UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, *Plaintiffs*,	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, *Defendants.*	§	

PLAINTIFFS' BRIEF IN SUPPORT OF
MOTION FOR TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

State Cases

Regulations

Other Authorities

The Biden Administration seeks to codify a right to abortion by rogue agency action that requires hospitals and physicians to perform elective abortions in violation of Texas law. Defendants' unconstitutional Abortion Mandate, ostensibly issued under the Emergency Medical Treatment and Labor Act (EMTALA), is already in effect. It requires doctors and hospitals to choose between performing abortions in violation of State law, their consciences, and their medical licenses, or complying with State law and caring for women as they always have and losing their Medicare and Medicaid funding.

Defendants' novel Abortion Mandate is causing imminent and irreparable harm. Plaintiffs respectfully request that the Court temporarily and preliminarily enjoin Defendants from enforcing it in Texas and against members of the plaintiff associations AAPLOG and CMDA.

I. BACKGROUND

On the same day the Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), ending the era of *Roe v. Wade*, President Biden announced immediate steps to counteract what he characterized as the Court's "extreme decision."[1] *Dobbs* returns the issue of abortion to the States. *Dobbs*, 142 S. Ct. at 2279, 2284. Accordingly, Texas law governs the regulation of abortion in Texas. But the Biden Administration has made its goal clear: to subvert State laws that protect unborn life.[2]

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[1] *Remarks by President Biden on the Supreme Court Decision to Overturn Roe v. Wade*, THE WHITE HOUSE (June 24, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/24/remarks-by-president-biden-on-the-supreme-court-decision-to-overturn-roe-v-wade/; President Biden (@POTUS), Twitter (July 8, 2022, 11:39 AM), https://twitter.com/POTUS/status/1545447455558406145?cxt=HHwWgsC4-bmRxPIqAAAA.

[2] *See, e.g.*, *What They Are Saying: President Biden Signs Executive Order to Protect Access to Reproductive Healthcare Services*, THE WHITE HOUSE (July 8, 2022),

A. The Abortion Mandate

On July 8, 2022, President Biden issued an Executive Order[3] that required HHS Secretary Becerra to submit a report to the President "identifying steps to ensure that all patients—including pregnant women and those experiencing pregnancy loss, such as miscarriages and ectopic pregnancies—receive the full protections for emergency medical care afforded under the law, including by considering updates to current guidance on obligations specific to emergency conditions and stabilizing care under the Emergency Medical Treatment and Labor Act [EMTALA], 42 U.S.C. §1395dd." *Id.* at 42054.

Four days later, President Biden announced HHS's new mandate purporting to override individual states' abortion laws under the authority of EMTALA,[4] and the Centers for Medicare and Medicaid Services (CMS) of HHS issued agency guidance to all State Directors entitled "Reinforcement of EMTALA Obligations Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss" (EMTALA Guidance).[5] Additionally, Secretary Becerra issued a

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https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/08/what-they-are-saying-president-biden-signs-executive-order-to-protect-access-to-reproductive-healthcare-services/ ("This Executive Order builds on the actions his Administration has already taken to defend reproductive rights by . . . [s]afeguarding access to reproductive health care services, including abortion and contraception.").

[3] "Protecting Access to Reproductive Healthcare Services." Exec. Order No. 14,076, 87 Fed. Reg. 42053 (2022), available at https://www.federalregister.gov/documents/2022/07/13/2022-15138/protecting-access-to-reproductive-healthcare-services.

[4] President Biden (@POTUS), TWITTER (July 12, 2022, 3:25 PM), https://twitter.com/potus/?lang=en.

[5] Exh. 1, Appx. 002 *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss*, CENTERS FOR MEDICARE & MEDICAID SERVICES (July 11, 2022), https://www.cms.gov/files/document/qso-20-15-hospital-cah-emtala-revised.pdf (last visited Aug. 3, 2022).

letter to providers[6] describing the guidance (together, the "Abortion Mandate").

While the EMTALA Guidance claims to simply remind hospitals of existing legal obligations,[7] it does far more. It imposes unprecedented new requirements to provide abortions that have never existed under federal law or EMTALA. The Abortion Mandate requires that a provider perform an abortion if "abortion is the stabilizing treatment necessary to resolve [an emergency medical condition]," which could encompass elective abortions such as in the case of "incomplete medical abortion."[8] This mandate is novel, unauthorized, and illegal.

EMTALA does not mandate specific procedures. It is a provision of the Social Security Act that ensures Medicare-participating hospitals stabilize patients with emergency medical conditions regardless of the patient's ability to pay. 42 U.S.C. § 1395dd. This is an "anti-dumping" requirement. *See Burditt v. U.S. Dept. of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991). In EMTALA, Congress did not impose a "national standard of care" or seek "to improve the overall standard of medical care." *See, e.g., Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995). EMTALA requires only that hospitals stabilize indigent patients with the same care afforded to other patients. *See Marshall on Behalf of Marshall v. E. Carroll Par. Hosp. Serv. Dist.*, 134 F.3d 319, 323–24 (5th Cir. 1998) (holding that an EMTALA violation, requires "that the Hospital tread her differently from other patients"); *see also Baber v. Hosp. Corp. of America*, 977 F.2d 872, 878 (4th Cir. 1992) EMTALA only requires hospitals to apply their standard

[6] Exh. 2 at Appx. 009 Letter to Health Care Providers, SECRETARY OF HEALTH AND HUMAN SERVICES, https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf (last visited Aug. 3, 2022).

[7] Exh. 1 at Appx. 003.

[8] *Id.* at Appx. 002, 007.

screening procedure for identification of an emergency medical condition uniformly to all patients").

Under EMTALA, the relevant issue is "whether the challenged procedure was identical to that provided similarly situated patients, as opposed to whether the procedure was adequate as judged by the medical profession." *Eberhardt*, 62 F.3d at 1258. Indeed, "[a] hospital's liability under EMTALA is not based on whether the physician . . . failed to adhere to the appropriate standard of care." *Battle ex rel. Battle v Mem'l Hosp. at Gulfport*, 228 F.3d 544, 557 (5th Cir. 2000); *see also Guzman v. Mem'l Hermann Hosp. Sys.*, 637 F. Supp. 2d 464, 487 (S.D. Tex. 2009) (Rosenthal, J.) ("EMTALA does not create a national standard of care and is not a medical malpractice statute."). EMTALA confers no right to any specific treatment and does not operate as federal oversight on the practice of medicine.

EMTALA requires stabilizing patients in an "emergency medical condition," which includes "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in–(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily function or part." 42 U.S.C. § 1395dd(e)(1)(A). "To stabilize" means "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. § 1395dd(e)(3).

EMTALA does not specify what treatment to provide, much less authorize an Abortion Mandate. Notably, EMTALA requires stabilizing "the unborn child," *id.* at 1395dd(c), (e), as do CMS rules. 42 C.F.R. § 489.24. By leaving standards of care to State law, Congress imposed a presumption against preemption of State law under EMTALA, unless a State requirement "directly conflicts with a requirement of this section." *Id.* at § 1395dd(f). The Social Security Act reiterates that "[n]othing in this subchapter [which includes § 1395dd] shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration or operation of any such institution, agency, or person [providing health services]." 42 U.S.C. § 1395. Further, EMTALA's enforcement provisions show that State law sets the standard of care by specifying that a private suit for violating EMTALA will be subject to "the law of the *State* in which the hospital is located." 42 U.S.C. § 1395dd(d)(2) (emphasis added).

But the Biden administration has chosen to weaponize EMTALA to mandate abortions as a politicized reaction to the *Dobbs* decision. The Biden Administration has already filed suit against the State of Idaho, asserting that EMTALA requires the State's hospitals to provide abortions when the mother's "health"—but not her life—is at risk.[9] The Abortion Mandate's penalties include civil fines of over $119,000 per violation.[10] The Abortion Mandate threatens to terminate

[9] *United States v. Idaho*, No. 1:22-cv-329 (D. Idaho Aug. 2, 2022).

[10] Ex. 1 at Appx. 005-007.

hospitals' Medicare provider agreements and exclude them from State health care programs, which include Medicaid, CHIP, and certain block grants.[11]

This represents a significant amount of funding. Texas hospitals and physicians receive approximately $15.98 billion per year from the federal government in the form of reimbursements for services under Medicaid alone.[12] Texas Tech University System operates Texas Tech University Health Science Center and Texas Tech University Health Science Center El Paso, both of which are State of Texas institutions of higher education.[13] Those institutions received almost $149 million in Medicare and Medicaid funding since September 1, 2021 through August 2, 2022.[14] Under the Abortion Mandate, individual physicians and hospitals must risk these fines and exclusions, unless they violate their religious and conscience rights and risk prosecution under state abortion laws. An injunction from this Court is necessary to prevent these imminent and irreparable harms.

B. The Mandate Infringes on Texas's Abortion Laws and Physicians' Consciences

The Abortion Mandate injures Texas because it purports to preempt Texas laws.[15] First, the Human Life Protection Act states that "[a] person may not knowingly perform, induce, or attempt an abortion." Act of May 25, 2021, 87th Leg., R.S., ch. 800, § 2, 2021 Tex. Sess. Law

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[11] *Id.* at Appx. 005-007; 42 U.S.C. § 1395dd(d)(1); 42 U.S.C. § 1320a-7(h) (defining State health care programs); see also 1 Tex. Admin. Code § 354.1077(a) (requiring that a hospital must be "enrolled and participating in the Medicare Program as a hospital" to "qualify for participation as a hospital in the Texas Medical Assistance (Medicaid) Program").

