No. 21-3725

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

STATE OF MISSOURI, et al.,

Plaintiffs-Appellees,

v.

JOSEPH BIDEN, JR., et al.,

Defendants-Appellants.

DEFENDANTS-APPELLANTS' EMERGENCY MOTION FOR STAY PENDING APPEAL

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INTRODUCTION AND SUMMARY OF ARGUMENT

Congress spends hundreds of billions of dollars each year under the Medicare and Medicaid programs to protect the health of Americans. Congress specified that hospitals and other participating facilities must meet requirements set by the Secretary of Health and Human Services (HHS) to ensure the health and safety of patients. In the rule at issue here, the Secretary established a condition of participation requiring covered staff at such facilities to be vaccinated against COVID-19, to prevent transmission of the virus to patients. Because cases and deaths are expected to spike in the coming winter months, unvaccinated staff at participating facilities must receive their first vaccine dose by December 6, or request an exemption by that date. The Secretary projected that the rule will save hundreds and potentially thousands of lives every month.

More than 50 leading professional organizations representing health care workers—including the American Medical Association and the American Nurses Association—support COVID-19 vaccination requirements for health care workers. *Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care (Joint*

Statement).[1] These organizations emphasized that this step "is the logical fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being." *Id*. As the Secretary explained, health care workers have long been required by employers to be vaccinated against diseases such as influenza, hepatitis B, and other infectious diseases.

Nonetheless, the district court enjoined the vaccination rule's enforcement against any Medicare- and Medicaid-participating facilities within the ten plaintiff States. The court declared that the rule exceeds the Secretary's statutory, that it is arbitrary and capricious, and that the Secretary did not have good cause to make the rule effective without delay.

The preliminary injunction rests on a series of errors and should be immediately stayed pending appeal. The Secretary has explicit statutory authority to require facilities voluntarily participating in Medicare and Medicaid to meet health and safety standards for the protection of patients. Longstanding regulations require these facilities to have infection-control

[1] https://perma.cc/ECD8-ARE2.

programs that prevent the transmission of communicable disease. And ample evidence supports the Secretary's determination that the staff-vaccination requirement will provide crucial protections for patients in the coming months, when COVID-19 cases are expected to spike.

The Secretary comprehensively addressed the only concrete countervailing concern that plaintiffs identified: the risk that the vaccination requirement will prompt unvaccinated workers to quit in large numbers and exacerbate labor shortages. The Secretary found on the basis of recent empirical evidence that this concern is overstated and outweighed by other effects. The Secretary explained, for example, that after a large hospital system in Texas imposed a COVID-19 vaccine mandate, 99.5% of its 26,000 workers received the vaccine. Likewise, 98% of 33,000 workers complied with a Detroit-based system's vaccine mandate. More than 97% complied with vaccine mandates imposed by a Delaware-based health system with more than 14,000 employees and a North Carolina-based system with more than 35,000 employees. Furthermore, the Secretary found that the potential adverse effect of the vaccination rule in the labor market would be offset by reduced staff absenteeism from lowered staff infection, quarantine, and illness, and would also be dwarfed by the

regular churn of employees in the health care workforce, where about a quarter of a health care facility's staff on average are new hires each year.

In short, plaintiffs' claims are meritless, and the remaining stay factors overwhelmingly favor the federal government. The preliminary injunction should be immediately stayed pending appeal.

STATEMENT

A. The Medicare And Medicaid Programs

Under the Medicare and Medicaid programs, Congress spends hundreds of billions of dollars each year to pay for health care. *See Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019) (noting that Medicare alone spends about $700 billion annually). Medicare, which is funded entirely by the federal government, covers individuals who are over age 65 or who have specified disabilities. *See id.* Medicaid, which is funded by the federal government and States, covers eligible low-income individuals including those who are elderly, pregnant, or disabled. *See National Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583, 585 (2012).

The facilities that provide health care to Medicare and Medicaid beneficiaries are entities such as hospitals, skilled nursing facilities (also known as nursing homes or long-term care facilities), home-health

agencies, and hospices. If a facility wishes to participate in these programs, it enters into a provider agreement for the applicable program after demonstrating that it meets the conditions for participation. 42 U.S.C. §§ 1395cc, 1396a(a)(27).

