NOS. 23-726 and 23-727

IN THE

Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL.

Petitioners,

v.

UNITED STATES OF AMERICA,

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES OF AMERICA,

JOINT APPENDIX
(Volume 2 of 3)

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Exhibit C to Plaintiff's MPI

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF KYLIE COOPER, M.D.**

DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a double board-certified Obstetrician-Gynecologist ("Ob-Gyn") and Maternal-Fetal Medicine ("MFM") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in high-risk obstetrics. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. I graduated from the University of Iowa Carver College of Medicine and subsequently completed my residency in Obstetrics and Gynecology

at the University of Vermont. Following residency, I completed my Maternal-Fetal Medicine Fellowship at the University of Vermont. I am the current vice chair of the Idaho section of the American College of Obstetricians and Gynecologists (ACOG). I am teaching faculty for the Primary Care Obstetrics Fellowship with Full Circle Health Family Medicine Residency which is a program to train family medicine physicians in obstetrical care to be used in their rural practice settings. This is particularly important given that there are no residency programs in OB/Gyn in Idaho. I also serve as an advisory board member for the Idaho Perinatal Project. My professional memberships include ACOG, the Society of Maternal-Fetal Medicine, and the Idaho Medical Association.

3. I came to Idaho specifically for my job as a maternal-fetal medicine physician at St. Luke's Regional Medical Center. As I was interviewing for MFM positions around the country it was clear that Idaho had a great need for high-risk obstetricians given the growing population and multitude of health conditions and pregnancy complications, such as obesity which impacts pregnancy in a multitude of ways. Additionally, there were very few female MFM physicians in Idaho, and I wanted to provide high quality and compassionate care to Idahoan families.

Idaho Code§ 18-622 and the Impact on Providers and Patients

4. Over the course of my seven-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women and delivered innumerable babies.

5. Pregnancy is not always straight forward and complication free. As an MFM physician my goal is to achieve the healthiest outcomes possible for my patients; however, there are many situations where pregnancy termination is the medically indicated treatment and is in the best interest of the patient's health and life. I will describe several recent examples of patients whom I have treated, which illustrate some circumstances that make it medically necessary to terminate a pregnancy. These cases occurred between September 2021 and June 2022.

Jane Doe 1

6. Jane Doe I presented to the emergency department at 15 weeks gestation feeling unwell and was found to have severe range blood pressures. Her fetus had recently been diagnosed with triploidy, a chromosomal abnormality with an entire extra set of chromosomes leading to multiple severe birth defects and though there was a fetal heartbeat, this condition was not compatible with life. Fetal triploidy carries an increased risk of development of preeclampsia in the mother. She was admitted to the hospital with persistent stroke range blood pressures requiring high dose antihypertensive therapy and magnesium to reduce her risk for seizures. A diagnosis of preeclampsia with severe features was made. The only cure for preeclampsia is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. The medical treatment for preeclampsia with severe features in patients who are at a previable gestational age is termination of pregnancy. Given her severe illness placing her at risk for stroke, seizure, pulmonary edema, development of HELLP syndrome

(hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life.

7. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

JaneDoe2

8. Jane Doe 2 presented to the emergency room at 20 weeks gestation with acute and progressive right upper abdominal pain requiring intravenous narcotics. Her pregnancy was complicated by a recent diagnosis of severe intrauterine growth restriction and though there was a fetal heartbeat, there was abnormal amniotic fluid level and abnormal umbilical cord blood flow portending a poor prognosis. She was found to have elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Her labs quickly deteriorated as would be expected with HELLP syndrome. Her platelets were dropping so quickly she required a platelet transfusion; she had evidence of hemolysis and concern for liver injury based on rising liver enzymes and upper abdominal pain. HELLP syndrome placed her at risk for Disseminated Intravascular Coagulation (DIC) which is a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The only cure is to end a pregnancy either by delivery of the neonate if after viability or by termination of pregnancy if pre-viable. In the setting of pre-viable

HELLP syndrome, urgent termination of pregnancy is the necessary treatment to stop her disease progression to preserve her health and life.

9. The only medically acceptable action to preserve her health and life was termination of the pregnancy.

Jane Doe 3

10. Jane Doe 3 presented to the emergency room at 15 weeks gestation with acute onset severe abdominal pain. She was noted to be hypertensive and lab abnormalities were consistent with a diagnosis of HELLP syndrome. Additionally, fetal and placental ultrasound was concerning for anomalies most consistent with fetal triploidy, a lethal fetal condition. Her abdominal pain and rapidly rising liver enzymes were indicative of liver injury, and her platelets were declining rapidly. In the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary edema. The medically necessary treatment to stop her disease progression and protect her health and life was termination of pregnancy.

11. The only medically acceptable action to preserve her health and life was to terminate the pregnancy.

12. Prior to Idaho's trigger law, my medical training and judgment allowed me to promptly identify what the appropriate standard of care treatment was for these patients. I was able to expeditiously care for them in the appropriate manner to prevent long-term harm. The trigger law

threatens to criminalize medically indicated termination of pregnancy. In the future, though I know what the appropriate medical treatment is for my patients, I would be hesitant to provide the necessary care due to the significant risk to my professional license, my livelihood, my personal security, and the well-being of my family.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/8/2022
Date

Kylie Cooper MD
Kylie Cooper MD

Exhibit D to Plaintiff's MPI

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF STACY T. SEYB, M.D.**

DECLARATION OF STACY T. SEYB, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Stacy T. Seyb, M.D., being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at St. Luke's Regional Medical Center in Boise, Idaho. In that capacity, I specialize in Maternal-Fetal Medicine. I submit this declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. I graduated from University of Kansas and subsequently completed my residency in Obstetrics and Gynecology at the University of Colorado and

fellowship in Maternal Fetal Medicine at Northwestern University Feinberg School of Medicine. I practiced as a general ObGyn and served as teaching faculty before completing my fellowship specializing in high risk and abnormal pregnancy management.

3. I have practiced as a Maternal-Fetal Medicine provider in Idaho for 22 years working not only on the front lines treating complicated pregnancies but also as a consultant to general OB-Gyn providers and Family Medicine providers providing obstetric care primarily in Southwest Idaho as well as across the state. I worked over a decade with the Idaho March of Dimes improving programming support and updating providers on evolving practices to improve the health of women and children in our state. Currently I serve as a state liaison to Idaho for the Society for Maternal Fetal Medicine.

Idaho Code § 18-622 and the Impact on Providers and Patients

4. Over the course of my nearly 35-year career as a practicing Ob-Gyn, I have treated thousands of pregnant women, delivered thousands of healthy babies, and managed a variety of life-threatening conditions in pregnancy.

5. Although as physicians we work to help our patients to experience normal pregnancies, culminating in the delivery of a healthy baby, not all pregnancies are as simple and complication-free as physicians and patients would like.

6. In the practice of Ob-Gyn, there are situations where pregnancy termination is the only medical

intervention that can preserve a patient's health or save their life. Abortion is a very important tool that has contributed to the reduction of the maternal mortality rate from nearly 800 to 25 deaths per 100,000 live births across the United States in the last century. Obstetrics & Gynecology: November 2019 - Volume 134 - Issue 5 - p 1105-1108. I will describe examples of patients my colleagues and I have treated, which illustrate the dire circumstances that can make it medically necessary to terminate a pregnancy. My colleagues and I encounter these pregnancy-related emergencies approximately a dozen times per year.

Jane Doe 1

7. A 22-year old woman at 18 weeks of her pregnancy presented to the Emergency Department and a Medical Screening Exam was remarkable for fever, tender uterus, elevated heart rate and evidence of an intrauterine infection without other obvious sources of infection. Her history was also suspicious, she may have ruptured her bag of water 10 days prior, and ultrasound confirmed both a fetal heartbeat as well as no fluid around the baby confirming that she has a condition termed Septic Abortion. While antibiotics are important for treating severe infections, a general tenet of medicine is that without drainage or removal of infected tissue the infection is unlikely to improve.

8. Had Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high. If she survived, other risks of not removing the infection

include infertility or hysterectomy, as well as other sequala of sepsis including renal failure and clotting disorder, also known as Disseminated Intervascular Coagulation (DIC). The national standard for treating this condition is both antibiotics and emptying the contents of the uterus.

Jane Doe 2

9. A 35-year old woman presented to the Emergency Department with headache, vision changes, and feeling poorly for a few days. A Medical Screening Examination revealed severe range blood pressures, and laboratory values that were consistent with a pregnancy condition known as pre-eclampsia with severe features. Ultrasound revealed a fetal heartbeat but the fetus was small for dates and the placenta was large, consistent with what is termed a partial molar pregnancy.

10. The only medically acceptable action to preserve her life was termination of the pregnancy. Not only was the pregnancy ultimately not viable due to the nature of the molar pregnancy but removal of the placenta, i.e., delivery was the only cure to reverse the severe preeclampsia.

JaneDoe 3

11. A 25-year old woman in her 19th week of pregnancy presented to the Emergency Department after she started bleeding very heavily per vagina. The Medical Screening Examination indicated hypovolemic shock due to her blood loss. Initial resuscitation improved her condition but she continued to bleed in an uncontrolled manner. Although there was a fetal heartbeat present, without

further treatment the bleeding was likely to continue. A Dilation and Evacuation (D and E) was performed, terminating the pregnancy.

12. The only medically available tool to stop the bleeding was termination of the pregnancy. If left untreated the risks of life-threatening shock, even with blood replacement were very high.

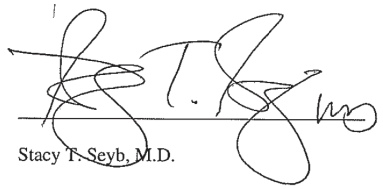
13. Idaho Code § 18-622 threatens to criminalize abortion, without clear definition of medically necessary circumstances. The assertion that "prevent the death of the pregnant woman" is clear to the medical community is not useful to medical providers because this is not a dichotomous variable.

In the three cases above, the medical standard was clear and if the trigger law goes into effect, providers will likely delay care for fear of criminal prosecution and loss of licensure. For example, as a high-risk pregnancy consultant, I recently received a call from an outside institution where the provider encountered a woman at 20-weeks of gestation, with severe bleeding similar to the one described above, and wanted to transfer her. He was qualified but was afraid of the potential ramifications of his actions if he proceeded with termination. It was clear that the mother was in danger and that treatment could not be delayed. This situation was clear that termination was the only option, and I reassured this provider and recommended that management. This is one example that providers do not have a clear guide as to what situations will place their livelihood in danger. Providers from all over the state are voicing that they cannot rely upon their medical judgment or best practices for handling pregnancy complications.