[12] Exh. 3 at Appx. 012 (Declaration of Victoria Grady).

[13] Exh. 9 at Appx. 038 (Declaration of Eric Bentley).

[14] *Id.* at Appx. 039.

[15] Exh. 1 at Appx. 002. And the Federal Government has represented to the federal Court in Idaho that it does. *See United States v. Idaho*, No. 1:22-cv-329.

Serv. 1887 (H.B. 1280) (effective Aug. 25, 2022) (to be codified at Tex. Health & Safety Code Ch. 170A). The penalty for violating the HLPA includes two years to life in prison and a fine of not less than $100,000. *Id.* (to be codified at Tex. Health & Safety Code §§170A.004–.005); Tex. Penal Code §§ 12.32–.33. That prohibition contains an exception where the woman "has a life-threatening physical condition" arising from a pregnancy that places her "at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed." H.B. 1280 at § 2 (to be codified at Tex. Health & Safety Code § 170A.002(b)(2)). The Human Life Protection Act is effective on the thirtieth-day after the issuance of a United States Supreme Court judgment in a decision overruling *Roe v. Wade*. H.B. 1280 at § 3(1)—which has already occurred. No further action by the Texas Legislature or any state official is required. Accordingly, it will become effective on August 25, 2022.

In addition to the Human Life Protection Act, Texas has current laws predating *Roe* that address the subject of abortion. *See* Tex. Rev. Civ. Stat. arts. 4512.1–.4, .6 (2010) (former Tex. Penal Code arts. 1191–1194, 1196 (1925)). Under those statutes, any person who causes an abortion is guilty of an offense and shall be confined in a penitentiary. *Id.* at 4512.1. Moreover, an individual may not act as an accomplice to abortion or an attempted abortion. *Id.* at 4512.2–.3. However, it is not on offense if the abortion is performed under "medical advice for the purpose of saving the life of the mother." *Id.* at 4512.6.

In Texas, if a physician "commits an act that violates any state or federal law . . . connected with the physician's practice of medicine," Tex. Occ. Code § 164.053(a)(1), the Texas Medical Board may revoke or suspend the physician's license. Tex. Occ. Code § 164.001; Tex. Occ. Code

§ 164.052(a)(5). Accordingly, if Texas physicians violate State law by providing abortions when the life of the mother is not in danger, they risk losing their licenses.[16]

The Abortion Mandate also tramples on the statutory religious and conscience rights of members of plaintiff physician groups the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and the Christian Medical and Dental Associations (CMDA), who practice in Texas and in states nationwide. The Abortion Mandate directly violates federal laws such as 42 U.S.C. § 238n, which prohibits the federal government from requiring a physician to perform an abortion, and the Religious Freedom Restoration Act (RFRA), 42 U.S.C. § 2000bb–2000bb-4, which restricts the federal government from substantially burdening the religious beliefs of physicians. Texas also protects the conscience right of physicians to object to performing abortions, Tex. Occ. Code § 103.001, and EMTALA does not authorize Defendants to preempt that law.

II. ARGUMENT

A plaintiff seeking a temporary restraining order or preliminary injunction must establish (1) that it is likely to succeed on the merits of its claims, (2) "that he is likely to suffer irreparable harm in the absence of preliminary relief," (3) "that the balance of equities tips in his favor," and (4) "that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The standards for securing a temporary restraining order or preliminary injunction are

[16] Moreover, Texas law explicitly provides that the removal of an ectopic pregnancy or a dead, unborn child is not an abortion. Under Texas Health and Safety Code § 245.002, "[a]n act is not an abortion if the act is done with the intent to: (A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion; or (C) remove an ectopic pregnancy." If, for example, "stabilizing treatment" means treating an ectopic pregnancy, that is not a violation of Texas law.

substantively the same. *Clark v. Richard*, 812 F.2d 991, 993 (5th Cir. 1987); *Texas v. United States*, 524 F. Supp. 3d 598, 651 (S.D. Tex. 2021). To preserve the status quo, federal courts have regularly enjoined federal agencies from implementing and enforcing new regulations pending litigation challenging them. *See, e.g.*, *Texas v. United States*, 787 F.3d 733 (5th Cir. 2015) (enjoining executive order inconsistent with immigration statutes); *Texas*, 524 F. Supp. 3d at 667.

A. Texas and the Medical Groups are likely to succeed on the merits of their claims.

Agency rules and guidance are subject to judicial review. *See Texas v. EEOC*, 933 F.3d 433, 441 (5th Cir. 2019); *see also Coliseum Square Ass'n, Inc. v. Jackson*, 465 F.3d 215, 232 (5th Cir. 2006); *Chamber of Commerce of U.S. v. Reich*, 74 F.3d 1322, 1324 (D.C. Cir. 1996). Plaintiffs challenge the Abortion Mandate on both statutory and constitutional grounds and are likely to succeed on the merits of their claims because the Abortion Mandate is unlawful. First, Defendants acted *ultra vires* in promulgating the Mandate. Second, the Abortion Mandate violates the Administrative Procedure Act (APA) and is contrary to law. Finally, the Abortion Mandate violates the United States Constitution.

1. Defendants acted *ultra vires* in issuing the Abortion Mandate.

The Social Security Act contemplates limited rulemaking. The Secretary of HHS is authorized to prescribe only those regulations as are "necessary to carry out the *administration* of the insurance programs under this subchapter." 42 U.S.C. § 1395hh(a)(1) (emphasis added). That the "administration" of EMTALA would mandate abortions is belied by the very text of the statute. EMTALA recognizes and protects the unborn child in the context of an emergency medical condition. *See* 42 U.S.C. § 1395dd(e)(1)(A)(i); *Id.* at § 1395dd(e)(1)(B)(ii). EMTALA requires Medicare-participating hospitals to consider and "minimize[] the risk to . . . the health of the unborn child" when transferring the mother to another medical facility. *Id.* at

§ 1395dd(c)(2)(A). A requirement that physicians abort unborn children cuts squarely against this express command. No one disputes that, in some tragic cases, stabilizing treatment may result in the death of an unborn child—such as the treatment of an ectopic pregnancy.[17] But those cases have never justified an abortion *mandate* under EMTALA—that statute protects the "unborn child," does not impose a standard of care, and imposes a presumption against preempting state laws, including laws regulating abortion and protecting rights of conscience.

EMTALA's recognition and protection of unborn life demonstrates that Congress did not confer any authority to mandate abortions, much less "direct" preemption of Texas law. And at the very least, EMTALA's language protecting the unborn demonstrates that Congress could not have intended that abortion would constitute "stabilizing treatment" for any situation *other* than when the life of the mother is at risk. Defendants cannot accomplish through administrative action something they are prohibited from doing by statute. *See, e.g.*, *BST Holdings, LLC v. Occupational Safety & Health Admin.*, 17 F.4th 604, 611–12 (5th Cir. 2021).

EMTALA's recognition and protection of unborn life is consistent with other federal laws. The Hyde Amendment prohibits federal funds from being used to pay for abortions except in ses of rape, incest, or a threat to the life of the mother. Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Div. H., Tit. V, §§ 506–07. The Weldon Amendment prohibits federal agencies from discriminating against any institutional or individual health care entity "on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." *Id.* The Coats-Snowe Amendment (enacted in 1996) prohibits "[t]he Federal Government" from discriminating against any health care entity on the basis that it refuses to perform induced

[17] *See* Exh. 4 at Appx. 019.

abortions or to provide referrals for such abortions. 42 U.S.C. § 238n. The Church Amendments prohibit recipients of funds from HHS from discriminating against personnel because they refuse to perform or assist an abortion based on their religious or moral beliefs, and say an individual in an HHS funded health or research program cannot be forced to perform or assist in procedures contrary to his religious or moral beliefs. 42 U.S.C. § 300a-7(c) & (d). There is no evidence Congress intended to override these abortion conscience statutes—two of which were enacted after EMTALA—when EMTALA requires stabilizing the "unborn child."

Defendants lack statutory authority to promulgate the Abortion Mandate requiring Medicare-participating hospitals and their physicians to provide access to—and perform—abortions. The EMTALA Guidance includes a number of provisions that have never been part of EMTALA. The EMTALA Guidance claims that "[w]hen a state law prohibits abortion and does not include an exception for the life of the pregnant person—or draws the exception more narrowly than EMTALA's emergency medical condition definition—***that state law is preempted***."[18] This has never been part of EMTALA. To the contrary, EMTALA "do[es] not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of [EMTALA]." 42 U.S.C. § 1395dd(f).

The health conditions in which the EMTALA Guidance purports to require abortions are far broader than the life of the mother exception found in Texas laws concerning abortion or the federal Hyde Amendment, but instead include undefined "health" conditions of a pregnant woman, including situations such as "incomplete medical abortions," and situations that do not

[18] Exh 1 at Appx. 002-003 (emphasis in original).

presently threaten the life of the mother but are "likely . . . to become emergent."[19] The EMTALA Guidance further specifies that "an emergency medical condition that has not been stabilized" can include "a patient with an incomplete medical abortion," and that the sorts of abortion that EMTALA can require include "methotrexate therapy" or "dilation and curettage."[20] Thus the EMTALA Guidance attempts to force hospitals and physicians to complete chemical abortions that began elsewhere—even illegally—even when the mother's life is not at risk.[21]

EMTALA does not authorize the promulgation of rules mandating certain procedures. Even if it did, the EMTALA Guidance was not issued by persons with statutory authority to do so. The Social Security Act authorizes the Secretary of HHS to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter." 42 U.S.C. § 1395hh(a)(1); 42 U.S.C. § 1301(a)(6). Indeed, the Act stipulates that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits, the payments for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits . . . shall take effect *unless* it is promulgated by the Secretary [of HHS]." 42 U.S.C. § 1395hh(2). But, here, the Guidance was issued by the Director of the Survey & Operations Group of CMS and the Director of the Quality, Safety & Oversight Group of CMS.[22]

Defendants' attempt to impose the Abortion Mandate (without regard to State law) is a question of deep economic and political significance, and Congress did not intend—nor does

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[19] Exh. 1 at Appx. 002,007.