Congress charged the Secretary with responsibility to ensure that facilities participating in these programs protect the health and safety of their patients. For example, the Medicare statute authorizes payments for "hospital services," 42 U.S.C. § 1395d(a), and defines a "hospital" as an institution that meets such "requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution," *id.* § 1395x(e)(9); *see also, e.g.*, *id.* § 1395i-3(d)(4)(B) (providing that a "skilled nursing facility must meet" such "requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary"). The Medicaid statute also imposes health and safety requirements, *see, e.g.*, *id.* § 1396r(d)(4)(B)), or incorporates by cross reference analogous Medicare standards for psychiatric hospitals, *see id.* § 1396d(h); rural health clinics, *id.* § 1396d(*l*)(1), and hospices, *id.* § 1396d(o).

Longstanding regulations establish detailed "Conditions of Participation" for participating facilities that address (among other things), the qualifications of employees, the condition of the facilities, and other requirements that the Secretary deems necessary to protect patient health and safety. These regulations include the requirement that the facility maintain an effective "infection prevention and control program" to "provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." *See, e.g.*, 42 C.F.R. § 483.80 (long-term care facilities); *id.* § 482.42(a) (hospitals); *id.* § 416.51(b) (ambulatory surgical centers).

B. The Vaccination Rule For Facilities That Participate In Medicare Or Medicaid

The rule at issue here amended the infection-control regulations for facilities that participate in Medicare or Medicaid. To prevent health care workers from infecting patients with the virus that causes COVID-19, the rule requires facilities participating in Medicare or Medicaid to ensure that their staff are fully vaccinated against COVID-19, unless exempt for medical or religious reasons. 86 Fed. Reg. 61,555, 61,561, 61,572 (Nov. 5,

2021).[2] Covered staff must receive the first dose of a two-dose vaccine or a single-dose vaccine by December 6, 2021, or otherwise request an exemption by that date. *Id.* at 61,573. Non-exempt covered staff must be fully vaccinated by January 4, 2022. *Id.*

The rule rests on the Secretary's comprehensive analysis and finding that "vaccination of staff is necessary for the health and safety of individuals to whom care and services are furnished." *Id.* at 61,561. While many health care workers are vaccinated against COVID-19, vaccination rates remain too low in many health care facilities. *Id.* at 61,559. For example, as of mid-September 2021, COVID-19 vaccination rates for hospital staff and long-term care facility staff averaged 64% and 67%, respectively. *Id.*

Unvaccinated staff pose a threat to patients, because the virus that causes COVID-19 is highly transmissible and dangerous. *Id.* at 61,556-57. Given the virulence of this virus, it is readily spread among health care workers and from health care workers to patients. *Id.* at 61,557 n.16. In

[2] The rule exempts staff who telework full-time, and vendors and other professionals who perform infrequent, non-healthcare services. 86 Fed. Reg. at 61,571.

particular, unvaccinated health care workers are highly susceptible to transmitting the virus to their colleagues and patients. *Id.* at 61,558 n.42. And due to many of the factors that qualify them for enrollment (such as age, disability, and/or poverty), Medicare and Medicaid patients are more likely to face a high risk of developing severe disease and of experiencing severe outcomes from COVID-19 if infected. *Id.* at 61,566, 61,609.

Unvaccinated staff also jeopardize patients' access to needed medical care and services. *Id.* at 61,558. Out of a fear of exposure to the virus, patients are refusing care from unvaccinated staff, thereby limiting the ability of providers to meet the health care needs of their patients. *Id.* Patients also are forgoing medically necessary care altogether to avoid contracting the virus that causes COVID-19 from health care workers. *Id.* Absenteeism from health care staff as a result of infection with the virus has also created staffing shortages that have disrupted patient access to care. *Id.* at 61,559.

The Secretary explained that, in July 2021, more than 50 health care associations —including the American Medical Association and the American Nurses Association—jointly advocated for vaccine mandates for health care workers. 86 Fed. Reg. at 61,565 & n.122. The signatories

represent millions of workers throughout the U.S. health care industry, including groups representing doctors, nurses, long-term care workers, home care workers, pharmacists, physician assistants, public health workers, hospice workers, and epidemiologists. *Id.* Due to "the recent COVID-19 surge and the availability of safe and effective vaccines," these organizations urged that "all health care and long-term care employers require their workers to receive the COVID-19 vaccine." *Joint Statement*. The signatories explained that this step "is the logical fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being." *Id*.

