionally coercive under the Spending Clause and violates the anti-commandeering doctrine. Under the Spending Clause, this Court recognizes that "the financial inducement offered by Congress might be so coercive

as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine Co.* v. *Davis*, 301 U.S. 548, 590 (1937)). And CMS cannot use Congress's spending power to "commandeer[] a State's ... administrative apparatus for federal purposes," *NFIB*, 567 U.S. at 577, or "conscript state [agencies] into the national bureaucratic army," *id.* at 585. The States cannot be "dragoon[ed]" to "administer" "federal regulatory programs." *Printz* v. *United States*, 521 U.S. 898, 928 (1997). "That is true whether Congress directly commands a State to regulate or indirectly coerces a State to adopt a federal regulatory system as its own." *NFIB*, 567 U.S. at 578.

CMS lacks its own apparatus to enforce the Mandate; instead, CMS presses "State surveyors" into federal service to enforce the Mandate. 86 Fed. Reg. 61,574. These include hundreds of surveyors who are officials of the States. Mo. Stay App. 36a-37a, 57a-60a, 95a, 134a, 139a. If States instruct their surveyors not to enforce the Mandate, that will disqualify Medicare- and Medicaid-certified providers in their States from reimbursements. *See id.* at 95a. It is hard to imagine a more coercive condition. Forcing States to administer the Mandate or risk jeopardizing all Medicare and Medicaid funds flowing into their States is "a gun to the head" that compels States to participate against their will. *NFIB*, 567 U.S. at 581. It is "economic dragooning" that leaves States "with no real option but to acquiesce." *Id.* at 582. And because it is unconstitutionally coercive, it also "dragoon[s]" the States into enforcing it. *Printz*, 521 U.S. at 928.

Third, for similar reasons, the Mandate violates the Tenth Amendment. As mentioned, compulsory

vaccinations "do not ordinarily concern the national government." *Jacobson*, 197 U.S. at 38. "So far as they can be reached by any government," they lie within the police power of the States, and "depend, primarily, upon such action as the state, in its wisdom, may take." *Id.* "The safety and health of the people of" each State "are, in the first instance, for that commonwealth to guard and protect." *Id.* This "police power" is "a power which the state did not surrender when becoming a member of the Union under the Constitution." *Id.*

D. The Mandate suffers from other fatal defects.

The Mandate also exceeds CMS's statutory authority, is arbitrary and capricious, and violates the APA's procedural requirement for notice-and-comment, for the reasons stated in the States' Response to the Government's Application for a Stay. *See* Mo. Stay Opp. 10-24, 24-32, 32-34.

III. The Court Should Grant Expedited Review.

The Court should grant expedited review and hear this case at the first sitting of the October 2022 Term. The States have filed this petition early, one month after the Eighth Circuit's judgment. The Government should be required to file its brief in opposition within 30 days without extension. The States will waive the 14-day period for filing their reply brief before distribution to conference. The Court should then grant the petition and order a merits briefing schedule to allow argument at the first sitting in October 2022. At the Government's request, the Court recently adopted a similar approach in *Biden* v. *Texas*, No. 21-954. This case, likewise, merits expedited consideration. *See also, e.g., Department of Commerce*

v. *New York*, 139 S. Ct. 953 (2019); STEPHEN M. SHAPIRO ET AL., SUPREME COURT PRACTICE 13-5, 14-13 & n.25 (11th ed. 2019) (listing 17 cases in which such expedited scheduling was granted).

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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