[20] *Id.* at Appx. 006.

[21] *See* Exh. 4 at Appx. 018, 020 (Declaration of Donna Harrison, M.D.).

[22] Exh. 1 at Appx. 007.

EMTALA allow—Defendants to exercise such broad authority in the absence of clear and explicit congressional authorization. *See Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014) (holding that Congress must "speak clearly if it wishes to assign . . . decisions of vast economic and political significance."). "Whatever power the United States Constitution envisions for the Executive . . . it most assuredly envisions a role for all three branches when individual liberties are at stake." *Hamdi v. Rumsfeld*, 542 U.S. 507, 536 (2004). This is particularly significant here where the Abortion Mandate requires Texas hospitals to perform abortions in violation of State law.

EMTALA does not authorize Defendants to achieve their social policy objectives through the Abortion Mandate. Defendants exceeded their statutory authority and acted *ultra vires* in issuing the Abortion Mandate.

2. The Abortion Mandate violates the APA.

The Abortion Mandate is final agency action subject to judicial review under the APA. *See Texas v. EEOC*, 933 F.3d at 441(explaining that agency action treated as binding is reviewable as final agency action). Though framed as guidance reminding hospitals and physicians of their existing obligations, the agency's characterization of its own action is not dispositive. *Nat'l Min. Ass'n v. McCarthy*, 758 F.3d 243, 252 (D.C. Cir. 2014) (Kavanaugh, J.); *Texas v. United* States, 787 F.3d at 764 (explaining that an agency's characterization of its own action as "guidance" or a "policy statement" is not determinative). Courts consider whether agency action constitutes "final agency action" with a "pragmatic approach" and "view[] the APA's finality requirement as flexible." *Texas v. EEOC*, 933 F.3d at 441 (internal quotations omitted). In determining whether agency action is final agency action, Courts consider whether the agency action imposes liability for failure to comply with its demands. *McCarthy*, 758 F.3d at 252.

Here, the Abortion Mandate includes several provisions that create new legal obligations

and threaten substantial legal and monetary penalties. *See id.* at 253. Plaintiffs are far from free to ignore the Abortion Mandate without consequence. *Id.* at 253. They risk their Medicare and Medicaid funding as well as significant civil monetary penalties up to $119,942.[23] According to CMS, in 2020, the United States' total spending for Medicare and Medicaid amounted to over $1.5 trillion.[24] Moreover, Defendants themselves are treating the Abortion Mandate as binding; the federal government has filed suit in the District of Idaho to enforce its terms.[25]

a. The Abortion Mandate exceeds statutory authority and is not in accordance with law.

Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

The Abortion Mandate attempts to codify a "legal duty" to perform abortions as an openly political reaction against *Dobbs*.[26] But Defendants lack statutory authority to exercise "any supervision or control over the practice of medicine or the manner in which medical services are provided," 42 U.S.C. § 1395, and EMTALA cannot be construed to "directly" preempt state abortion laws. *See* 42 U.S.C. § 1395dd(f). As explained above, the mandate also contradicts federal laws that prohibit Defendants from requiring physicians to perform abortions. Further, the major questions doctrine applies. If Congress intended to confer Defendants with authority to require

[23] Exh. 1 at Appx 006; 42 U.S.C. § 1395dd(d)(1); 42 U.S.C. § 1320a-7(h).

[24] *NHE Fact Sheet*, CMS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (last visited July 28, 2022).

[25] *See United States v. Idaho*, No. 1:22-cv-329.

[26] Exh. 1 at Appx. 002, 006.

physicians and hospitals to perform abortion even where they are prohibited by State law, it would have spoken clearly on the that subject. *See West Virginia v. EPA*, 142 S. Ct. 2587, 2609 (June 20, 2022). Defendants' promulgation of the Abortion Mandate exceeded their statutory authority and should be set aside.

b. Defendants failed to conduct notice and comment.

Defendants failed to conduct notice and comment as required under the Medicare-specific notice-and-comment procedures under 42 U.S.C. § 1395hh(b), as well as the notice-and-comment procedures under 5 U.S.C. § 553. *See Texas v. Becerra*, No. 5:21-cv-300-H, 2021 WL 6198109, at *13 n.12 (Dec. 31, 2021) (Hendrix, J.) (discussing applicable precedent). Under 42 U.S.C. § 1395hh(b)(1), the Secretary must "provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon." Defendants failed to comply with this statutory requirement before promulgating the Abortion Mandate.

Defendants could only explain their failure to conduct notice and comment by invoking one of the exceptions in 42 U.S.C. § 1395hh(b)(2). But they have not—and they cannot. The first exception allows for a shorter notice and comment period when another statute so authorizes. 42 U.S.C. § 1395hh(b)(2)(A). The second exception applies when "a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained." *Id.* § 1395hh(b)(2)(B). Here, the Abortion Mandate is effective immediately.[27] The final exception allows the Secretary to bypass the Social Security Act's notice and comment requirements by relying on the good cause exception under the APA. 42 U.S.C. § 1395hh(b)(2)(C); 5 U.S.C. § 553(b)(B). The agency did

[27] Exh. 1 at Appx. 007.

not invoke this exception; accordingly, it is inapplicable here.

"The essential purpose of according § 553 notice and comment opportunities is to reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies." *Batterton v. Marshall*, 648 F.2d 694, 703 (D.C. Cir. 1980). Here, the Secretary deprived the public of this opportunity without any statutory basis.

c. The Abortion Mandate is arbitrary and capricious.

Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary and capricious." *See* 5 U.S.C. § 706(2)(A). An agency action is arbitrary or capricious if it fails to "articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

The Abortion Mandate was promulgated by mere executive fiat in response to the Supreme Court's decision in *Dobbs*.[28] After the *Dobbs* decision, Secretary Becerra announced that Americans "can no longer trust" the Supreme Court, and HHS would "be aggressive and go all the way" to pushback against the Court's decision.[29] As the Fifth Circuit has held, "courts have an affirmative duty *not* to" "turn a blind eye to the statements" of those promulgating these extreme mandates. *BST Holdings*, 17 F.4th at 614. "The reasoned explanation requirement of administrative law . . . is meant to ensure that agencies offer genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public. Accepting contrived

[28] Exh. 1 at Appx. 002, 006.

[29] *HHS Secretary Becerra talks women's future with abortion following Roe v. Wade decision* (NBC NEWS broadcast June 25, 2022) https://www.nbcnews.com/video/women-s-future-with-abortion-implementing-harm-reduction-with-addiction-142836293922, at 1:45 (last visited July 28, 2022).

reasons would defeat the purpose of the enterprise." *Id.* at 2575–76.

The Abortion Mandate does not acknowledge the agency's change in position from never having previously required abortions under EMTALA; it offers no reasoned explanation of how EMTALA can require abortions when EMTALA requires stabilizing the "unborn child"; it offers no explanation of the interaction between its mandate and religious freedom and conscience laws; and it discusses no alternative approaches. To the contrary, Defendants justify the Abortion Mandate as necessary to fight the Supreme Court. More is required. *See Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct 1891, 1911–15 (2020).

"[W]here the agency has failed to provide even that minimum level of analysis, its action is arbitrary and capricious and so cannot carry the force of law." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 136 S. Ct. 2117, 2125 (2016). Courts "do not defer to the agency's conclusory or unsupported suppositions," *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557 (D.C. Cir. 2010), nor are agency actions "involving an issue of deep economic and political significance" entitled to deference, *City & Cnty. of San Francisco v. Trump*, 897 F.3d 1225, 1242 (9th Cir. 2018) (cleaned up). This Court cannot "supply a reasoned basis for the agencies' actions that the agencies themselves have not given." *Id.* (cleaned up). Nor can the agency's litigation counsel. *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 50 ("courts may not accept appellate counsel's *post hoc* rationalizations for agency action").

Further, the Abortion Mandate discusses no reliance interests by regulated entities, especially pro-life physicians and hospitals, on never having previously been subject to an abortion mandate under EMTALA. "Because it is generally arbitrary or capricious to depart from a prior policy *sub silentio*, agencies must typically provide a detailed explanation for contradicting a prior

policy, particularly when the prior policy has engendered serious reliance interests." *BST Holdings*, 17 F.4th at 614. Defendants provide no basis for the new mandate. Defendants provide no evidence that violations of EMTALA precluded women from receiving emergency care.

Defendants are hinging hundreds of billions in federal Medicare dollars on compliance with this mandate for the sole purpose of subverting the Supreme Court's holding in *Dobbs* and States' authority to regulate abortion.[30] The Abortion Mandate must be set aside and held unlawful.