In issuing the rule, the Secretary acknowledged the concern that the vaccination requirement could prompt some health care workers to leave their jobs rather than be vaccinated, but concluded on the basis of recent empirical evidence that this concern was overstated and outweighed by other effects and countervailing considerations. 86 Fed. Reg. at 61,608. The Secretary explained, for example, that after a large hospital system in Texas imposed a vaccine mandate, 99.5% of its staff received the vaccine. *Id*. at 61,569. Only 153 of its 26,000 workers—that is, only 0.6%—resigned rather

than receive the vaccine. *Id*. at 61,566, 61,569.[3] Similarly, a Detroit-based health system that imposed a vaccine mandate reported that 98% of its 33,000 workers were fully or partially vaccinated or in the process of obtaining a religious or medical exemption when the requirement went into effect, with exemptions comprising less than 1% of staff members. *Id*. at 61,569. A long-term care parent corporation established a vaccine mandate for its more than 250 facilities, leading to more than 95% of its workers being vaccinated; again, very few workers quit their jobs rather than be vaccinated. *Id*. A health care system that is the largest private employer in Delaware with more than 14,000 employees, and an integrated health system in North Carolina with more than 35,000 employees, instituted vaccination requirements and achieved vaccination rates of at least 97% among their staffs. *Id*. at 61,566. And when New York enacted a state-wide vaccine mandate for health care workers, it recorded a jump in vaccine compliance in the final days before the requirements took effect on October 1, 2021. *Id*. at 61,569.

[3] *See also More than 150 Employees Resign or Are Fired from Houston Hospital System After Refusing to Get Vaccinated*, Tex. Trib. (June 23, 2021), https://perma.cc/F2SA-53D6.

Furthermore, the Secretary concluded that the potential adverse effect in the health care labor market would be offset by reduced staff absenteeism from lowered rates of infection, quarantine, and illness among staff, as well as a return to work of employees who have stayed out of the workforce for fear of contracting the virus that causes COVID-19. *Id*. at 61,608. More generally, the Secretary explained that about a quarter of a health care facility's staff on average are new hires each year, and that this regular churn in the health care workforce would dwarf the effect of workers leaving for other employment as a result of the vaccination requirement. *Id.*

Based on his comprehensive analysis, the Secretary determined that "the available evidence for ongoing healthcare-associated COVID-19 transmission risk is sufficiently alarming in and of itself to compel [the agency] to take action," i*d*. at 61,558, and that the rule should be made effective without delay, *id*. at 61,583-85. The Secretary explained that patients in facilities funded by the Medicare and Medicaid programs are more likely than the general population to suffer severe illness or death from COVID-19, *id*. at 61,609; that there have already been more than half a million COVID-19 cases among health care staff, *id*. at 61,585; that COVID-

19 case rates among staff have grown since the Delta variant's emergence, *id*.; that COVID-19 cases are expected to spike during the coming winter months, *id*. at 61,584; and that this spike will coincide with flu season, raising the additional danger of combined infections, *id*. The Secretary predicted that the rule will save hundreds and potentially thousands of lives every month, and that "a further delay in imposing a vaccine mandate would endanger the health and safety of additional patients and be contrary to the public interest." *Id*. at 61,584.

ARGUMENT

In considering a stay motion, a court considers: (1) whether the applicant has made a strong showing that it is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies. *Nken v. Holder*, 556 U.S. 418, 425–26 (2009). Every factor supports the federal government here.

A. The District Court Lacked Jurisdiction To Enjoin Enforcement Of A Condition On Medicare Funding.

The preliminary injunction rests on a series of independent legal errors. As a threshold matter, the order—which purports to enjoin HHS from enforcing the vaccination rule "against any and all Medicare- and Medicaid-certified providers and suppliers within" the plaintiff States, R. Doc. 28, at 32—contravenes the Supreme Court's decision in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000). As that decision explained, the Medicare statute precludes a district court from exercising jurisdiction over a pre-enforcement challenge to a condition of Medicare participation; such challenges may proceed only through the special review system that the Medicare statute provides. Likewise, if a facility violates a rule that applies to both Medicare and Medicaid, the facility must seek review of the determination through the Medicare administrative appeals procedure. *Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 366 (6th Cir. 2000).