14. Idaho Code § 18-622 threatens to make it difficult to recruit Ob-Gyns to the State of Idaho, where we have no in-state training for this specialty. In emergency situations, physicians may delay the medically necessary care because they fear a financially ruinous investigation or criminal liability. If an Ob-Gyn can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/8/2022
Date



Stacy T. Seyb, M.D.

Exhibit E to Plaintiff's MPI

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329-BLW

DECLARATION OF DAVID R. WRIGHT

I, David R. Wright, of the Centers for Medicare & Medicaid Services ("CMS") declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the course of my official duties.

1. I am the Director of the Quality, Safety & Oversight Group ("QSOG") in the CMS Center for Clinical Standards & Quality ("CCSQ"), United States Department of Health and Human Services ("HHS"). QSOG provides guidance to state survey agencies and accrediting organizations that evaluate Medicare health and safety standards for providers on behalf of CMS. One of these Medicare health and safety standards is the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd.

2. Hospitals apply to become Medicare-certified by completing a CMS Form 855, Medicare Enrollment Application (https://www.cms.gov/medicare/cms-forms/cmsforms/downloads/cms855a.pdf).

3. Once the 855 form is submitted and approved, there is a certification process, designed to determine whether a hospital complies with the standards required by Federal law and regulation, including Medicare Conditions of Participation ("CoPs"). 42 C.F.R. pt. 482 and 2 C.F.R. pt. 485.

4. If approved for Medicare certification, the hospital receives a CMS Form 1561-Health Insurance Benefit Agreement, which is signed by both the hospital and CMS (on behalf of the Secretary of HHS). https://www.cms.gov/Medicare/CMS-Forms/CMS Forms/Downloads/CMS1561.pdf. The CMS Form 1561 states that "…the provider of services, agrees to conform to the provisions of section 1866 of the Social Security Act and applicable provisions in 42 CFR," which includes EMTALA.

5. The hospital additionally submits an assurance of compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended.

6. Similar to the affirmations above, when a hospital submits its Medicare cost report following the completion of its fiscal years, the Chief Financial Officer or hospital Administrator must certify that he or she is "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations," which include EMTALA. *See*

https://www.cms.gov/Regulationsand-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf

7. All of the attestations on these forms and reports discussed above—including the CMS Form 1561, the assurance of compliance with nondiscrimination laws, and the certification on the hospital's Medicare cost report—are essential to the functioning of the Medicare program. CMS reimburses providers only upon the understanding that those providers are complying with the statutes and regulations governing the program.

8. There are 52 Medicare-participating hospitals in Idaho. 39 of these hospitals filed claims with CMS for emergency room costs on their Medicare cost reports.

9. There are sixteen government-owned hospitals that participate in Medicare in Idaho. State Hospital South (Blackfoot, Idaho) is a psychiatric hospital owned by the State of Idaho. Additionally, Madison Memorial Hospital (Rexburg, Idaho), Kootenai Health (Coeur d'Alene, Idaho), Bear Lake Memorial Hospital (Montpelier, Idaho), Benewah Community Hospital (St. Maries, Idaho), Caribou Medical Center (Soda Springs, Idaho), Cascade Medical Center (Cascade, Idaho), Lost Rivers Medical Center (Arco, Idaho), Minidoka Memorial Hospital (Rupert, Idaho), Nell J. Redfield Memorial Hospital (Malad, Idaho), Power County Hospital District (American Falls, Idaho), Shoshone Medical Center (Kellogg, Idaho), Steele Memorial Medical Center (Salmon, Idaho), Syringa General Hospital (Grangeville, Idaho), Valor Health (Emmett, Idaho), and Weiser Memorial Hospital (Weiser, Idaho) are

county-owned hospitals. All of the above-listed hospitals, with the exception of State Hospital South, have filed cost reports that include emergency department costs.

10. Medicare participating hospitals must meet the requirements of the EMTALA statute enacted as Section 1867 of the Social Security Act (42 U.S.C. § 1395dd), the accompanying regulations in 42 CFR § 489.24, and the related requirements at 42 CFR § 489.20(l), (m), (q), and (r). EMTALA requires hospitals with emergency departments to provide an appropriate medical screening examination to any individual who comes to the emergency department and requests such an examination. And EMTALA prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The term "hospital" includes critical access hospitals, which are typically smaller hospitals in rural communities that provide limited inpatient and outpatient services.

11. Some obligations under EMTALA apply only to Medicare-participating hospitals that have a dedicated emergency department, e.g., requirements related to providing a medical screening examination and any necessary stabilizing treatment. However, some EMTALA recipient hospital obligations, such as the obligation to provide stabilizing treatment, can also apply to Medicare-participating hospitals that do not have a dedicated emergency department, such as a hospital with specialized capabilities or facilities.

12. A hospital's EMTALA obligations apply both when a patient presents to the emergency department

directly or by way of a transfer[1] from another medical provider. A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual with an unstabilized emergency medical condition that requires such specialized capabilities or facilities. Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units, or hospitals that are regional referral centers that serve rural areas as defined by the requirements at 42 CFR 412.96. This requirement to accept a transfer applies to any Medicare-participating hospital with specialized capabilities that has appropriate staff and facilities available to treat the condition, regardless of whether the hospital has a dedicated emergency department.

13. The goal of CMS' health and safety oversight is compliance with the Medicare CoPs and EMTALA, which themselves have the object of ensuring adequate care and advancing beneficiary and general patient health and safety. 42 CFR § 489.53(b) provides the basis for termination of a hospital's Medicare provider agreement for failure to comply with the requirements of EMTALA.

---

[1] A Medicare-participating hospital's EMTALA obligations apply regardless of how a patient arrives at its emergency department. However, in cases where a patient has arrived at that hospital through an inappropriate transfer from another Medicare-providing hospital, the receiving facility should also report the inappropriate transfer to CMS. 42 U.S.C. §1395(d)(2)(B).

14. Through the passage of EMTALA, Congress obligated the Secretary of HHS to enforce the statute to protect any individual coming to the emergency department requesting examination or treatment for an emergency medical condition. As previously noted, CMS conditions the receipt of Medicare money, in part, on compliance with the EMTALA statute.

15. HHS cannot meet its Congressional EMTALA mandate if state law prohibits providers from providing the full range of care contemplated by the statute. Enforcing EMTALA aligns with the missions of HHS and CMS, of which protecting and promoting access to healthcare and emergency care are paramount.

16. EMTALA assists in protecting those objectives while requiring healthcare providers to render care to all individuals presenting to an emergency department that accepts Medicare funding, regardless of their medical condition, ability to pay for medical services, or directly conflicting state laws.

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

Executed this 8th day of August, 2022 in Baltimore, Maryland.

David R. Wright -S
Digitally signed by David R. Wright -S
Date: 2022.08.08 16:09:29 -04'00'

David Wright
Director
Quality, Safety, and Oversight Group
Centers for Clinical Standards & Quality
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Exhibit F to Plaintiff's MPI

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	)	Civ. Action No. 1:22-cv-329

DECLARATION OF BARBARA SHADLE

I, Barbara Shadle, declare as follows:

1. I am an Auditor within the Division of Provider Audit Operations ("DPAO") in the Centers for Medicare and Medicaid Services ("CMS") within the United States Department of Health and Human Services ("HHS"). DPAO is an office within the Financial Services Group of CMS Office of Financial Management. DPAO oversees and coordinates the Medicare cost report audit and reimbursement process, in order to ensure that payments made to institutional providers are accurate. I have held this position since 2018. In my role, I regularly communicate with Medicare Administrative Contractors ("MACs"), which are private insurance companies acting on behalf of CMS that process Medicare claims and cost reports and determine payment amounts to providers. I also review Medicare cost report reimbursement issues. The statements made in this declaration are based on my

personal knowledge, information I obtained from DPAO support contractors, and information contained in cost reports submitted by Medicare providers.

2. Institutional providers include hospitals, critical care facilities, and skilled nursing centers. Institutional providers participating in the Medicare program are required to submit a Medicare cost report following the completion of their fiscal years. This Medicare cost report contains the provider's costs, charges, and financial information used to establish the provider's Prospective Payment rates and final Medicare reimbursement.

3. The first page of each provider's submitted cost report requires the Chief Financial Officer or hospital Administrator to certify that he or she is "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations." A copy of the certification form that must be completed and certified by participating providers is included as Exhibit 1.

4. The laws and regulations to which the certification refers include the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, as well as other portions of the Social Security Act and accompanying regulations.

5. This certification carries legal consequences. In highlighted capital letters, the form warns: "Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil, and administrative action, fine, and/or

imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative fines and/or imprisonment may result."

6. I was asked to identify the amount of Medicare funds provided to hospital emergency departments in Idaho. Based on the data available and supplied by a DPAO support services contractor, I have determined that the total rough estimate of emergency department payments in Idaho during fiscal years 2018-2020 was approximately $74,739,853 out of the providers' total payments of $3,413,768,066. This total rough estimate was calculated for 39 hospitals as to which costs were able to be identified for emergency department services via data in the Healthcare Cost Report Information System ("HCRIS").

7. The DPAO support services contractor identified this data regarding Medicare payments in Idaho based on finalized cost report information that is loaded to HCRIS where it is housed and can be accessed by CMS for Medicare rate-setting purposes.

8. In institutional providers' cost reports, providers identify their total hospital costs and costs attributable to their emergency departments. *See* Ex. 1, Worksheet A. To determine a rough estimate of emergency department payments, the emergency department costs were divided by total hospital costs to determine a percentage related specifically to the emergency department. I then multiplied this percentage by the hospital's total payments to reach

the rough estimate of payments related to emergency department services identified above in paragraph 6.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 8th day of August, 2022 in Baltimore, Maryland.

Barbara Shadle Digitally signed by Barbara Shadle Date: 2022.08.08 17:27:15 -04'00'

Barbara Shadle

Exhibit G to Plaintiff's MPI

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329-BLW

DECLARATION OF LISA NEWMAN

Pursuant to 28 U.S.C. § 1746, I, Lisa Newman, hereby declare:

1. I am an attorney in the U.S. Department of Justice, Civil Division, Federal Programs Branch. I am assigned to represent the United States in the above-captioned case. The statements made herein are based on my personal knowledge, and on information made available to me in the course of my duties and responsibilities as Government counsel in this case.