3. Defendants' actions violate the Constitution.

a. Unconstitutional delegation of legislative power

If Defendants contend that the Social Security Act's delegation of authority to the Secretary is so broad that it authorizes him to impose an Abortion Mandate on hospitals and physicians as a condition of receiving Medicare funds, then the Social Security Act violates the nondelegation doctrine because it lacks any "intelligible principle" to guide the Secretary's actions. *See J.W. Hampton v. United States*, 276 U.S. 394, 409 (1928). "In the absence of a clear mandate" in the Social Security Act, "it is unreasonable to assume that Congress intended to give [the Secretary of HHS] unprecedented power" over American social policy and standards of care. *See Indus. Union Dep't, AFL-CIO v. American Petroleum Inst.*, 448 U.S. 607, 645 (1980). And if it did, it would be unconstitutional under *A.L.A. Schechter* and *Panama Refining Co. v. Ryan*, 293 U.S. 388 (1935). Accordingly, if Congress wanted to delegate this legislative authority to the Secretary of HHS through the Social Security Act—and there is no evidence that it did—then Congress's attempt to do so was unconstitutional.

[30] *See* Exh. 2 at Appx. 009.

b. Major Questions Doctrine Applies

Moreover, this is an issue of vast political significance to which the major question doctrine applies. *See West Virginia*, 142 S. Ct. at 2614. Whether and when to permit abortions is an issue of vast policy and political significance, as the Supreme Court explained in *Dobbs*. Those questions are to be answered by the States through their elected representatives. *See id.* at 2626 (Gorsuch, J., concurring). If Congress meant to impose abortion mandates through EMTALA, the major questions doctrine requires it to speak clearly. Indeed, that Defendants have found this purported authority to promulgate the Abortion Mandate in EMTALA after Congress has rejected attempts to codify a federal right to abortion demonstrates that this is an issue of vast political significance to which the major-question doctrine applies. In *West Virginia v. EPA*, the Court held that it could not "ignore that the regulatory writ EPA newly uncovered conveniently enabled it to enact a program that, long after the dangers posed by greenhouse gas emissions had become well known, Congress considered and rejected multiple times." *Id.* at 2614 (internal quotations omitted). Similarly, here, Congress has failed to codify a federal right to abortion, which is highly probative of the significance of the issue and, therefore, the application of the major-questions doctrine.[31]

c. Violation of the Spending Clause

The central concerns of Spending Clause jurisprudence are federalism and individual liberty. *See, e.g.*, *NFIB v. Sebelius*, 567 U.S. 519, 577 (2012) ("Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system. That system 'rests on what might at first seem a

[31] *Senate fails to pass abortion rights bill—again*, POLITICO (May 11, 2022), https://www.politico.com/news/2022/05/11/senate-doomed-vote-roe-abortion-rights-00031732 (last visited July 27, 2022).

counterintuitive insight, that freedom is enhanced by the creation of two governments, not one.'") (citing *Bond v. United States*, 564 U.S. 211, 220–21 (2011)). In this case, separation-of-powers concerns are multiplied atop these traditional federalism and individual liberty concerns by the Executive's unilateral adoption of significant conditions on the recipients of federal funds because "[t]he United States Constitution exclusively grants the power of the purse to Congress." *City & Cnty. of San Francisco*, 897 F.3d at 1231 (citing U.S. Const. art. I, § 9, cl. 7; U.S. Const. art. I, § 8, cl.1).

The legitimacy of an exercise of the federal spending power "rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Sebelius*, 567 U.S. at 577 (citing *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17 (1981)). This leads courts to "scrutinize Spending Clause legislation to ensure that Congress is not using financial inducements to exert a 'power akin to undue influence.'" *Sebelius*, 567 U.S. at 577 (citing *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)). When "conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes." *Id.* at 580.

While Congress may condition federal funding with certain obligations, "the States must have a genuine choice whether to accept the offer." *Id.* at 588. There is no such choice here. Texas hospitals must either accept the new condition or risk losing all Medicare, Medicaid, and other funding. "'Though Congress' power to legislate under the spending power is broad, it does not include surprising the States with post-acceptance or 'retroactive' conditions." *Pennhurst*, 451 U.S. at 25. Texas could not have known that Defendants would claim a new condition on hospitals' Medicare provider agreements that would force them to provide abortions in violation of State law.

Texas hospitals and physicians receive approximately $16 billion per year in federal dollars for Medicaid services.[32] The State of Texas receives approximately $30 billion per year from the federal government to fund the Texas Medicaid program.[33] Forcing Texas hospitals and physicians to comply with the Abortion mandate under threat of the loss of all Medicare funding is unconstitutionally coercive; it is a gun to the head that compels them to violate State law. *See Sebelius*, 567 U.S. at 580. Defendants have no authority to condition federal funding on such an untenable choice. *Pennhurst*, 451 U.S. at 25. Defendants promulgated the Abortion mandate via an unconstitutional exercise of authority, and it must be held unlawful and set aside. The Abortion Mandate is not a valid exercise of the Spending Power; it is an *ultra vires* order that is not enforceable against Plaintiffs.

Finally, a valid exercise of the Spending Power—which the Abortion Mandate is not—can only *induce* States to change their own laws. It does not preempt State law, and the Guidance's statement to the contrary is wrong. Non-State recipients of Medicare funds, such as local governments and private entities, cannot change State law, and are not licensed to violate State law just by accepting federal funds with allegedly preemptive conditions. For instance, if a condition of Medicare funding required a non-State recipient to provide abortions in violation of Texas law, the recipient would have a choice of (1) not taking the funds; (2) taking the funds and providing abortions in violation of State law; or (3) taking the funds but not performing abortions in violation of Texas law, potentially subjecting them to penalties from Defendants.

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[32] Exh. 3 at Appx. 013.

[33] *Id.* at Appx. 013-014; *see also* 42 U.S.C. § 1396d.

d. Violation of the Tenth Amendment

The powers not delegated by the Constitution to the federal government are reserved to the States. The Supreme Court has clarified that State law governs abortion. "[T]he Constitution does not confer a right to abortion," "does not prohibit the citizens of each State from regulating or prohibiting abortion," and "return[ed] that authority to the people and their elected representatives." *Dobbs*, 142 S. Ct. at 2279, 2284.

"[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cnty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985). The Supreme Court has clarified that this includes State laws regulating abortion. *Dobbs*, 142 S. Ct. at 2284. Texas has a legitimate interest in the "preservation of prenatal life at all stages of development." *Id.* This interest cannot be blithely dismissed by the Defendants' unlawful Abortion Mandate. "Historic police powers of the States" are not superseded by federal law unless that is "the clear and manifest purpose of Congress." *Id.*; *City of Columbus v. Ours Garage & Wrecker Serv. Inc.*, 536 U.S. 424, 432 (2002). Congress did not authorize Defendants to promulgate any right to an abortion. No provision of the Social Security Act authorizes Defendants to do so.

e. Defendants' actions violate RFRA.

All of CMDA's members are Christians who object to performing abortions, and many of AAPLOG's members have religious objections to abortions in addition to their medical and ethical views. [34] As to CMDA and AAPLOG's members who have religious objections, the Abortion Mandate violates RFRA, which prohibits Defendants from imposing a substantial burden on their religious exercise unless doing so serves the least restrictive means of advancing a compelling

[34] Exh. 4–8, Appx. 015-036 (Declarations of Drs. Harrison, Barrows, Hutzler, Valley, and Foley).

government interest. 42 U.S.C. § 2000bb-1. The sincere religious beliefs of CMDA's and many of AAPLOG's members are set forth in declarations, *id.*, and imposing massive monetary penalties and exclusions from Medicare, Medicaid, CHIP, and other medical programs for not violating those beliefs is undoubtedly a substantial burden on their religious exercise. *See Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 720 (2014).

The Abortion Mandate fails strict scrutiny. Defendants cannot have a compelling interest to mandate abortions because, as explained above: (1) Congress gave HHS no such power in EMTALA, which instead protects the "unborn child" in addition to her mother; (2) EMTALA leaves medical standards of care, necessarily including abortion, to state law, and Texas as well as other states protect physicians' conscience rights on abortion; and, (3) Congress prohibited federal abortion mandates by enacting the Weldon, Coats-Snowe, and Church Amendments. By definition, a federal agency has no compelling interest doing what Congress gave it no authority to do. As to specific circumstances, the Abortion Mandate's vague terms cover many elective abortions that are not even within EMTALA much less do they pose a compelling need. For example, the Abortion Mandate's application to "incomplete medical abortion" is a requirement that pro-life doctors complete abortions started elsewhere even where the child might be saved.

B. Plaintiffs are likely to suffer irreparable harm.

"To show irreparable injury . . . it is not necessary to demonstrate that harm is inevitable and irreparable." *Humana, Inc. v. Jacobson*, 804 F.2d 1390, 1394 (5th Cir. 1986). Rather, Plaintiffs need only demonstrate that they are "likely to suffer irreparable harm in the absence of preliminary relief." *Benisek v. Lamone*, 138 S. Ct. 1942, 1944 (2018).

Texas faces an imminent, irreparable, sovereign injury from the Abortion Mandate, which purports to preempt any State law that differs from its requirements.[35] Numerous courts have made clear that preventing the State from enforcing its laws is itself an irreparable harm. *See, e.g.*, *Abbott v. Perez*, 138 S. Ct. 2305, 2324 n.17 (2018) ("[T]he inability to enforce its duly enacted plan clearly inflicts irreparable harms on the State."); *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Robert, C.J.) ("Any me [a State is blocked] from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury."); *Org. for Black Struggle v. Ashcroft*, 978 F.3d 603, 309 (8th Cir. 2020). When the State is blocked from implementing its laws, "the State necessarily suffers the irreparable harm of denying the public interest in the enforcement of its law." *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013); *Coal. for Econ. Equity v. Wilson*, 122 F.3d 718, 719 (9th Cir. 1997).