Accordingly, if a participating facility were to disregard the vaccination rule and be sanctioned for that reason, its remedy would be to challenge the sanction through the Medicare statute's administrative

appeal procedure. It makes no difference that the plaintiffs here are States. Just as the trade association in *Illinois Council* could not circumvent the Medicare statute's jurisdictional bar by bringing a pre-enforcement action on behalf of its members, neither can a State circumvent that bar by asking a district court to enjoin enforcement of a funding condition against participating facilities.

There is, moreover, an additional bar to plaintiffs' attempt to seek relief on behalf of privately-run facilities. The Supreme Court has long held that "[a] State does not have standing as *parens patriae* to bring an action against the Federal Government." *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 610 n.16 (1982). "While the state, under some circumstances, may sue in that capacity for the protection of its citizens," "it is no part of its duty or power to enforce their rights in respect of their relations with the federal government." *Massachusetts v. Mellon*, 262 U.S. 447, 485-486 (1923).

B. Plaintiffs' Challenges To The Vaccination Rule Are Meritless.

Assuming there is jurisdiction to consider the issues, plaintiffs' challenges to the vaccination rule are meritless.

1. The vaccination rule is within the Secretary's statutory authority.

The Secretary has statutory authority to require facilities participating in Medicare or Medicaid to adhere to standards that protect the health and safety of their patients. For example, the Medicare statute authorizes payments for "hospital services," 42 U.S.C. § 1395d(a), and defines a "hospital" as an institution that meets such "requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution," *id.* § 1395x(e)(9); *see also supra*, p. 5 (similar provisions for other types of facilities). Requiring health care workers to become vaccinated is a straightforward example of a "requirement[]" that is "necessary in the interest of the health and safety" of the patients that medical facilities exist to serve.

Moreover, Congress vested the Secretary with authority to issue such regulations "as may be necessary to the efficient administration of the functions with which" he is charged under the Social Security Act, which include the Medicare and Medicaid programs. 42 U.S.C. § 1302(a). The Supreme Court has emphasized that § 1302(a) and similarly worded delegations confer "broad rule-making powers." *Thorpe v. Housing Auth. of Durham*, 393 U.S. 268, 277 n.28 (1969). "Where the empowering provision

of a statute states simply that the agency may 'make . . . such rules and regulations as may be necessary to carry out the provisions of this Act,'" "the validity of a regulation promulgated thereunder will be sustained so long as it is 'reasonably related to the purposes of the enabling legislation.'" *Mourning v. Family Publ'ns Serv., Inc.*, 411 U.S. 356, 369 (1973) (quoting *Thorpe*, 393 U.S. at 280-81).

Contrary to the district court's premise, the CMS vaccination rule does not present an issue of "vast economic and political significance," "significantly alter the balance between federal and state power," or "invoke[] the outer limits of Congress' power." R. Doc. 28, at 4. Congress spends hundreds of billions of dollars annually to pay for health care at facilities that participate in Medicare and Medicaid. "Congress has authority under the Spending Clause to appropriate federal moneys to promote the general welfare" and "to see to it that taxpayer dollars appropriated under that power are in fact spent for the general welfare." *Sabri v. United States*, 541 U.S. 600, 605 (2004). This power applies regardless of whether Congress legislates "in an area historically of state concern." *Id.* at 608 n.*. The vaccination rule is a condition on federal funding for health care facilities, and it does not intrude on state police

powers any more than do the longstanding, unchallenged regulations requiring such providers to prevent the spread of infection within their facilities. *See, e.g.*, 42 C.F.R. §§ 416.51(b), 482.42(a), 483.80.