2. I submit this declaration in support of the United States' Motion for a Preliminary Injunction.

3. Filed herewith as United States' Exhibits 1-3 are true and correct copies of the following documents that I downloaded from the indicated websites:

Exhibit No.	Exhibit Name
1	Centers for Medicare & Medicaid Service (CMS) Form 855, *available at* https://perma.cc/84T6-S2DP (last visited Aug. 8, 2022)
2	Centers for Medicare & Medicaid Service (CMS) Form 1561, *available at* https://perma.cc/5EPE-YLRE (last visited Aug. 8, 2022)
3	Idaho Dep't of Health & Welfare, *2010-2020 Idaho Resident Births*, *VS Natality – Data Results, 2010-2020*, *available at* https://www.gethealthy.dhw.idaho.gov/388hris-births-vital-statistics (last visited Aug. 8, 2022)

I swear under penalty of perjury that the foregoing is true and correct. Executed on August 8, 2022, in Washington, D.C.

/s/ Lisa Newman
Lisa Newman

Counsel for the United States

Newman Declaration: Exhibit A

MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855a

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION

SEE PAGE 52 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

WHO SHOULD COMPLETE THIS APPLICATION

Institutional providers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

• The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
• The paper enrollment application process (e.g., CMS 855A).

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, *go to www.cms.gov/MedicareProviderSupEnroll*.

Institutional providers who are enrolled in the Medicare program, but have not submitted the CMS 855A since 2003, are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS 855A) as an initial application when reporting a change for the first time.
The following health care organizations must complete this application to initiate the enrollment process:

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy/Occupational Therapy /Speech Pathology Services
- Religious Non-Medical Health Care Institution
- Rural Health Clinic
- Skilled Nursing Facility

If your provider type is not listed above, contact your designated fee-for-service contractor before you submit this application.

Complete this application if you are a health care organization and you:

- Plan to bill Medicare for Part A medical services, or
- Would like to report a change to your existing Part A enrollment data. A change must be reported within 90 days of the effective date of the change; per 42 C.F.R. 424.516(e), changes of ownership or control must be reported within 30 days of the effective date of the change.

BILLING NUMBER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). **Medicare healthcare providers, except organ procurement organizations, must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information.** Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at https://NPPES.cms.hhs.gov. As an organizational health care provider, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if

they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

IMPORTANT: For NPI purposes, sole proprietors and sole proprietorships are considered to be "Type 1" providers. Organizations (e.g., corporations, partnerships) are treated as "Type 2" entities. When reporting the NPI of a sole proprietor on this application, therefore, the individual's Type 1 NPI should be reported; for organizations, the Type 2 NPI should be furnished.

For more information about subparts, visit *www.cms.gov/NationalProvIdentStand* to view the "Medicare Expectations Subparts Paper."

The Medicare Identification Number, often referred to as the CMS Certification Number (CCN) or Medicare "legacy" number, is a generic term for any number other than the NPI that is used to identify a Medicare provider.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.

• Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the provider's address.
- Enter your NPI in the applicable sections.
- Enter all applicable dates.
- Ensure that the correct person signs the application.
- Send your application and all supporting documentation to the designated fee-for-service contractor.

OBTAINING MEDICARE APPROVAL

The usual process for becoming a certified Medicare provider is as follows:

1. The applicant completes and submits a CMS-855A enrollment application and all supporting documentation to its fee-for-service contractor.
2. The fee-for-service contractor reviews the application and makes a recommendation for approval or denial to the State survey agency, with a copy to the CMS Regional Office.
3. The State agency or approved accreditation organization conducts a survey. Based on the survey results, the State agency makes a recommendation for approval or denial (a

certification of compliance or noncompliance) to the CMS Regional Office. Certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a State survey.

4. A CMS contractor conducts a second contractor review, as needed, to verify that a provider continues to meet the enrollment requirements prior to granting Medicare billing privileges.
5. The CMS Regional Office makes the final decision regarding program eligibility. The CMS Regional Office also works with the Office of Civil Rights to obtain necessary Civil Rights clearances. If approved, the provider must typically sign a provider agreement.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit *www.cms.gov/MedicareProviderSupEnroll*.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. You are responsible for providing this documentation in a timely manner.

The information you provide on this application will not be shared. It is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a fiscal intermediary or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to www.cms.gov/MedicareProviderSupEnroll.

SECTION 1: BASIC INFORMATION

NEW ENROLEES

If you are:

- Enrolling with a particular fee-for-service contractor for the first time.
- Undergoing a change of ownership where the new owner will not be accepting assignment of the Medicare assets and liabilities of the seller/former owner.

ENROLLED MEDICARE PROVIDERS

The following actions apply to Medicare providers already enrolled in the program:

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, you must be able to submit a valid claim and meet all current requirements for your provider type before reactivation can occur.

Voluntary Termination

A provider should voluntarily terminate its Medicare enrollment when:

- It will no longer be rendering services to Medicare patients,
- It is planning to cease (or has ceased) operations,
- There has been an acquisition/merger and the new owner will not be using the identification number of the entity it has acquired,
- There has been a consolidation and the identification numbers of the consolidating providers will no longer be used, or
- There has been a change of ownership and the new owner will not be accepting assignment of the Medicare assets and liabilities of the seller/former owner, meaning that the number of the seller/former owner will no longer be used.

NOTE: A voluntary identification number termination cannot be used to circumvent any corrective action plan or any pending/ongoing investigation, nor can it be used to avoid a period of reasonable assurance, where a provider must operate for a certain period without recurrence of the deficiencies that were the basis for the termination. The provider will not be reinstated until the completion of the reasonable assurance period.

Change of Ownership (CHOW)

A CHOW typically occurs when a Medicare provider has been purchased (or leased) by another organization. The CHOW results in the transfer of the old owner's Medicare Identification Number and provider agreement (including any outstanding Medicare debt of the old owner) to the new owner. The regulatory citation for CHOWs can be found at 42 C.F.R. 489.18. If the purchaser (or lessee) elects not to accept a transfer of the provider agreement, then the

old agreement should be terminated and the purchaser or lessee is considered a new applicant.

SECTION 1: BASIC INFORMATION (Continued)

Acquisition/Merger
An acquisition/merger occurs when a currently enrolled Medicare provider is purchasing or has been purchased by another enrolled provider. Only the purchaser's Medicare Identification Number and tax identification number remain.

Acquisitions/mergers are different from CHOWs. In the case of an acquisition/merger, the seller/former owner's Medicare Identification Number dissolves. In a CHOW, the seller/former owner's provider number typically remains intact and is transferred to the new owner.

Consolidation
A consolidation occurs when two or more enrolled Medicare providers consolidate to form a new business entity.

Consolidations are different from acquisitions/ mergers. In an acquisition/merger, two entities combine but the Medicare Identification Number and tax identification number (TIN) of the purchasing entity remain intact. In a consolidation, the TINs and Medicare Identification Numbers of the consolidating entities dissolve and a new TIN and Medicare Identification Number are assigned to the new, consolidated entity.

Because of the various situations in which a CHOW, acquisition/merger, or consolidation can

occur, it is recommended that the provider contact its fee-for-service contractor or its CMS Regional Office if it is unsure as to whether such a transaction has occurred. The provider should also review the applicable federal regulation at 42 C.F.R. 489.18 for additional guidance.

Change of Information

A change of information should be submitted if you are changing, adding, or deleting information under your current tax identification number. Changes in your existing enrollment data must be reported to the Medicare fee-for-service contractor in accordance with 42 C.F.R. 424.516(e).

NOTE: Ownership changes that do not qualify as CHOWs, acquisitions/mergers, or consolidations should be reported here. The most common example involves stock transfers. For instance, assume that a business entity's stock is owned by A, B, and C. A sells his stock to D. While this is an ownership change, it is generally not a formal CHOW under 42 C.F.R. 489.18. Thus, the ownership change from A to D should be reported as a change of information, not a CHOW. If you have any questions on whether an ownership change should be reported as a CHOW or a change of information, contact your fee-for-service contractor or CMS Regional Office.

If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 application. All future payments will then be made via EFT.

Revalidation
CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

SECTION 1: BASIC INFORMATION (Continued)

A. Check one box and complete the required sections

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
□You are a **new enrollee** in Medicare	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G**, and **2H**
□ You are enrolling with another fee-for-service contractor's jurisdiction □ You are **reactiviatin**	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**

g your Medicare enrollment		
□ You are **voluntarily terminatin g** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate (*if issued*): National Provider Identifier (*if issued*)	**Complete sections: 1, 2B1, 13,** and either **15** or **16**
□ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: □ Seller/ Former Owner □ Buyer/New Owner	Tax Identification Number:	**Seller/ Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/Ne w Owner: Complete all** sections except **2G** and **2H**
□ Your organization has taken part in an	Medicare Identification Number of the	**Seller/ Former Owner: 1A, 2G, 13,**

Acquisition or **Merger** You are the: □ Seller/ Former Owner □ Buyer/New Owner	Seller/Former Owner (*if issued*): NPI: Tax Identification Number:	and either **15** or **16** **Buyer/New Owner: 1A, 2G, 4, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this provider.
□ Your organization has **Consolidated** with another organization	Medicare Identification Number of the Seller/Former Owner (*if issued*):	**Former Organizations: 1A, 2H, 13,** and either **15** or **16**

You are the: □ Former organization □ New organization	NPI: Tax Identification Number:	**New Organization:** **Complete all** sections except **2F** and **2G**
□ You are **Changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	**Go to Section 1B**
□ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
□ Identifying Information	**1, 2** (complete only those sections that are changing), **3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.