AAPLOG and CMDA's members are forced by the Abortion Mandate to choose between, on the one hand, continuing to care for women as they have always done and facing crippling fines from HHS and exclusion from Medicare, Medicaid, CHIP, and effectively all hospital practice, or on the other hand, violating their religious and moral beliefs and risking prosecution for committing elective abortions that may be illegal under state law. AAPLOG and CMDA need injunctive relief to protect all their members from this threat, both in Texas and other States. The loss of individual liberty and the trampling of religious freedom cannot be remedied. Simply put, if the Abortion Mandate is permitted to go into effect, the State of Texas's sovereignty will be affronted, and Plaintiffs' rights will be forever diminished.

[35] Exh. 1 at Appx. 003.

C. The balance of the equities and public interest favor preliminary injunctive relief.

When governmental action is implicated, the third and fourth factors merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). To preserve the relative positions of the parties until a trial on the merits, federal courts regularly enjoin federal agencies from implementing and enforcing new regulations pending litigation challenging them. *Texas v. United States*, 787 F.3d 733. Here, the status quo since Congress enacted EMTALA has been no Abortion Mandate. Defendants should not be permitted to upset that status quo by purportedly finding new provisions in the law.

An injunction promotes and protects the public interest by avoiding the myriad harms that Defendants' lawlessness will bring. Texas physicians will be protected from having to choose between their employment and risking their medical licenses. Unborn children will be protected by Texas's abortion laws. Hospitals and physicians will be protected from the coercive threat of substantial penalties or violating State law. "The public interest is also served by maintaining our constitutional structure," giving Texas law its full due. *BST Holdings*, 17 F.4th at 618.

The balance of the equities and the public interest favor the intervention of the Court to preserve the status quo. [36]

III. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court enjoin Defendants from implementing and enforcing the Abortion Mandate.

[36] Because the injunctive relief requested would serve the public interest, Plaintiffs ask the Court to exercise its discretion to not require a security or bond under Fed. R. Civ. P. 65(c). *See City of Atlanta v. Metro. Atlanta Rapid Transit Auth.*, 636 F.2d 1084, 1094 (5th Cir. 1981).

Respectfully submitted.

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**Application for admission forthcoming*

CERTIFICATE OF SERVICE

We certify that a true and accurate copy of the foregoing document was filed electronically via CM/ECF and is being sent via CMRRR to Defendants.

/s/ Amy S. Hilton Amy S. Hilton

/s/ Ryan Bangert Ryan Bangert

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, *Plaintiffs*,	§	
	§	**CIVIL ACTION NO. 5:22-CV-00185**
v.	§	
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, *Defendants.*	§	

APPENDIX TO BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Exhibit	Description	Appendix No.
1	EMTALA Guidance	Appx. 001 - 007
2	Becerra Letter to Providers	Appx. 008 – 010
3	Declaration of Victoria Grady	Appx. 011 – 014
4	Declaration of Donna Harrison, M.D.	Appx. 015 - 021
5	Declaration of Jeffrey Barrows, D.O.M.A.	Appx. 022 – 027
6	Declaration of Susan Hutzler, M.D.	Appx. 028 – 030
7	Declaration of Michael T. Valley, M.D.	Appx. 031 – 033
8	Declaration of Steven A. Foley, M.D.	Appx. 034 – 036
9	Declaration of Eric Bentley	Appx. 037 - 039

EXHIBIT 1

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-22-22-Hospitals

DATE: **July 11, 2022**

TO: State Survey Agency Directors

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

SUBJECT: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals-UPDATED JULY 2022)

NOTE: This memorandum is being issued to remind hospitals of their existing obligation to comply with EMTALA and does not contain new policy.

Memorandum Summary

- ***The Emergency Medical Treatment and Labor Act (EMTALA)*** *provides rights to any individual who comes to a hospital emergency department and requests examination or treatment. In particular, if such a request is made, hospitals must provide an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the person is in labor. If an emergency medical condition is found to exist, the hospital must provide available stabilizing treatment or an appropriate transfer to another hospital that has the capabilities to provide stabilizing treatment. The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary,* ***irrespective of any state laws or mandates that apply to specific procedures.***
- ***The determination of an emergency medical condition*** *is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.*
- ***Hospitals should ensure all staff*** *who may come into contact with a patient seeking examination or treatment of a medical condition are aware of the hospital's obligation under EMTALA.*
- ***A physician's professional and legal duty*** *to provide stabilizing medical treatment to a patient who presents under EMTALA to the emergency department and is found to have an emergency medical condition* ***preempts any directly conflicting state law or mandate*** *that might otherwise prohibit or prevent such treatment.*
- ***If a physician believes that a pregnant patient*** *presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician* ***must*** *provide that treatment. When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition —* ***that state law is preempted****.*

Background

The purpose of this memorandum is to restate existing guidance for hospital staff and physicians regarding their obligations under the Emergency Medical Treatment and Labor Act (EMTALA), in light of new state laws prohibiting or restricting access to abortion.

The EMTALA statute is codified at section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. Hospitals and physicians generally have three obligations under EMTALA.[1] The first is commonly referred to as the *screening requirement*, and applies to any individual who comes to the emergency department for whom a request is made for examination or treatment of a medical condition, including people in labor or those with an emergency condition such as an ectopic pregnancy. Such an individual is entitled to have a medical screening examination to determine whether an emergency medical condition (EMC) exists. The second obligation is commonly referred to as the *stabilization requirement*, which applies to any individual who comes to the hospital whom the hospital determines has an emergency medical condition. Such an individual is entitled to stabilizing treatment within the capability of the hospital. The third obligation flows from the second, and also applies to any individual in a hospital with an emergency medical condition. This obligation is sometimes known as the *transfer requirement*, which restricts the ability of the hospital to transfer that individual to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks (e.g., the hospital does not have the capability to stabilize the condition).

While a patient may request a transfer for any reason, a hospital is restricted by EMTALA to transfer patients only after a physician certifies that the medical benefits of the transfer outweigh the risks. The EMTALA regulation at 42 CFR §489.24 clarifies that the screening requirement applies to any individual who presents to an area of the hospital that meets the definition of a "dedicated emergency department" and makes a request for a medical screening examination. The regulation defines dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it holds itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. Based on this definition, it is likely that the labor and delivery unit of a hospital could meet the definition of dedicated emergency department.

Medicare Conditions of Participation

Hospitals are also bound by the Medicare conditions of participation (CoPs) to provide appropriate care to inpatients (42 C.F.R. 482.1 through 482.58). In particular, four CoPs are potentially applicable when a hospital provides treatment for an admitted patient. For example, the governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients (42 C.F.R. 482.12(a)(5) and 42 C.F.R. 482.22). Further, the discharge planning CoP (42 C.F.R. 482.43), which requires that hospitals have a discharge planning process, applies to all patients. Finally, the hospital governing body must ensure that the hospital has an organization-wide quality assessment and performance improvement program to evaluate the provision of patient care (42 C.F. R. 482.21). These CoPs are intended to protect patient health and safety, and to ensure that high quality medical care is provided to all patients. Failure to meet these CoPs could result in a finding of noncompliance at

[1] Appendix V of the CMS State Operations Manual-: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf

the condition level for the hospital and lead to termination of the hospital's Medicare provider agreement.

EMTALA
There are several specific provisions we wish to call attention to under EMTALA[i] :

Emergency Medical Condition (EMC):
Once an individual has presented to the hospital seeking emergency care, the determination of whether an Emergency Medical Condition exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

An EMC includes medical conditions with acute symptoms of sufficient severity that, in the absence of immediate medical attention, could place the health of a person (including pregnant patients) in serious jeopardy, or result in a serious impairment or dysfunction of bodily functions or any bodily organ. Further, an emergency medical condition exists if the patient may not have enough time for a safe transfer to another facility, or if the transfer might pose a threat to the safety of the person.

Labor
"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A person experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other qualified medical person acting within their scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the person is in false labor.

Medical Screening Examination
Individuals coming to the "emergency department" must be provided a medical screening examination appropriate to the presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate medical screening exam can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if they do, until they are stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

People in Labor
- Regardless of State laws, requirements, or other practice guidelines, EMTALA requires that a person in labor may be transferred only if the individual or their representative requests the transfer after informed consent or if a physician or other qualified medical personnel signs a certification at the time of transfer, with respect to the person in labor, that "the benefits of the transfer to the woman and/or the unborn child outweigh its risks."[2] For example, if the hospital does not have staff or

[2] State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating

resources to provide obstetrical services, the benefits of a transfer may outweigh the risks.

- **A hospital cannot cite State law or practice as the basis for transfer.** Fear of violating state law through the transfer of the patient cannot prevent the physician from effectuating the transfer nor can the physician be shielded from liability for erroneously complying with state laws that prohibit services such as abortion or transfer of a patient for an abortion when the original hospital does not have the capacity to provide such services. When a direct conflict occurs between EMTALA and a state law, EMTALA must be followed.

- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

Stabilizing Treatment

After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity. Section 42 CFR 489.24(b) defines **stabilized** to mean:

> "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition…."

The EMTALA statute requires that stabilizing treatment prevent material deterioration and compels hospitals and physicians to act prior to the patient's condition declining. The course of stabilizing treatment is under the purview of the physician or qualified medical personnel. If qualified medical personnel determine that the patient's condition, such as an ectopic pregnancy, requires stabilizing treatment to prevent serious jeopardy to the patient's health (including a serious impairment or dysfunction of bodily functions or any bodily organ or a threat to life), the qualified medical personnel is required by EMTALA to provide the treatment.