Nor does the vaccination rule impermissibly "dictate the private medical decisions of millions of Americans." R. Doc. 28, at 6-7. Health care workers have no right to endanger their patients. As the leading organizations representing health care workers explained, the requirement that such workers be vaccinated for COVID -19 "is the logical fulfillment of the ethical commitment of all health care workers to put patients as well as residents of long-term care facilities first and take all steps necessary to ensure their health and well-being." *Joint Statement*. The "ethical duty of receiving vaccinations is not new, as staff have long been required by employers to be vaccinated against certain diseases, such as influenza, hepatitis B, and other infectious diseases." 86 Fed. Reg. at 61,569. And even outside the health care context, the Supreme Court has rejected the contention that there is an individual right to refuse vaccination for communicable disease. *See Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

2. *Ample evidence supports the Secretary's determination that the vaccination rule will provide crucial protections for patients.*

There is likewise no merit to plaintiffs' contention that the vaccination rule is arbitrary and capricious. Ample evidence supports the Secretary's determination that staff vaccination at facilities participating in Medicare and Medicaid will provide important protections for patients.

More than 50 health care associations—including the American Medical Association and the American Nurses Association—jointly urged that "all health care and long-term care employers require their workers to receive the COVID-19 vaccine." *Joint Statement*. The signatories represent millions of workers throughout the U.S. health care industry, including groups representing doctors, nurses, long-term care workers, home care workers, pharmacists, physician assistants, public health workers, hospice workers, and epidemiologists. 86 Fed. Reg. at 61,565 & n.122. For example, the American Nurses Association—which "represent[s] the interests of the nation's 4.2 million registered nurses"—"supports health care employers mandating nurses and all health care personnel to get vaccinated against COVID-19 in alignment with current recommendations for immunization

by public health officials." *ANA Supports Mandated COVID-19 Vaccinations for Nurses and All Health Care Professionals* (July 26, 2021).[4]

The district court erred by substituting its views on epidemiology for the judgment of public health experts. Its discussion of "natural immunity" is illustrative. The court opined that health care workers previously infected with the virus that causes COVID-19 should be allowed to rely on "natural immunity," instead of vaccination, to prevent transmission of the virus to patients. R. Doc. 28, at 17. But as the Secretary explained, infection-induced immunity is not equivalent to receiving vaccination for COVID-19, 86 Fed. Reg. at 61,559, and even among those persons with prior infections, vaccination provides strong protection against reinfection, *id*. at 61,585 n.205. The Secretary accordingly followed the recommendations of the Centers for Disease Control & Prevention (CDC), which has found that the best academic evidence supports vaccination regardless of infection history. *Id*. at 61,560 & n.70.

[4] https://perma.cc/MS5A-4WTU.

3. Ample evidence supports the Secretary's determination that the rule's benefits for patients exceed the risks of causing labor shortages.

The Secretary specifically addressed the countervailing concern that the district court identified: the risk that the vaccination requirement will prompt significant numbers of health care workers to quit rather than receive the vaccine and exacerbate labor shortages. The Secretary found based on recent empirical data that any adverse impact on the labor market is likely to be small, offset by countervailing effects, and dwarfed by the regular churn in the health care workforce.

For example, after the Houston Methodist Hospital system imposed a COVID-19 vaccine mandate, only 153 of its more than 26,000 workers—that is, only 0.6%—resigned rather than receive the vaccine. *See supra*, pp. 9-10. Widespread compliance with vaccine mandates likewise occurred at a North Carolina-based health system with more than 35,000 employees, a Detroit-based health system with more than 33,000 employees, a Delaware-based health system with more than 14,000 employees, and a long-term care corporation with more than 250 facilities. 86 Fed. Reg. at 61,566, 61,569. For example, at the North Carolina-based Novant Health system, only 375 of 35,000 employees across 15 hospitals, 800 clinics, and hundreds

of outpatient facilities—that is, only 1% of the workforce—failed to comply.[5] Moreover, as the American Hospital Association emphasized, the vaccination rule at issue here "provides a level playing field across healthcare facilities," which further reduces the likelihood that health care workers will leave their jobs for other employment. *AHA Statement on CMS and OSHA Vaccine Mandate Rules* (explaining that the American Hospital Association "has been supportive of hospitals that call for mandated vaccination of health care workers in order to better protect patients and the communities we serve").[6]

Furthermore, the Secretary found that any adverse effect on the labor market caused by the rule would be offset by a reduction in COVID-19-induced staff absenteeism. 86 Fed. Reg. at 61,608. And more generally, such effects are dwarfed by the ordinary churn in the market for labor in the health care industry. In any given year, it is typical for about 2.66 million employees in health care settings to be new hires, in comparison to a total workforce of 10.4 million employees. *Id*. Plaintiffs provided no basis to reject these findings.