□ Adverse Legal Actions/ Convictions	**1, 2B1, 3, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
□ Practice Location Information, Payment Address & Medical Record Storage Information	**1, 2B1, 3, 4** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
□ Ownership Interest and/or Managing Control Information (Organizations)	**1, 2B1, 3, 5, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider
□ Ownership Interest and/or Managing Control Information (Individuals)	**1, 2B1, 3, 6, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider

□ Chain Home Office Information	**1, 2B1, 3, 7, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
□ Billing Agency Information	**1, 2B1, 3, 8** (complete only those sections that are changing), **13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
□ Special Requirements for Home Health Agencies	**1, 2B1, 3, 12, 13,** and either **15** (if you are the authorized official) **or 16** (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
□ Authorized Official(s)	**1 2B1, 3, 6, 13,** and **15.**
□ Delegated Official(s) (Optional)	**1, 2B1, 3, 6, 13, 15,** and **16.**

SECTION 2: IDENTIFYING INFORMATION

NEW ENROLLEES

Submit separate CMS-855A enrollment applications if the types of providers for which this application is being submitted are separately recognized provider types with different rules regarding Medicare participation. For example, if a provider functions as both a hospital and an end-stage renal disease (ESRD) facility, the provider must complete two separate enrollment applications (CMS-855A)—one for the hospital and one for the ESRD facility. If a hospital performs multiple types of services, only one enrollment application (CMS-855A) is required.

For example, a hospital that has a swing-bed unit need only submit one enrollment application (CMS–855A). This is because the provider is operating as a single provider type—a hospital—that happens to have a distinct part furnishing different/additional services.

SPECIAL ENROLLMENT NOTES

- If you are adding a psychiatric or rehabilitation unit to a hospital, check the appropriate subcategory under the "Hospital" heading. (A separate enrollment for the psychiatric/rehabilitation unit is not required). The unit should be listed as a practice location in Section 4.
- If you are adding a home health agency (HHA) branch, list it as a practice location in Section 4. A separate enrollment application is not necessary.
- If you are changing hospital types (e.g., general hospital to a psychiatric hospital), indicate this

in Section 2. A new/separate enrollment is not necessary.

- If you are adding an HHA sub-unit (as opposed to a branch), this requires an initial enrollment application for the sub-unit.
- If the hospital will focus on certain specialized services, the applicant should analyze whether the facility will be a general hospital or will fall under the category of a specialty hospital. A specialty hospital is defined as a facility that is primarily engaged in cardiac, orthopedic, or surgical care. Based upon Diagnosis Related Group/Major Diagnosis Category (DRG/MDC) and type (medical/surgical), the applicant should project all inpatient discharges expected in the first year of the hospital's operation. Those applicants that project that 45% or more of the hospital's inpatient cases will fall in either cardiac (MDC-5), orthopedic (MDC-8), or surgical care should check the Hospital—Specialty Hospital block in Section 2A2.
- Physician-owned hospital means any participating hospital (as defined in 42 CFR § 489.24) in which a physician, or an immediate family member of a physician has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that

satisfy the requirements at 42 CFR § 411.356(a) or (b).

A. Type of Provider

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals-See2A2). Check only one:

□ Community Mental Health Center

□ Comprehensive Outpatient Rehabilitation Facility

□ Critical Access Hospital

□ End-Stage Renal Disease Facility

□ Federally Qualified Health Center

□ Histocompatibility Laboratory

□ Home Health Agency

□ Home Health Agency (Sub-unit)

□ Hospice

□ Indian Health Services FAcility

□ Organ Procurement Organization

□ Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services

□ Religious Non-Medical Health Care Institution

□ Rural Health Clinic

□ Skilled Nursing Facility

□ Other (Specify): _____

2. If this provider is a hospital, check all applicable subgroups and units listed below and complete Section 2A3.

□ Hospital—General

□ Hospital—Acute Care

□ Hospital—Children's (excluded from PPS)

□ Hospital—Long-Term (excluded from PPS)

□ Hospital—Psychiatric (excluded from PPS)

□ Hospital—Rehabilitation (excluded from PPS)

□ Hospital—Short-Term (General and Specialty)

□ Hospital—Swing-Bed approved

□ Hospital—Psychiatric United

□ Hospital—Rehabilitation Unit

□ Hospital—Specialty Hospital (cardiac, orthopedic, or surgical)

□ Other (Specify): _____

3. If hospital was checked in Section 2A1 or 2A2, does this hospital have a compliance plan that states that the hospital checks all managing employees against the exclusion/ debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA)?

□ YES □ NO

4. Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 9)?

□ YES □ NO

B. Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Identify the type of organizational structure of this provider/supplier (*Check one*)

□ Corporation □ Limited Liability Company

□ Partnership □ Sole Proprietor

□ Other (*Specify*):

Tax Identification Number

Incorporation Date (*mm/dd/yyyy*) (*if applicable*)

State Where Incorporated (*if applicable*)

Other Name

Type of Other Name

□ Former Legal Business Name

□ Doing Business As Name

□ Other (*Specify*): ____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or

State government provider or supplier indicate "Non-Profit" below):

□ Proprietary □ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/ supplier will be defaulted to "Proprietary."

What is the supplier's year end cost report date? (*mm/dd/yyyy*)

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (HIS) Medicare Administrative Contractor (MAC)?

□ Yes □ No

2. STATE LICENSE INFORMATION/ CERTIFICATION INFORMATION

Provide the following information if the provider has a State license/certification to operate as the provider type for which you are enrolling.

□ State License Not Applicable

License Number	State Where Issued
Effective Date (*mm/dd/yyyy*)	Expiration/Remea; Date (*mm/dd/yyyy*)

Certification Information

□ Certification Not Applicable

Certification Number	State Where Issued

Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 (*Street Name and Number*)

Mailing Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code +4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

D. Accreditation

Is this provider accredited? □ YES □ NO

If YES, complete the following:

Date of Accreditation (mm/dd/yyyy)	Expiration Date of Accreditation (mm/dd/yyyy)

Name of Accrediting Body

Type of Accreditation or Accreditation Program (e.g., hospital accreditation program, home health accreditation, etc.)

E. Comments

Use this section to clarify any information furnished in this section.

F. Change of Ownership (CHOW) Information

Both the seller/former owner and the new owner should complete this section. (As the new owner may not know all of the seller/former owner's data, it should furnish this information on an "if known" basis.) The seller/former owner must complete Sections 1A, 2F, 13, and either 15 or 16. (Section 6 must also be completed if the signer has never completed Section 6 before.) The new owner must complete the entire application.

Legal Business Name of "Seller/Former Owner" as reported to the Internal Revenue Service
"Doing Business As" Name of Seller/Former Owner (*if applicable*)
Old Owner's Medicare Identification Number (*if issued*)

Old Owner's NPI	Effective Date of Transfer (this can be a future date) (mm/dd/yyyy)	Name of Fee-For-Service Contractor of

		Seller/Former Owner

Will the new owner be accepting assignment of the current "Provider Agreement?" □ YES □ NO

If the answer is "No," then this is an initial enrollment and the new owner should follow the instructions for "New Enrollees" in Section 1 of this form.

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

G. Acquisitions/Mergers

Effective Date of Acquisition (*mm/dd/yyyy*)

The seller/former owner need only complete Sections 1A, 2G, 13, and either 15 or 16; the new owner must complete Sections 1A, 2G, 4, 13, and either 15 or 16. (Section 6 must also be completed if the signer has never completed Section 6 before.)

1. PROVIDER BEING ACQUIRED
This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service

Current Fee-for-Service Contractor

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/ DEPARTMENT	**MEDICARE IDENTIFICATION NUMBER (IF ISSUED)**	**NATIONAL PROVIDER IDENTIFIER**

2. ACQUIRING PROVIDER

This section is to be completed with information about the organization acquiring the provider identified in Section 2G1.

Legal Business Name of the "Acquiring Provider" as Reported to the Internal Revenue Service	Medicare Identifation Number (if issued)
Current Fee-for-Service Contractor	National Provider Identifier

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

H. Consolidations

The newly formed provider completes the entire application. The providers that are being consolidated are reported below.

1. 1ST CONSOLIDATING PROVIDER

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare Identification Number.

Legal Business Name of the "Provider Being Acquired" as Reported to the Internal Revenue Service
Current Fee-for-Service Contractor
Effective Date of Consolidation
Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swingbed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/ DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

2. 2ND CONSOLIDATING PROVIDER

This section is to be completed with information about the 2nd currently enrolled provider that, as a result of this consolidation, will also no longer retain its current Medicare Identification Number.

Legal Business Name of the "Provider Being Acquired" as Reported to the Internal Revenue Service

Current Fee-for-Service Contractor

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing-bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/ DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

3. NEWLY CREATED PROVIDER IDENTIFICATION INFORMATION

Complete this section with identifying information about the newly created provider resulting from this consolidation.

Legal Business Name of the New Provider as Reported to the Internal Revenue Service	Tax Identification Number

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions,

revocations, and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement,

breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

2. Any revocation or suspension of accreditation.

3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

4. Any current Medicare payment suspension under any Medicare billing number.

5. Any Medicare revocation of any Medicare billing number.

FINAL ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had a final adverse action listed on page 16 of this application imposed against it?

□ YES—Continue Below □ NO—Skip to Section 4

2. If yes, report each final adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

- Report all practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application.
- If the provider is adding a practice location in the same State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. The

location is considered a separate provider for purposes of enrollment, and is not considered a practice location of the main provider. If a provider agreement is not required, the location can be added as a practice location.

- If the provider is adding a practice location in another State and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. (This often happens when a home health agency wants to perform services in an adjacent State.)
- If the provider is adding a practice location within another fee-for-service contractor's jurisdiction and the provider is not already enrolled with that fee-for-service contractor, the provider must submit a full, complete CMS-855A to that fee-for-service contractor—regardless of whether a separate provider agreement is required. It cannot add the location as a mere practice location.
- Provide the specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box.

IMPORTANT: The provider should list its primary practice location first in Section 4A. The "primary practice location" must be associated with the NPI that the provider intends to use to bill for Medicare services.

If you have any questions as to whether the practice location requires a separate State survey or

provider agreement, contact your fee-for-service contractor.

Community Mental Health Centers (CMHCs) must report all alternative sites where core services are provided (proposed alternative sites for initial enrollment and actual alternative sites for those CMHCs already participating in Medicare). In accordance with provisions of the Public Health Service Act, a CMHC is required to provide mental health services principally to individuals who reside in a defined geographic area (service area). Therefore, CMHCs must service a distinct and definable community. Those CMHCs operating or proposing to operate outside of this specific community must have a separate provider agreement/number, submit a separate enrollment application, and individually meet the requirements to participate. CMS will determine if the alternative site is permissible or whether the site must have a separate agreement/number. CMS will consider the actual demonstrated transportation pattern of CMHC clients within the community to ensure that all core services and partial hospitalization services are available from each location within the community. A CMHC patient must be able to access and receive services he/she needs at the parent CMHC site or the alternative site within the distinct and definable community served by the parent.