As indicated above, the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to: ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., methotrexate therapy, dilation and curettage (D&C), removal of one or both fallopian tubes, anti-hypertensive therapy, etc.).

Hospital's Obligation

A hospital's EMTALA obligation ends when a physician or qualified medical person has

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Hospitals in Emergency Cases, 52, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf.

made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);
- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or
- That an emergency medical condition exists and the individual is stabilized or admitted to the hospital for further stabilizing treatment.

Any state that has a more restrictive definition of emergency medical condition or that has a definition that directly conflicts with any definition above is preempted by the EMTALA statute. Physicians and hospitals have an obligation to follow the EMTALA definitions, even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located. Hospitals and physicians have an affirmative obligation to provide all necessary stabilizing treatment options to an individual with an emergency medical condition.

The EMTALA statute requires that all patients receive an appropriate medical screening, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures.

A physician's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment. EMTALA's preemption of state law could be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute's retaliation provision.

Enforcement

HHS, through its Office of the Inspector General (OIG), may impose a civil monetary penalty on a hospital ($119, 942 for hospitals with over 100 beds, $59,973 for hospitals under 100 beds/per violation) or physician ($119,942/violation) pursuant to 42 CFR §1003.500 for refusing to provide either any necessary stabilizing care for an individual presenting with an emergency medical condition that requires such stabilizing treatment, or an appropriate transfer of that individual if the hospital does not have the capacity to stabilize the emergency condition. Under this same authority, HHS OIG may also exclude physicians from participation in Medicare and State health care programs. CMS may also penalize a hospital by terminating its provider agreement. Additionally, private citizens who are harmed by a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located, in addition to recouping any equitable relief as is appropriate. 42 U.S.C. § 1395dd(d)(2)(A).

Any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital would be preempted by the federal EMTALA statute due to the direct conflict with the "stabilized" provision of the statute. Moreover, EMTALA contains a whistleblower provision that prevents

retaliation by the hospital against any hospital employee or physician who refuses to transfer a patient with an emergency medical condition that has not been stabilized by the initial hospital, such as a patient with an emergent ectopic pregnancy, or a patient with an incomplete medical abortion.

To file an EMTALA complaint, please contact the appropriate state survey agency: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation

Individuals who believe they have been discriminated against on the basis of race, color, national origin, sex (including sexual orientation, gender identity, and pregnancy), age, disability, religion, or the exercise of conscience in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, may file a complaint with the HHS Office for Civil Rights at http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.[3] With regard to civil rights protections against national origin discrimination, hospitals covered by EMTALA must take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency (LEP). In most cases, hospitals must provide some form of language assistance service, such as provide an interpreter at no cost to the patient or provide important documents translated into the patient's preferred language. Hospitals may learn more about their obligations to persons with LEP by visiting the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*.

Contact: Questions about this memorandum should be addressed to QSOG_Hospital@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

Karen L. Tritz
Director, Survey & Operations Group

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

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

[3] For more information about the laws and regulations enforced by OCR, please visit https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html.

EXHIBIT 2

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

July 11, 2022

VIA ELECTRONIC MAIL

Dear Health Care Providers:

In light of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization,* I am writing regarding the Department of Health and Human Services (HHS) enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA). As frontline health care providers, the federal EMTALA statute protects your clinical judgment and the action that you take to provide stabilizing medical treatment to your pregnant patients, regardless of the restrictions in the state where you practice.

The EMTALA statute requires that all patients receive an appropriate medical screening examination, stabilizing treatment, and transfer, if necessary, irrespective of any state laws or mandates that apply to specific procedures. It is critical that providers know that a physician or other qualified medical personnel's professional and legal duty to provide stabilizing medical treatment to a patient who presents to the emergency department and is found to have an emergency medical condition preempts any directly conflicting state law or mandate that might otherwise prohibit such treatment.

As indicated above and in our guidance[1], the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel. Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features. Any state laws or mandates that employ a more restrictive definition of an emergency medical condition are preempted by the EMTALA statute.

The course of treatment necessary to stabilize such emergency medical conditions is also under the purview of the physician or other qualified medical personnel. Stabilizing treatment could include medical and/or surgical interventions (e.g., abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy etc.), irrespective of any state laws or mandates that apply to specific procedures.

Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. And when a state law prohibits

[1] *Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss* (QSO-21-22-Hospitals- UPDATED JULY 2022), available at https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy-0

abortion and does not include an exception for the life and health of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — that state law is preempted.

The enforcement of EMTALA is a complaint driven process. The investigation of a hospital's policies/procedures and processes, or the actions of medical personnel, and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the provisions of EMTALA, a hospital may be subject to termination of its Medicare provider agreement and/or the imposition of civil monetary penalties. Civil monetary penalties may also be imposed against individual physicians for EMTALA violations. Additionally, physicians may also be subject to exclusion from the Medicare and State health care programs. To file an EMTALA complaint, please contact the appropriate state survey agency[2].

EMTALA's preemption of state law could also be enforced by individual physicians in a variety of ways, potentially including as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute's retaliation provision

As providers caring for pregnant patients across the country, thank you for all that you do. The Department of Health and Human Services will take every action within our authority to protect the critical care that you provide to patients every day.

Sincerely,

/s/

Xavier Becerra

[2] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation

EXHIBIT 3

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, ***Plaintiffs,***	§	
v.	§	**CIVIL ACTION NO. 5:22-cv-00185**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, ***Defendants.***	§	

DECLARATION OF VICTORIA GRADY

I, Victoria Grady, have personal knowledge of the matters stated herein, and they are true and correct. I hereby make the following declaration under penalty of perjury:

1. "My name is Victoria Grady. I am over 18 years of age, of sound mind, and capable of making this declaration. I have personal knowledge of the facts stated herein.

2. I currently work as the Director of Provider Finance for the Texas Health and Human Services Commission (HHSC) and have oversight of the Provider Finance Department. I've held this position since September 24, 2018. Before that, I was the Deputy Director of Provider Finance, Senior Advisor to the Director of Provider Finance, and Government Relations Specialist for Finance. I have worked at HHSC since 2014.

3. The HHSC Provider Finance Department is responsible for establishing reimbursement rates for fee-for-service Medicaid for Hospitals, Acute Care Services, and Long-Term Services and Supports and for the administration of various supplemental and directed-payment programs. The Provider Finance Department has 214 full time employees that work across six major areas: (1) hospital finance, (2) long-term services and supports finance, (3) acute care finance, (4) cost reporting and time studies, (5) local funds monitoring, and (6) business operations (including payment collection and administration). At any given time, Provider Finance is reviewing 10,000 unique rates, administering hundreds of millions of dollars in payments, developing and amending 20 or more administrative rules, reviewing 5000+ cost reports, and working in coordination with the more than 12 other major business divisions within HHSC.

4. Through the combination of Medicaid reimbursement rates for Hospitals for inpatient and outpatient services, directed payment programs for hospitals, and supplemental payments for hospitals, I am responsible for the administration of the state's financing of the hospital finance system. As a result, I have knowledge of the interplay of Medicare, Medicaid, self-pay, and third-party payments to hospitals and the impact on the stability of the hospital safety-net system that relies on those payments.

5. I am aware of the existence of the federal government's EMTALA Guidance titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss" issued on July 11, 2022 (attached here as Exhibit 1).

6. The EMTALA Guidance conditions federal Medicare and Medicaid funding on the provision of abortions. The EMTALA Guidance stipulates that failure to comply with its terms may result in the Centers for Medicare & Medicaid Services terminating hospitals' provider agreements and excluding physicians from participation in Medicare and State health care programs. Exh. 1 at 2–3, 5.

7. If Texas hospitals and physicians fail to comply with EMTALA guidance, they risk losing significant federal funds.

8. As of 2017, Medicare was the largest payor source for Texas hospitals, constituting 40% of gross patient revenue charges. Government payor sources, including Medicare and Medicaid, were responsible for more than half (57%) of the gross patient revenue charges. This information is reflected in the 2017 Acute Care Hospitals Fact Sheet (attached here as Exhibit 2) which is kept by HHSC in the regular course of business.

9. Texas hospitals and physicians receive approximately $15.98 billion per year from the federal government in the form of reimbursements for services under Medicaid.

10. The State of Texas receives approximately $29.42 billion per year from the federal

government to fund the Texas Medicaid program.

11. There are 487 hospitals in Texas with emergency departments, and they are recipients of these Medicaid dollars. In FY 2020, these hospitals received approximately $18.22 billion in Medicaid payments. The loss of these funds would represent a significant impact on these providers' ability to provide healthcare in Texas.

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

Victoria Grady, Declarant

EXHIBIT 4

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, *Plaintiffs,*	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185-H**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, *Defendants.*	§	

DECLARATION OF DONNA HARRISON, M.D.

1. My name is Donna Harrison, M.D., of Eau Claire, Michigan.

2. I am over eighteen years old and make this declaration on personal knowledge.

3. I am a board certified Ob/Gyn.

4. I am also the Chief Executive Officer of the American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG"), a plaintiff in this case.

5. I am familiar with AAPLOG, its members, their fields of practice, and AAPLOG's policies and positions, including as set forth in the first amended complaint, which I have reviewed.

6. I am also familiar with the medical situations that can arise in pregnancy or in emergency room settings, including those covered by EMTALA or by the Abortion Mandate described in the first amended complaint.