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[5] *See* Novant Health, *About Us*, https://perma.cc/K4PH-EE66.
[6] https://perma.cc/H6D9-XEQK.

4. Ample evidence supports the Secretary's determination that the vaccination rule should be established without delay.

There is likewise no basis to reject the Secretary's determination that there was good cause to make the vaccination rule effective immediately. *See* 86 Fed. Reg. at 61,583-85. The Secretary explained that patients in facilities funded by the Medicare and Medicaid programs are more likely than the general population to suffer severe illness or death from COVID-19, *id*. at 61,609; that there have already been more than half a million COVID-19 cases among health care staff, *id*. at 61,585; that rates among staff have grown since the Delta variant's emergence, *id*.; that COVID-19 cases are expected to spike during the coming winter months, *id*. at 61,584, and that this spike will coincide with flu season, raising the additional danger of combined infections, *id*.

The Secretary determined that "a further delay in imposing a vaccine mandate would endanger the health and safety of additional patients and be contrary to the public interest." *Id*. The Secretary predicted that the rule will save hundreds and potentially thousands of lives every month, *id*. at 61,612, which is ample cause to proceed without advance notice and comment. *See Sorenson Communications Inc. v. FCC*, 755 F.3d 702, 706 (D.C.

Cir. 2014) ("[W]e have approved an agency's decision to bypass notice and comment where delay would imminently threaten life."). The district court's suggestion that the Secretary should have acted "earlier," R. Doc. 28 at 10, would not, even if true, be reason to block a rule that will prevent many patient deaths in the coming months.

C. The Remaining Factors Overwhelmingly Favor A Stay Pending Appeal.

The remaining factors all support a stay pending appeal. There should be no doubt that delaying the rule would cause serious irreparable harm and be contrary to the public interest. If the rule is not implemented in advance of the anticipated COVID-19 surge, hundreds and potentially thousands of patients may die at hospitals, nursing homes, and other facilities participating in Medicare and Medicaid, as the result of COVID-19 infections transmitted to them by staff.

That threat to human life and health far exceeds the potential indirect harms to patients resulting from workers who may quit rather than receive the vaccine. There is no sound reason to reject the consensus of leading health care organizations and the judgment of the Secretary that the benefits of requiring health care workers to be vaccinated far outweigh any

countervailing concerns. Moreover, any sanctions that might be imposed against facilities that fail to comply with the rule are neither imminent nor irreparable, because they are reviewable in court.

The balance of equities and public interest are unaltered by state laws purporting to restrict vaccine mandates. Even assuming that a sovereign's abstract interest in enforcing its law is a cognizable Article III interest, the federal government has a sovereign interest in enforcing the vaccination rule at issue here. Thus, the balance of equities and public interest do not depend on abstract notions of sovereignty, but on the real world impact of the CMS vaccination rule. And as already explained, the protections that the rule provides for the health and safety of patients vastly outweigh any countervailing concerns.

D. Any Relief Must Be Limited To Those State-Run Facilities That Established Irreparable Injury.

Assuming *arguendo* that any relief is appropriate, it must be limited to those state-run facilities that demonstrated irreparable injury. The Supreme Court has emphasized that a "remedy must be tailored to redress the plaintiff's particular injury," *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018), and "injunctive relief should be no more burdensome to the defendant

than necessary to provide complete relief to the plaintiffs," *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (quotation marks omitted). Here, as already explained, plaintiffs cannot speak for privately run facilities or their workers, whose leading professional associations strongly support vaccination requirements for staff. A "showing of irreparable injury is the sine qua non of injunctive relief." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc) (quotation marks omitted). Thus, the Court should at a minimum stay the injunction except as to those state-run facilities that demonstrated irreparable harm.

CONCLUSION

The preliminary injunction should be stayed pending appeal or, at a minimum, stayed except as to those state-run facilities that demonstrated irreparable harm from the vaccination rule.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This motion complies with the type-volume limit of Federal Rule of Appellate Procedure 27(d)(2)(A) because it contains 4,710 words. This opposition also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Book Antiqua 14-point font, a proportionally spaced typeface.

s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF SERVICE

I hereby certify that on November 30, 2021, I electronically filed the foregoing motion with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Alisa B. Klein
Alisa B. Klein