Hospitals must report all practice locations where the hospital provides services. Do not report separately enrolled provider types such as skilled nursing facilities (SNFs), HHAs, RHCs, etc., even if

these entities are provider-based to the hospital. Suppose a hospital owns a SNF and an HHA. The hospital should not list the SNF and HHA on its application, as they are not locations where the hospital furnishes services.

They are providers that are separate and distinct from the hospital, and will be reported on their respective CMS-855A applications.

Base of Operations Address

• If this provider does not have a physical location where equipment and/or vehicles are stored or from where personnel report on a regular basis, complete this section with information about the location of the dispatcher/scheduler. This situation may occur if the provider operates mobile units that travel continuously from one location directly to another.

• HHAs must complete this section.

Mobile Facility and/or Portable Units

To properly pay claims, Medicare must know when services are provided in a mobile facility or with portable units. (This section is mostly applicable to providers that perform outpatient physical therapy, occupational therapy, and speech pathology services.)

• A "mobile facility" is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

• A "portable unit" is when the provider transports medical equipment to a fixed location (e.g., a physician's office or nursing home) to render services to the patient.

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

Practice Location Name ("Doing Business As" name if different from Legal Business Name)
Practice Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)
Practice Location Street Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code +4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number (*if issued*)	NPI
Medicare Identification Number (*if issued*)	NPI
Medicare Identification Number (*if issued*)	NPI
Medicare Identification Number (*if issued*)	NPI
CLIA Number for this location (*if applicable*)	FDA/Radiology (Mammography) Certification Number for this location (*if issued*)

Hospitals and HHAs only (*Identify type of practice location*):

□ HHA branch

□ Hospital Psychiatric Unit

□ Hospital Rehabilitation Unit

□ Hospital Swing-Bed Unit

□ Main/Primary Hospital Location

□ OPT Extension Site

□ Other Hospital Practice Location: _____

B. Where Do You Want Remittance Notices Or Special Payments Sent?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

□ CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

□ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**

□ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

"Special Payments" Address Line 1 (*PO Box or Street Name and Number*)		
"Special Payments" Address Line 2 (*Suite, Room, etc.*)		
City/Town	State	ZIP Code +4

C. Where Do You keep Patients' Medical Records?

If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4D, complete this section with the address of the storage location.

If this section is not complete, you are indicating that all records are stored at the practice locations reported in Section 4A or 4D. The records must be the provider's records, not the records of another provider. Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained.

For mobile facilities/portable units, the patients' medical records must be under the provider's control.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility for Current and Former Patients

□ CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

Storage Facility Address Line 1 (Street Name and Number)

Storage Facility Address Line 2 (Suite, Room, etc.)

City/Town	State	ZIP Code +4

Second Medical Record Storage Facility for Current and Former Patients

□ CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

Storage Facility Address Line 1 (Street Name and Number)		
Storage Facility Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code +4

D. Base of Operations Address for Mobile or Portable Providers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

□ CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

Check here □ and skip to Section 4E if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

Street Address Line 1 (*Street Name and Number*)
Street Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code +4
Telephone Number	Fax Number (*if applicable*)	E-mail Address (*if applicable*)

E. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not furnish information about ambulance vehicles, or vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office). If more than three vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE (van, mobile home, trailer, etc.)	VEHICLE IDENTIFICATION NUMBER
□ CHANGE □ ADD □ DELETE		
Effective Date:		

□ CHANGE □ ADD □ DELETE		
Effective Date:		
□ CHANGE □ ADD □ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

F. Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For home health agencies (HHAs) and mobile/portable providers, furnish information identifying the geographic area(s) where health care services are rendered.

NOTE: If you provide mobile health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855A) for each Medicare fee-for-service contractor's jurisdiction.

1. INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

□ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

2. DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

□ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

This section is to be completed with information about any organization that has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in Section 2. If there is more than one organization, copy and complete this section for each. (See examples below of organizations that should be reported in this section.)

Only organizations should be reported in this section. Individuals should be reported in Section 6.

If adding, deleting, or changing information on an existing owner, partner, or managing organization, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

A. Ownership

The following ownership interests must be reported in this section.

1. DIRECT OWNERSHIP INTEREST

Examples of direct ownership are as follows:

• The provider is a skilled nursing facility that is wholly (100%) owned by Company A. As such, the provider would have to report Company A in this section.

• A hospice wants to enroll in Medicare. Company X owns 50% of the hospice. Company X would have to be reported in this section.

In the first example, Company A is considered a direct owner of the skilled nursing facility, in that it actually owns the assets of the business. Similarly, Company X is a direct owner of the hospice mentioned in the second example. It has 50% actual ownership of the hospice.

2. INDIRECT OWNERSHIP INTEREST

Many organizations that directly own a provider are themselves wholly or partly owned by other organizations (or even individuals). This is often the result of the use of holding companies and parent/subsidiary relationships. Such organizations and individuals are considered to be "indirect" owners of the provider. Using the first example in #1 above, if Company B owned 100% of Company A, Company B is considered to be an indirect owner of the provider. In other words, a direct owner has an actual ownership interest in the provider (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an organization that owns the provider.

Consider the following example of indirect ownership:

EXAMPLE 1: OWNERSHIP

LEVEL 3	Individual X	Individual Y
	5%	30%

LEVEL 2	Company C	Company B
	60%	40%
LEVEL 1	**Company A**	
	100%	

- Company A owns 100% of the Enrolling Provider
- Company B owns 40% of Company A
- Company C owns 60% of Company A
- Individual X owns 5% of Company C
- Individual Y owns 30% of Company B

In this example, Company A (Level 1) is the direct owner of the provider identified in section 2 of this application. Companies B and C, as well as Individuals X and Y, are indirect owners of the provider. To calculate ownership shares using the above-cited example, utilize the following steps:

LEVEL 1

The diagram above indicates that Company A owns 100% of the Enrolling Provider. Company A must be reported.

LEVEL 2

To calculate the percentage of ownership held by Company C of the Enrolling Provider, multiply:

- The percentage of ownership the LEVEL 1 owner has in the Enrolling Provider

MULTIPLIED BY

The percentage of ownership the LEVEL 2 owner has in that LEVEL 1 owner

• Company A, the LEVEL 1 (or direct) owner, owns 100% of the provider. The diagram also indicates that Company C, a LEVEL 2 owner, owns 60% of Company A. As such, multiply 100% (or 1.0) by 60% (.60). The result is .60. Therefore, Company C indirectly owns 60% of the provider, and must be reported.

• Repeat the same procedure for Company B, the other LEVEL 2 owner. Because Company B owns 40% of Company A, multiply this figure by 100% (again, the ownership stake Company A has in the Enrolling Provider). Company B thus owns 40% of the Enrolling Provider, and must be reported.

This process is continued until all LEVEL 2 owners have been accounted for.

LEVEL 3

To calculate the percentage of ownership that Individual X has in the Enrolling Provider, multiply:

• The percentage of ownership the LEVEL 2 owner has in the Enrolling Provider
MULTIPLIED BY
The percentage of ownership the LEVEL 3 owner has in that LEVEL 2 owner

• Company C owns 60% of the provider. According to the example above, Individual X (Level 3) owns 5% of Company C. Therefore, multiply 60% (.60) by 5% (.05), resulting in .03. This means that

Individual X owns 3% of the provider and does not need to be reported in this application.

• Repeat this process for Company B, which owns 40% of the provider. The diagram states that Individual Y (Level 3) owns 30% of Company B. We thus multiply 40% (.40) by 30% (.30). The result is .12, or 12%. Because Individual Y owns 12% of the provider, Individual Y must be reported in this application (in Section 6: Individuals).

This process is continued until all owners in LEVEL 3 have been accounted for. This process must be repeated for Levels 4 and beyond.

3. MORTGAGE OR SECURITY INTEREST

All entities with at least a 5% mortgage, deed of trust, or other security interest in the provider must be reported in this section. To calculate whether this interest meets the 5% threshold, use the following formula:

• Dollar amount of the mortgage, deed of trust, or other obligation secured by the provider or any of the property or assets of the provider
DIVIDED BY
Dollar amount of the total property and assets of the provider

Example: Two years ago, a provider obtained a $20 million loan from Entity X to add a third floor to its facility. Various assets of the provider secure the mortgage. The total value of the provider's property and assets is $100 million.

Using the formula described above, divide $20 million (the dollar amount of the secured mortgage)

by $100 million (the total property and assets of the Enrolling Provider). This results in .20, or 20%. Because Entity X's interest represents at least 5% of the total property and assets of the Enrolling Provider, Entity X must be reported in this section.

4. PARTNERSHIPS

All general partnership interests—regardless of the percentage—must be reported. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership.

For limited partnerships, all limited partners must be reported if their interest in the partnership is at least 10%. To illustrate, assume a provider is a limited partnership. The general partner has a 60% interest in the entity, while the 4 limited partners each own 10%. The general partnership must be reported in this application. Likewise, the 4 limited partners must be reported, as they each own at least 10% of the limited partnership.

5. ADDITIONAL INFORMATION ON OWNERSHIP

All entities that meet any the requirements above must be reported in this section, including, but not limited to:

• Entities with an investment interest in the provider (e.g., investment firms)

• Banks and financial institutions (e.g., mortgage interests)

• Holding companies

• Trusts and trustees

• Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe must be reported as an owner. The provider must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization, which attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an "authorized official" of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. See Section 15 for further information on "authorized officials."

• Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body should be reported in this section.

In addition to furnishing the information in this section, the provider must submit:

• An organizational diagram identifying all of the entities listed in this section and their relationships with the provider and with each other.

• If the provider is a skilled nursing facility, a diagram identifying the organizational structures of all of its owners, including owners that were not required to be listed in this section or in Section 6.

B. Managing Control

Any organization that exercises operational or managerial control over the provider, or conducts the day-to-day operations of the provider, is a managing organization and must be reported. The organization need not have an ownership interest in the provider in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the provider to furnish management services for the business.

C. Managing Control: Adverse Legal History
This section is to be completed with any adverse legal history information about any ownership organization, partnership and/or organization with managing control of the provider identified in Section 2.

□ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

□ CHECK ONE	□ CHANGE	□ ADD	□ DELETE

DATE (*mm/dd/yyyy*)			

A. Ownership/Managing Control Organization

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service		
"Doing Business As" Name (if applicable)		
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code +4
Tax Identification Number (required)		
Medicare Identification Number(s) (if issued)	NPI (if issued)	

2. TYPE OF ORGANIZATION

Check all that apply:

□ Corporation

□ Limited liability Company

□ Medical provider/supplier

□ Management services company

□ Medical staffing company

□ Holding company

□ Investment firm

□ Bank or other financial institution

□ Consulting firm

□ For-profit

□ Non-profit

□ Other *(please specify)*: _____

B. Ownership/Managing Control Information

Identify the type of ownership and/or managing control the organization identified in Section 5.A.1. has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

□ **5% or greater direct ownership interest**

Effective date of 5% or greater direct ownership interest (*mm/dd/yyyy*)

Exact percentage of direct ownership this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

□ Yes □ No

If this organization also provides contracted services to the provider, describe the types of services furnished (*e.g., managerial, billing, consultative, medical personnel staffing*).

□ **5% or greater indirect ownership interest**
Effective date of 5% or greater indirect ownership interest (*mm/dd/yyyy*)
Exact percentage of indirect ownership this organization has in the provider
Was this organization solely created to acquire/buy the provider and/or the provider's assets? □ Yes □ No
If this organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*
□ **5% or greater mortgage interest**
Effective date of 5% or greater mortgage interest (*mm/dd/yyyy*)
Exact percentage of mortgage interest this organization has in the provider
Was this mortgage solely created to acquire/buy the provider and/or the provider's assets? □ Yes □ No
□ **5% or greater security interest**
Effective date of 5% or greater security interest (*mm/dd/yyyy*)

Exact percentage of security interest this organization has in the provider

Was this security solely created to acquire/buy the provider and/or the provider's assets?

□ Yes □ No

□ **General Partnership interest**

Effective Date of the general partnership interest (*mm/dd/yyyy*)

Exact percentage of general partnership interest this organization has in the provider

Was this general partnership solely created to acquire/buy the provider and/or the provider's assets?

□ Yes □ No

If this general partnership also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

□ **Limited Partnership interest**

Effective Date of the limited partnership interest (*mm/dd/yyyy*)

Exact percentage of limited partnership interest this organization has in the provider

Was this limited partnership solely created to acquire/buy the provider and/or the provider's assets?

□ Yes □ No

If this limited partnership also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

□ Operational/Managerial Control

Effective Date of the operational/managerial control (*mm/dd/yyyy*)

Exact percentage of operational/managerial control this organization has in the provider

If this operational/managerial organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

□ Other ownership or control/interest (please specify): _____

Effective Date of other ownership or control/interest (*mm/dd/yyyy*)

Exact percentage of ownership or control/interest this organization has in the provider

Was this organization solely created to acquire/buy the provider and/or the provider's assets?

□ Yes □ No

If this organization also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing).*

C. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

□ Change □ Effective Date: _____

1. Has this organization in Section 5A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against it?

□ YES—Continue Below

□ NO—Skip to Section D

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

This section is to be completed with information about any individual who has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in Section 2 of this application. If there is more than one individual, copy and complete this section for each. Note that the provider must have at least one managing employee.

Only individuals should be reported in this section. Organizations should be reported in Section 5.

If adding, deleting, or changing information on an existing owner, partner, or managing individual, check the appropriate box, indicate the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement.

A. Ownership and Control

The following ownership control interests, as they are described in the instructions to Section 5, must be reported in this section:

- 5% or greater direct ownership interest
- 5% or greater indirect ownership interest
- 5% or greater mortgage or security interest
- All general partnership interests, regardless of the percentage. This includes: (1) all interests in a nonlimited partnership, and (2) all general partnership interests in a limited partnership.
- Limited partnership interests if the individual's interest in the partnership is at least 10%.

• Officers and Directors, if the entity is organized as a corporation.

For more information on these interests, please see Section 5. Note that the diagrams referred to in Section 5(A)(5) of the instructions must include all individuals with any of the ownership interests described above.

All managing employees of the provider must be reported in this section. The term "managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the provider, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the provider.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the provider is only required to report its managing employees in Section 6. Owners, partners, officers and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

B. Adverse Legal History

This section is to be completed with any adverse legal history information about any individual owner, partner and/or individual with managing control of the provider identified in Section 2.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

A. Identifying Information

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Medicare Identification Number *(if issued*		NPI *(if issued)*	
Social Security Number *(Required)*	Date of Birth mm/dd/yyyy)	Place of Birth (State)	Country of Birth

Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

□ 5% or greater direct ownership interest

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*
Exact percentage of direct ownership this individual has in the provider
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ 5% or greater indirect ownership interest
Effective Date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*
Exact percentage of indirect ownership this individual has in the provider
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ 5% or greater mortgage interest
Effective Date of 5% or greater mortgage interest (mm/dd/yyyy)
Exact percentage of mortgage interest this individual has in the provider
If this individual also provides contracted services to the provider, describe the types of services

furnished (e.g., managerial, billing, consultative, medical personnel staffing, etc.).
□ 5% or greater security interest
Effective Date of 5% or greater greater security interest *(mm/dd/yyyy)*
Exact percentage of security interest this individual has in the provider
If this individual also provides contracted services to the provider, describe the types of services furnished (e.g., managerial, billing, consultative, medical personnel staffing, etc.).
□ General Partnership interest
Effective Date of the general partnership interest *(mm/dd/yyyy)*
Exact percentage of general partnership interest this individual has in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ Limited Partnership interest

Effective Date of limited partnership interest *(mm/dd/yyyy)*
Exact percentage of limited partnership interest this individual has in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **Officer**
Effective Date of office *(mm/dd/yyyy)*
Exact percentage of control as an Officer this individual has in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **Director**
Effective Date as Director *(mm/dd/yyyy)*

Exact percentage of control as a Director this individual has in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **W-2 Managing Employee**
Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*
Exact percentage of management control this individual has in the provider
If applicable, furnish this manager's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **Contracted Managing Employee**
Effective Date of contract for managing employee *(mm/dd/yyyy)*

Exact percentage of this contracted managing employee's control in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished (*e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **Operational/Managerial Control**
Effective Date of the operational/managerial control *(mm/dd/yyyy)*
Exact percentage of operational/managerial control this individual has in the provider
If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*
If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*
□ **Other ownership or control/interest (please specify):** _____
Effective Date of other ownership or control/interest *(mm/dd/yyyy)*

Exact percentage of ownership or control/interest this individual has in the provider

If applicable, furnish this individual's title within the provider organization *(e.g., CEO, Board member, etc.)*

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above.

If you are changing information, check "change" box, furnish the effective date, and complete the appropriate fields in this section.

□ Change □ Effective Date:_____

1. Has the individual in Section 6A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against him/her?

□ YES—Continue Below □ NO—Skip to Section 7

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 7: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicare fee-for-service contractor.

For more information on chain organizations, see 42 C.F.R. 421.404.

Check here □ if this section does not apply and skip to Section 8.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy*)			

A. Type of Action this Provider is Reporting

CHECK ONE:	EFFECTIVE DATE	SECTIONS TO COMPLETE
□ Provider in chain is enrolling in Medicare for the first time *(Initial Enrollment or Change of Ownership).*		Complete all of Section 7.
□ Provider is no longer associated with the chain		Complete Section 7 identifying the former chain home office.
□ Provider has changed from one chain to another.		Complete Section 7 in full to identify the new chain home office.
□ The name of provider's chain home office is changing *(all other information remains the same).*		Complete Section 7C.

B. Chain Home Office Administrator Information

First Name of Home Office	Middle Initial	Last Name	Jr., Sr., etc.

Administrator or CEO			

Title of Home Office Administrator	Social Security Number	Date of Birth (*mm/dd/yyyy)*

C. Chain Home Office Information

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 *(Street Name and Number)*

Home Office Business Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code +4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date *(mm/dd)*
4. Home Office Fee-For-Service Contractor	Home Office Chain Number

D. Type of Business Structure of the Chain Home Office

Check One:

Voluntary:

□ Non-Profit – Religious Organization

□ Non-Profit – Other *(Specify)*: _____

Proprietary:

□ Individual

□ Corporation

□ Partnership

□ Other *(Specify)*: _____

Government:

□ Federal

□ State

□ City

□ County

□ City-County

□ Hospital District

□ Other *(Specify)*: _____

E. Provider's Affiliation to the Chain Home Office

Check one:

□ Joint Venture/Partnership

□ Operated/Related

□ Managed/Related

□ Wholly Owned

□ Leased

□ Other *(Specify)*: _____

SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

□ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE *(mm/dd/yyyy)*			

Legal Business/Individual Name as Reported to the Social Security Administration or Internal Revenue Service

If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*		
Billing Agency Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code +4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *if applicable)*

SECTION 9: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 10: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 11: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 12: SPECIAL REQUIREMENTS FOR HOME HEALTH AGENCIES (HHAS)

INSTRUCTIONS

All HHAs and HHA sub-units enrolling in the Medicare program must complete this section. HHAs and HHA sub-units initially enrolling in Medicare, Medicaid, or both programs on or after January 1, 1998 are required to provide documentation supporting that they have sufficient

initial reserve operating funds (capitalization) to operate for the first three months in the Medicare and/or Medicaid program(s). The capitalization requirement applies to all HHAs and HHA sub-units enrolling in the Medicare program, including HHAs or HHA sub-units currently participating in the Medicare program that, as a result of a change of ownership, will be issued a new provider number. The capitalization requirement does not apply to a branch of an HHA. Regulations found at 42 C.F.R. 489.28 require that the fee-for-service contractor determine the required amount of reserve operating funds needed for the enrolling HHA or HHA sub-unit by comparing the enrolling HHA or HHA sub-unit to at least three other new HHAs that it serves which are comparable to the enrolling HHA or HHA sub-unit. Factors to be considered are geographic location, number of visits, type of HHA or HHA sub-unit and business structure of the HHA or HHA sub-unit. The fee-for-service contractor then verifies that the enrolling HHA or HHA sub-unit has the required funds. To assist the fee-for-service contractor in determining the amount of funds necessary, the enrolling HHA or HHA sub-unit should complete this section.

Check here □ if this section does not apply and skip to Section 13.