7. AAPLOG is the largest organization of pro-life Ob/Gyns in the world and is headquartered in Michigan. AAPLOG includes Ob/Gyns and other physicians, with over 6,000 medical professionals nationwide, including over 300 members in Texas. AAPLOG members oppose elective abortion and are committed to the care and well-being of their patients including both pregnant women and their unborn children.

8. AAPLOG's mission includes advocating on behalf of its members, including in litigation. AAPLOG has participated as a party in litigation to defend protection of conscience rights in previous litigation, including the EMTALA case *ACLU v. Trinity Health Corp.*, No. 2:15-cv-12611-GAD-RSW, ECF No. 39 (E.D. Mich. order March 10, 2016), and the Weldon Amendment cases *California ex. rel. Lockyer v. United States*, 450 F.3d 436, 445 (9th Cir. 2006), *Nat'l Family Planning & Reproductive Health Ass'n v. Gonzales*, 468 F.3d 826, 827 (D.C. Cir. 2006), and *Nat'l Family Planning & Reproductive Health Ass'n*, No. 04-02148 (D. D.C. Sept. 28, 2005).

9. AAPLOG sues on behalf of its members.

10. AAPLOG has members in Texas and around the country who care for pregnant women in situations at hospitals subject to EMTALA.

11. AAPLOG has members in Texas that are physicians, nurses, staff members, or employees of a hospital or other health care facility, within the meaning of Tex. Occupations Code § 103.001.

12. AAPLOG has members in Texas and throughout the country protected under the Church, Coats-Snowe, and Weldon Amendments described in the first amended complaint, as many of

those members are individual physicians, other health care professionals, participants in programs of training in the health professions, health care personnel of health care entities receiving funds from HHS, or individuals participating in health service programs or research activities funded by HHS.

13. The Abortion Mandate described in the first amended complaint purports to establish a standard of care that requires abortions in various circumstances faced by AAPLOG's members in Texas and other states.

14. The Abortion Mandate purports to require abortions by AAPLOG's members in various circumstances not posing a risk to the life of the mother.

15. For example, the abortion mandate requires performing essentially an elective abortion where women present to an emergency room, having previously initiated medication abortions, but where the unborn child is still living and may still be preserved.

16. Intrauterine pregnancy itself is not an acute condition requiring any immediate intervention under EMTALA, and thus does not fit the criteria for EMTALA intervention. Intrauterine pregnancy is a normal bodily function.

17. As experienced practitioners and researchers in Obstetrics and Gynecology, I and AAPLOG affirm that elective abortion, defined as drugs or procedures taken with the primary intent to produce a dead unborn child in the process of separation from the mother, is not medically necessary to save the life of a woman. We uphold that there is a fundamental difference between such an elective abortion and necessary separation of the mother and her unborn child that are carried out to save the life of the mother, even if such separations results in the loss of life of her

unborn child. We confirm that the prohibition of elective abortion does not affect, in any way, the availability of optimal care to pregnant women.

18. Elective abortion is the purposeful killing of the unborn in the termination of a pregnancy for no medical reason. AAPLOG opposes elective abortion. When extreme medical emergencies that threaten the life of the mother arise (chorioamnionitis or HELLP syndrome could be examples), AAPLOG believes in separating the mother from her unborn child regardless of gestational age or the ability of the child to survive outside of the womb. Such "treatment to save the mother's life," differs from what is commonly termed "abortion", i.e. elective abortion, since the primary intent of an elective abortion is to ensure that the offspring is not living after the separation. We are treating two patients, the mother and the baby, and every reasonable attempt to save the baby's life would also be a part of our medical intervention. We acknowledge that, in some such instances, the baby would be too premature to survive.

19. When the continuation of a pregnancy is an immediate threat to the life of the mother, AAPLOG's view is that physicians may separate the mother and the unborn child regardless of gestational age. That action is allowed throughout the country and is unaffected by post-*Dobbs* laws prohibiting elective abortion. But we do not intend the death of the unborn child. Rather, if we can save the lives of both we would. In contrast, an elective abortion intends the death of the unborn child in the process of separation.

20. Therefore the Abortion Mandate's application to circumstances outside those necessary to save the life of the mother is a threat to AAPLOG's members as well as to the life and health of women and unborn children.

21. Because the conditions covered by the Abortion Mandate are broader than life of the mother situations and include elective abortions where the woman's life is not at stake, part of the effect of the Abortion Mandate is to force the performance of elective abortions by physicians, including AAPLOG members.

22. In cases where the unborn child's life can still be preserved, the Abortion Mandate purports to require AAPLOG's members to perform, assist in, or refer for elective abortions in violation of Texas law, the pro-life laws of other states, and EMTALA itself which requires stabilization of the unborn child.

23. AAPLOG and its members object to being forced to end the life of a human being in the womb for no medical reason. The objections are both ethical and medical and stem from the purpose of medicine itself, which is to heal and not to electively kill human beings regardless of their location.[1]

24. AAPLOG has issued several position statements and medical practice bulletins on situations threatening the life of the mother and the need to not conflate legitimate treatments provided in such circumstances with abortion provided in broader circumstances.[2]

25. The Abortion Mandate's requirement that AAPLOG's members perform abortions in circumstances which do not require separation of the mother and her unborn child to save the mother's life, would force AAPLOG's members to violate their sincerely held religious or moral beliefs or medical judgment.

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[1] See https://aaplog.org/resources/position-statements/.

[2] See, e.g., https://aaplog.org/what-is-aaplogs-position-on-abortion-to-save-the-life-of-the-mother/ , https://aaplog.org/premature-delivery-is-not-induced-abortion/ , and https://aaplog.org/wp-content/uploads/2020/12/FINAL-AAPLOG-PB-10-Defining-the-End-of-Pregnancy.pdf .

26. The Abortion Mandate forces AAPLOG's a Texas members to choose between following state laws and their own consciences prohibiting certain abortions and violating the Abortion Mandate, or following the Abortion Mandate and violating state law and their consciences.

27. The Abortion Mandate threatens crippling punishments against AAPLOG's members for failing to comply, including fines of $119,942 per violation and loss of qualification for federal programs such as Medicaid and Medicare.

28. These threats of punishment under EMTALA chill the exercise of religion of AAPLOG's religious members. Further these threats of punishment serve to coerce AAPLOG members to act in violation of their best medical judgement exercised on behalf of both of their patients, the pregnant mother and the human being in her womb.

29. I, Donna Harrison, M.D., a citizen of the United States, declare under penalty of perjury under 28 U.S.C. § 1746 that this Declaration is true and correct based on my personal knowledge.

Executed this 28th day of July, 2022.

Donna Harrison, M.D.
CEO of AAPLOG
Eau Claire, Michigan

EXHIBIT 5

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, ***Plaintiffs,***	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185-H**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, ***Defendants.***	§	

DECLARATION OF JEFFREY BARROWS, D.O. M.A. (Ethics)

1. My name is Jeffrey Barrows, D.O. M.A. (Ethics), of Blountville TN.

2. I am over eighteen years old and make this declaration on personal knowledge.

3. I am a board certified Ob/Gyn.

4. I am also the Senior Vice President of Bioethics and Public Policy for Christian Medical and Dental Associations ("CMDA"), a plaintiff in this case.

5. I am familiar with CMDA, its members, their fields of practice, and CMDA's policies and positions, including as set forth in the first amended complaint.

6. Plaintiff CMDA is a national nonprofit organization, headquartered in Tennessee, of Christian physicians, dentists, and allied health care professionals, with over 12,000 members nationwide. This includes 1,237 overall members in Texas, of whom 607 are practicing or retired physicians, and 35 are Ob/Gyns.

7. CMDA is opposed to the practice of abortion as contrary to Scripture, respect for the sanctity of human life, and traditional, historical and Judeo-Christian medical ethics.

8. CMDA's mission includes advocating on behalf of its members, including in litigation. CMDA has participated as a party in litigation to defend protection of conscience rights in previous litigation, including the EMTALA case *ACLU v. Trinity Health Corp.*, No. 2:15-cv-12611-GAD-RSW, ECF No. 39 (E.D. Mich. order March 10, 2016), and the Weldon Amendment cases *California ex. rel. Lockyer v. United States*, 450 F.3d 436, 445 (9th Cir. 2006), *Nat'l Family Planning & Reproductive Health Ass'n v. Gonzales*, 468 F.3d 826, 827 (D.C. Cir. 2006), and *Nat'l Family Planning & Reproductive Health Ass'n*, No. 04-02148 (D. D.C. Sept. 28, 2005).

9. CMDA sues on behalf of its members.

10. CMDA has members in Texas and around the country who care for pregnant women in situations at hospitals subject to EMTALA.

11. CMDA has members in Texas that are physicians, allied healthcare professionals, or employees of a hospital or other health care facility, within the meaning of Tex. Occupations Code § 103.001.

12. CMDA has members in Texas and throughout the country protected under the Church, Coats-Snowe, and Weldon Amendments described in the first amended complaint, as many of those members are individual physicians, other allied health care professionals, participants in

programs of training in the health professions, health care personnel of health care entities receiving funds from HHS, or individuals participating in health service programs or research activities funded by HHS.

13. The Abortion Mandate described in the first amended complaint purports to establish a standard of care that requires abortions in various circumstances faced by CMDA's members in Texas and other states.

14. The Abortion Mandate purports to require abortions by CMDA's members in various circumstances not posing a risk to the life of the mother.

15. For example, the abortion mandate requires performing essentially an elective abortion where women present to an emergency room, having previously initiated medication abortions, but where the unborn child is still living and may still be preserved.

16. Intrauterine pregnancy itself is not an acute condition requiring any immediate intervention under EMTALA, and thus does not fit the criteria for EMTALA intervention. Intrauterine pregnancy is a normal bodily function.

17. Because these broader conditions covered by the Abortion Mandate include elective abortions where the woman's life is not at stake, part of the effect of the Abortion Mandate is to force the performance of elective abortions by physicians, including CMDA members.

18. In cases where the unborn child's life can still be preserved, the Abortion Mandate purports to require CMDA's members to perform, assist in, or refer for abortions in violation of Texas law, the pro-life laws of other states, and EMTALA itself which requires stabilization of the unborn child.

19. CMDA and its members affirm the historical prohibition against abortion in the Christian Church and in application of the Hippocratic Oath. Their objections are Biblical, biological, social, medical, and ethical.[1]

20. The Abortion Mandate's requirement that CMDA's members perform abortions in circumstances not justified by CMDA's members' religious beliefs about protecting the life of the mother and her unborn child would force CMDA's members to violate their sincerely held religious or moral beliefs or medical judgment.

21. The Abortion Mandate forces CMDA's Texas members to choose between following state laws and their own consciences prohibiting certain abortions and violating the Abortion Mandate, or following the Abortion Mandate and violating state law and their consciences.

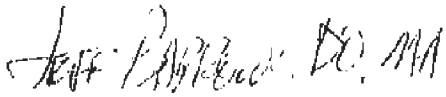
22. The Abortion Mandate threatens crippling punishments against CMDA's members for failing to comply, including fines of $119,942 per violation and loss of qualification for federal programs such as Medicaid and Medicare.

23. These threats of punishment under EMTALA chill the exercise of religion of CMDA's members. Further, these threats of punishment serve to coerce CMDA's members to act in violation of their best medical judgement exercised on behalf of both of their patients, the pregnant mother and the human being in her womb.

24. I, Jeffrey Barrows, D.O. M.A. (Ethics), a citizen of the United States, declare under penalty of perjury under 28 U.S.C. § 1746 that this Declaration is true and correct based on my personal knowledge.

[1] See https://cmda.org/abortion/.

Executed this 27th day of July, 2022.



Jeffrey Barrows, D.O. M.A. (Ethics)

Exhibit 6

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, ***Plaintiffs,***	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185-H**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, ***Defendants.***	§	

DECLARATION OF SEAN HUTZLER, M.D.

1. My name is Sean Hutzler, M.D., of Corpus Christi, Texas.

2. I am over eighteen years old and make this declaration on personal knowledge.

3. I am an emergency medicine physician in Corpus Christi, Texas, and am affiliated with multiple hospitals in the area.

4. I am a member of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), the organization that is a co-plaintiff in the first amended

complaint in this case to be filed on July 28, 2022, which I have reviewed. I am also a member of the Catholic Church.

5. I share the views of AAPLOG set forth in the first amended complaint, and of the Catholic Church, concerning abortion and the medical treatment that is appropriate for women and their unborn children.

6. As an emergency medicine physician, I regularly treat pregnant women who come to the emergency room in situations subject to EMTALA. I have treated many women with complications arising during pregnancy, including ectopic pregnancy.

7. I provide the best care possible to women and their unborn children in such circumstances, and I have complied with EMTALA, state law, and my medical, ethical, and religious beliefs.

8. I seek to practice medicine consistent with my medical and ethical views, my religious beliefs, and state law, but I am concerned that the Abortion Mandate, as discussed in the first amended complaint, could be enforced to require involvement in abortions inconsistent with my views, my beliefs, and state law.

9. I, Sean Hutzler, M.D., a citizen of the United States, declare under penalty of perjury under 28 U.S.C. § 1746 that this Declaration is true and correct based on my personal knowledge.

Executed this 27th day of July, 2022.

Sean Hutzler, M.D.
Corpus Christi, Texas

EXHIBIT 7

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, *Plaintiffs*,	§	
v.	§	CIVIL ACTION No. 5:22-cv-0018S-H
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, *Defendants.*	§	

DECLARATION OF MICHAEL T. VALLEY, M.D.

1. My name is Michael T. Valley, M.D., of Waconie, Minnesota.

2. I am over eighteen years old and make this declaration on personal knowledge.

3. I am an Ob/Gyn with board certified specialties in obstetrics and gynecology and urogynecology.

4. I practice in Minnesota and cover the emergency department at hospitals in Waconie and Chaska, Minnesota.

5. I am a member of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), the organization that is a co-plaintiff in the first amended complaint in this case to be filed on July 28, 2022, which I have reviewed. I am also a member of the Catholic Church.

6. I share the views of AAPLOG set forth in the first amended complaint, and of the Catholic Church, concerning abortion and the medical treatment that is appropriate for women and their unborn children.

7. In covering the emergency departments of two facilities as an Ob/Gyn, I regularly treat pregnant women who come to the emergency room in situations subject to EMTALA.

8. I provide the best care possible to women and their unborn children in such circumstances, and I have complied with EMTALA, state law, and my medical and ethical standards.

9. I seek to practice medicine consistent with my medical, ethical, and religious values, but I am concerned that the Abortion Mandate, as discussed in the first amended complaint, could be enforced to require my involvement in abortions inconsistent with those values.

10. I, Michael T. Valley, M.D., a citizen of the United States, declare under penalty of perjury under 28 U.S.C. § 1746 that this Declaration is true and correct based on my personal knowledge.

Executed this 27th day of July, 2022.

Michael T. Valley, M.D.
Waconia, Minnesota

EXHIBIT 8

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, *Plaintiffs,*	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185-H**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; **UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS; **DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS, *Defendants.*	§	

DECLARATION OF STEVEN A. FOLEY, M.D.

1. My name is Steven A. Foley, M.D., of Carmel, Indiana.

2. I am over eighteen years old and make this declaration on personal knowledge.

3. I am board certified in Obstetrics and Gynecology and I practice in Angola and Evansville, Indiana.

4. I am a member of the Christian Medical and Dental Associations (CMDA), the organization that is a co-plaintiff in the first amended complaint in this case to be filed on July 28, 2022, which I have reviewed.

5. I share the views of CMDA set forth in the first amended complaint concerning abortion and the medical treatment that is appropriate for women and their unborn children.

6. I am associated with several hospitals, I work as a hospitalist, and I cover the emergency department for hospitals. As an Ob/Gyn in those settings, I regularly treat patients that have come through the emergency room in situations subject to EMTALA.

7. I provide the best care possible to women and their unborn children in such circumstances, and I have complied with EMTALA, state law, and my medical, ethical, and religious beliefs.

8. I seek to practice medicine consistent with my medical, ethical, and religious views, but I am concerned that the Abortion Mandate, as discussed in the first amended complaint, could be enforced to require my involvement in abortions inconsistent with those views.

9. I, Steven A. Foley, M.D., a citizen of the United States, declare under penalty of perjury under 28 U.S.C. § 1746 that this Declaration is true and correct based on my personal knowledge.

Executed this 27th day of July, 2022.

Steven A. Foley, M.D.
Carmel, Indiana

EXHIBIT 9

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS; AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS; and CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS, ***Plaintiffs*****,**	§	
v.	§	**CIVIL ACTION NO. 5:22-CV-00185**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services**; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS); KAREN L. TRITZ,** in her official capacity as Director of the Survey and Operations Group for CMS**; DAVID R. WRIGHT,** in his official capacity as Director of the Quality Safety and Oversight Group for CMS**,** ***Defendants.***	§	

DECLARATION OF ERIC BENTLEY

My name is Eric Bentley, and I am over the age of 18 and fully competent in all respects to make this declaration. I have personal knowledge and expertise of the matters stated herein.

1. I am the Vice Chancellor and General Counsel of the Texas Tech University System (TTUS) and have been in my current position since September of 2018. In this capacity, I oversee the legal matters for TTUS and its five component institutions: Texas Tech University (TTU), Texas Tech University Health Sciences Center (TTUHSC), Texas Tech University Health Science Center El Paso (TTUHSC EP), Angelo State University (ASU), and Midwestern State University (MSU).

2. TTUS operates the following health sciences centers, both of which are separate state of Texas institutions of higher education: TTUHSC and TTUHSC EP.

3. I am aware of the federal government's EMTALA Guidance titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss" issued on July 11, 2022 (attached here as Exhibit 1).

4. The EMTALA Guidance conditions federal Medicare and Medicaid funding with compliance with its terms. The EMTALA Guidance stipulates that failure to comply with its terms may result in the Centers for Medicare & Medicaid Services terminating hospitals' provider agreements and excluding physicians from participation in Medicare and State health care programs. Exh. 1 at 2–3, 5.

5. Failure by health care providers employed by TTUHSC or TTUHSC EP to comply with the EMTALA guidance could result in the significant loss of federal funds by TTUHSC and TTUHSC EP.

6. The following figure represents the approximate Medicare and Medicaid funding received in Fiscal Year 2022 to date (September 1, 2021 through the date of this declaration) for emergency room medical services at TTUHSC and TTUHSC El Paso: $7,537,661.72.

7. It should be noted that Medicare and Medicaid funding received for emergency room medical services at TTUHSC and TTUHSC El Paso is minor in comparison to overall Medicare and Medicaid funding for TTUHSC and TTUHSC El Paso. For example, the following figure represents the approximate Medicare and Medicaid funding received in Fiscal Year 2022 to date (September 1, 2021 through the date of this declaration) for medical services at TTUHSC alone: $148,810,589.58.

8. All the facts and information contained within this declaration are within my personal knowledge and are true and correct. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 2nd day, August 2022, in Lubbock, Texas.

ERIC BENTLEY