A. Type of Home Health Agency

1. CHECK ONE:

□ Non-Profit Agency

□ Proprietary Agency

2. PROJECTED NUMBER OF VISITS BY THIS HOME HEALTH AGENCY

How many visits does this HHA project it will make in the first:

three months of operation? _____

twelve months of operation? _____

3. FINANCIAL DOCUMENTATION

A) In order to expedite the enrollment process, the HHA may attach a copy of its most current savings, checking, or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:

1) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

2) Certification from the HHA attesting that at least 50% of the reserve operating funds are nonborrowed funds.

B) Will the HHA be submitting the above documentation with this application? □ YES □ NO

NOTE: The fee-for-service contractor may require a subsequent attestation that the funds are still available. If the fee-for-service contractor determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

4. ADDITIONAL INFORMATION

Provide any additional documentation necessary to assist the fee-for-service contractor or State agency in properly comparing this HHA with other comparable HHAs. Use this space to explain or justify any unique financial situations of this HHA that may be helpful in determining the HHA's compliance with the capitalization requirements.

B. Nursing Registries

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE *(mm/dd/yyyy)*			

Does this HHA contract with a nursing registry whereby the latter furnishes personnel to perform HHA services on behalf of the provider?

□ YES—Furnish the information below

□ NO—Skip to Section 13

Legal Business/Individual Name as Reported to the Internal Revenue Service

Tax Identification Number *(required)*

"Doing Business As" Name *(if applicable)*
Billing Street Address Line 1 *(Street Name and Number)*
Billing Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code +4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

□ Contact an Authorized Official listed in Section 15

□ Contact a Delegated Official listed in Section 16

First Name	Middle Initial	Last Name	Jr., Sr., etc.
Telephone Number		Fax Number *(if applicable)*	
Address Line 1 (Street Name and Number)			
Address Line 2 (Suite, Room, etc.)			
City/Town	State	ZIP Code +4	

E-mail Address

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a

Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or

   b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representtations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual

shall be fined or imprisoned for any term of years or for life, or both.

7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the provider's enrollment record. A delegated official must be an individual with an "ownership or control interest in" (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the provider.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status. Even when delegated officials are reported in this

application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

> **NOTE:** Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855A, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the

information contained in this form, after the provider is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.516(e).

The provider can have as many authorized officials as it wants. If the provider has more than two authorized officials, it should copy and complete this section as needed.

Each authorized and delegated official must have and disclose his/her social security number.

A. Additional Requirements for Medicare Enrollment

These are additional requirements that the provider must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the provider is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the time frames established in 42 C.F.R. § 424.516(e). I understand that any change in the business structure of this provider may require the submission of a new application.

2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.

4. Neither this provider, nor any physician owner or investor or any other owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is

otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.

5. I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.

6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS), a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of

this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number		Title/Position	
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Date Signed *(mm/dd/yyyy)*	

C. 2ND Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree

to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g. Jr., Sr.)*
Telephone Number		Title/Position	
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Date Signed *(mm/dd/yyyy)*	

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL(S) (Optional)

• You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the provider's status in the Medicare program.

• The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.

• Delegated officials being deleted do not have to sign or date this application.

• Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.

• The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.

• If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy)*			
Delegated Official First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Date Signed *(mm/dd/yyyy)*	
□ Check here if Delgated Official is a W-2 Employee		Telephone Number	
Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Dated Signed *(mm/dd/yyyy)*	

B. 2ND Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	□ CHANGE	□ ADD	□ DELETE
DATE (*mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*
Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Date Signed *(mm/dd/yyyy)*	
□ Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*		Date Signed *(mm/dd/yyyy)*	

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, or are reactivating or revalidating your enrollment, you must provide all applicable documents. For changes, only submit documents that are applicable to that change. The enrolling provider may submit a notarized copy of a Certificate of Good Standing from the provider's State licensing/certification board or other medical associations in lieu of copies

of the above-requested documents. This certification cannot be more than 30 days old.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information that you have reported in this application. The Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

Required documents that can only be obtained after a State survey are not required as part of the application submission but must be furnished within 30 days of the provider receiving them. The Medicare fee-for–service contractor will furnish specific licensing requirements for your provider type upon request.

□ Licenses, certifications and registrations required by Medicare or State law.

□ Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.

□ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.

□ Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer.

NOTE: If a provider already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.

MANDATORY FOR SELECTED PROVIDER/ SUPPLIER TYPES

□ Copy(s) of all bills of sale or sales agreement (CHOWS, Acquisition/Mergers, and Consolidations only).

□ Copy(s) of all documents that demonstrate meeting capitalization requirements (HHAs only).

MANDATORY, IF APPLICABLE

□ Statement in writing from the bank. If Medicare payment due a provider of services is being sent to a bank (or similar financial institution) with whom the provider has a lending relationship (that is, any type of loan), then the provider must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

□ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).

□ Copy of an attestation for government entities and tribal organizations

□ Copy of HRSA Notice of Grant Award if that is a qualifying document for FQHC status

□ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit

□ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is

automatically classified as a Disregarded Entity. (e.g., Form 8832).

NOTE: A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;

2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;

3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;

4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;

5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;

6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;

7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the National Plan and Provider System is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;

8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;

9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;

10. State Licensing Boards for review of unethical practices or non-professional conduct;

11. States for the purpose of administration of health care programs; and/or

12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier's health care claims.

The supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

Newman Declaration: Exhibit B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act, _____ D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human

Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:	
NAME (*signature*)	
TITLE	DATE
ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:	
NAME (*signature*)	

TITLE	DATE
ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:	
NAME (*signature*)	
TITLE	DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid OMB control number for this information collection is 0938-0832. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Newman Declaration: Exhibit C

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

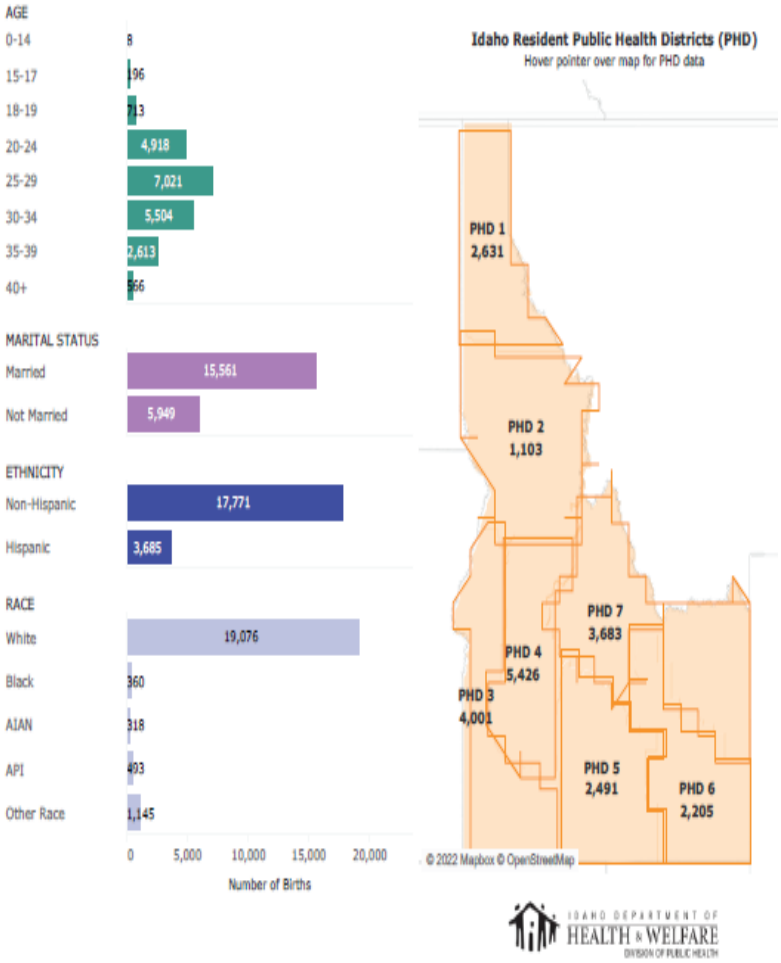
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2020	Use this filter to select Idaho (All) or PHD All

2020 All Idaho Resident Births: 21,540
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
572 2.7%	9,086 42.8%	5,662 26.7%	5,922 27.9%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
15-17
18-19
20-24
4,918
25-29
7,021
30-34
5,504
35-39
40+
MARITAL STATUS
Married
15,561
Not Married
5,949
ETHNICITY
Non-Hispanic
17,771
Hispanic
3,685
RACE
White
19,076
Black
AIAN
API
Other Race
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,631
PHD 2
1,103
PHD 3
4,001
PHD 4
5,426
PHD 5
2,491
PHD 6
2,205
PHD 7
3,683
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DIVISION OF PUBLIC HEALTH

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

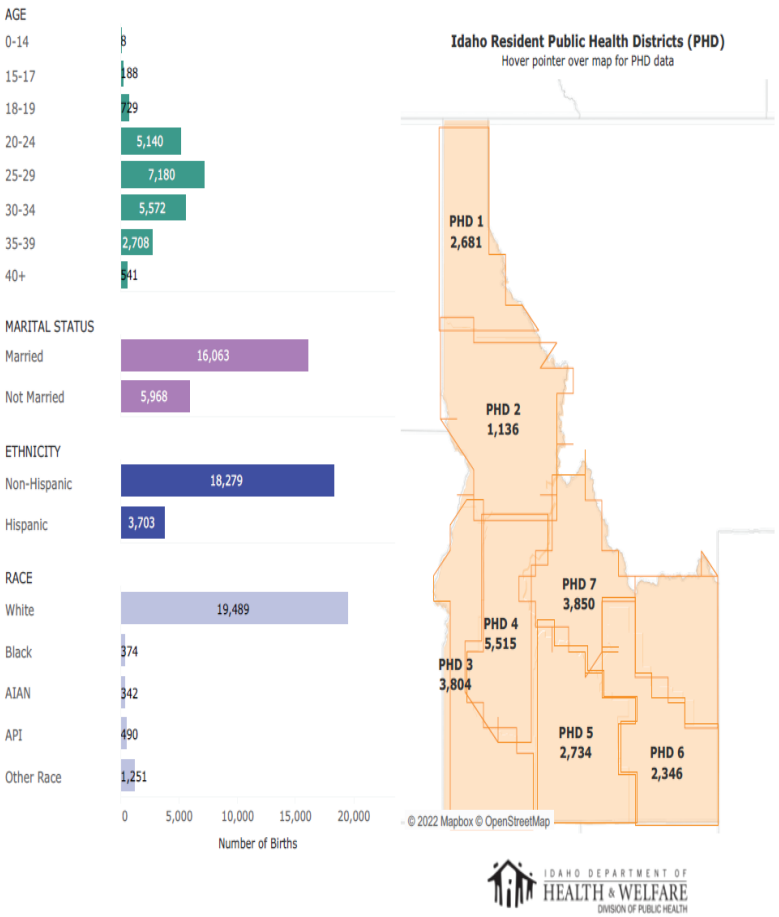
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2019	Use this filter to select Idaho (All) or PHD All

2019 All Idaho Resident Births: 22,066
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
595 2.7%	9,354 43.0%	5,849 26.9%	5,971 27.4%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
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15-17
188
18-19
729
20-24
5,140
25-29
7,180
30-34
5,572
35-39
2,708
40+
541
MARITAL STATUS
Married
16,063
Not Married
5,968
ETHNICITY
Non-Hispanic
18,279
Hispanic
3,703
RACE
White
19,489
Black
374
AIAN
342
API
490
Other Race
1,251
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,681
PHD 2
1,136
PHD 3
3,804
PHD 4
5,515
PHD 5
2,734
PHD 6
2,346
PHD 7
3,850
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Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

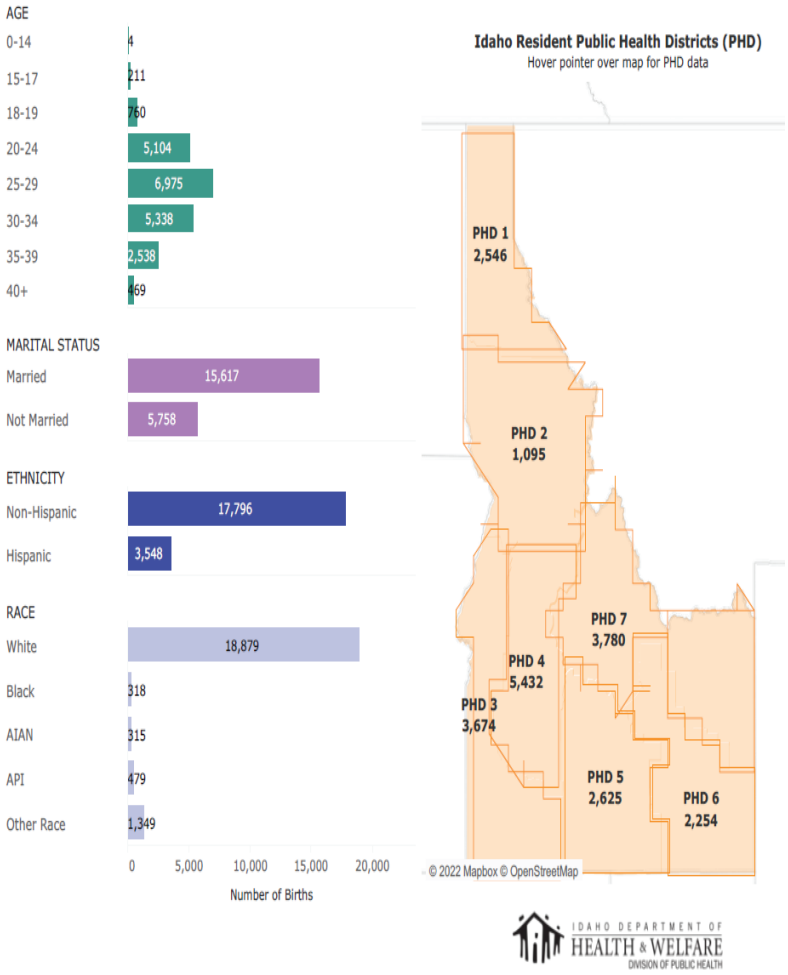
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2018	Use this filter to select Idaho (All) or PHD All

2018 All Idaho Resident Births: 21,406
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
617 2.9%	9,366 44.4%	5,542 26.2%	5,589 26.5%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.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0-14
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18-19
20-24
25-29
30-34
35-39
40+
4
211
760
5,104
6,975
5,338
2,538
469
MARITAL STATUS
Married
Not Married
15,617
5,758
ETHNICITY
Non-Hispanic
Hispanic
17,796
3,548
RACE
White
Black
AIAN
API
Other Race
18,879
318
315
479
1,349
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,546
PHD 2
1,095
PHD 3
3,674
PHD 4
5,432
PHD 5
2,625
PHD 6
2,254
PHD 7
3,780
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Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

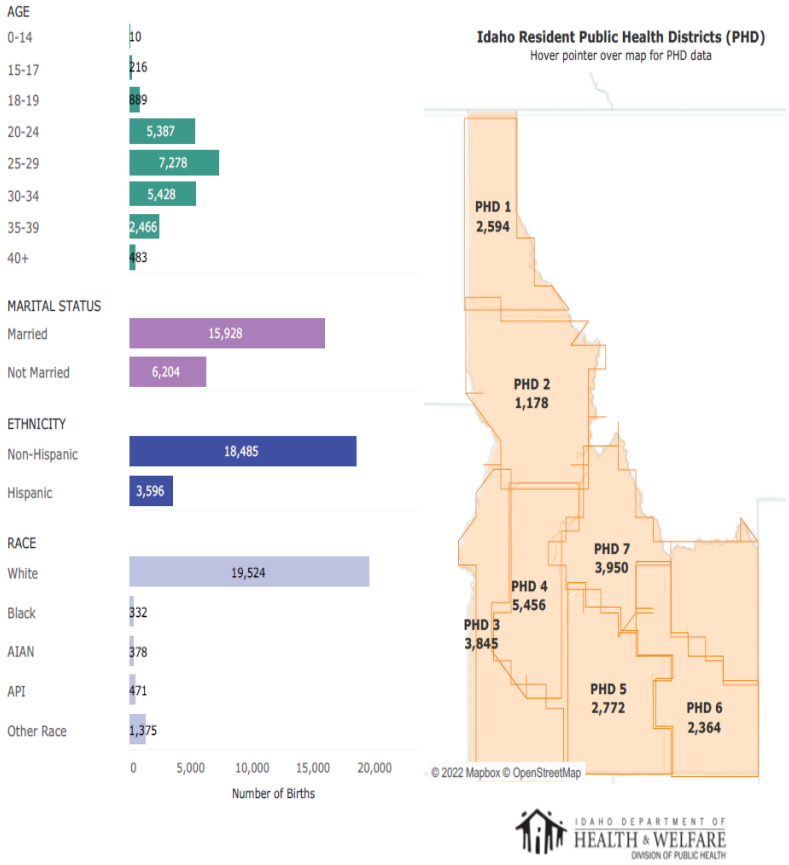
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2017	Use this filter to select Idaho (All) or PHD All

2017 All Idaho Resident Births: 22,159
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
682 3.1%	9,885 45.0%	5,674 25.9%	5,704 26.0%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.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15-17
216
18-19
389
20-24
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25-29
7,278
30-34
5,428
35-39
2,466
40+
483
MARITAL STATUS
Married
15,928
Not Married
6,204
ETHNICITY
Non-Hispanic
18,485
Hispanic
3,596
RACE
White
19,524
Black
332
AIAN
378
API
471
Other Race
1,375
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,594
PHD 2
1,178
PHD 3
3,845
PHD 4
5,456
PHD 5
2,772
PHD 6
2,364
PHD 7
3,950
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Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

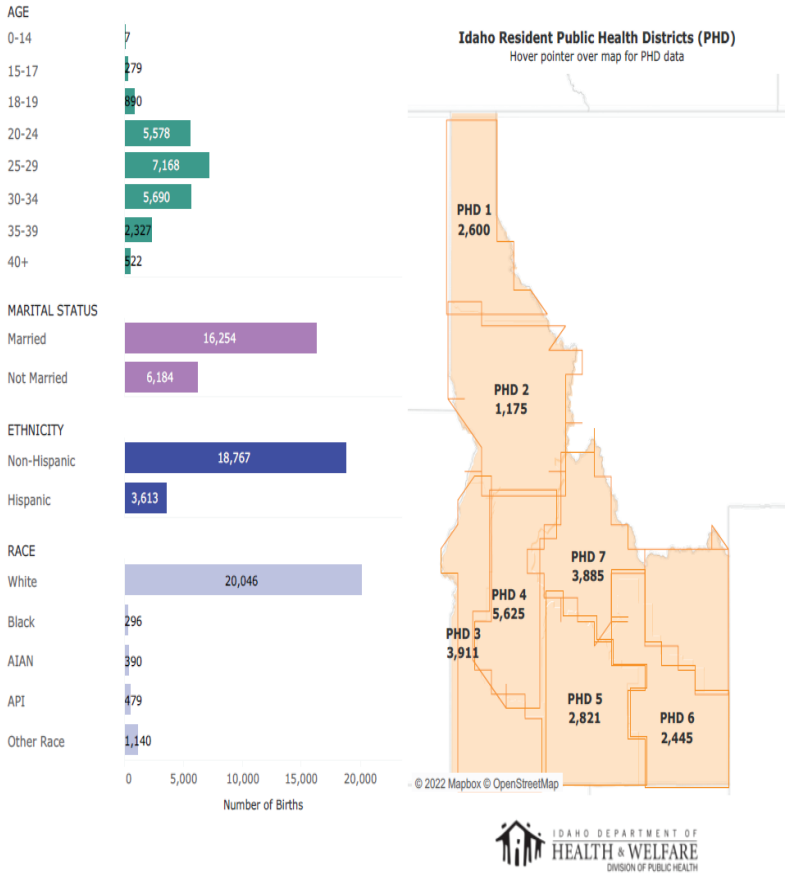
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2016	Use this filter to select Idaho (All) or PHD All

2016 All Idaho Resident Births: 22,462
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
707 3.2%	10,525 47.3%	5,536 24.9%	5,492 24.7%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
15-17
18-19
20-24
25-29
30-34
35-39
40+
7
279
890
5,578
7,168
5,690
2,327
522
MARITAL STATUS
Married
Not Married
16,254
6,184
ETHNICITY
Non-Hispanic
Hispanic
18,767
3,613
RACE
White
Black
AIAN
API
Other Race
20,046
296
390
479
1,140
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,600
PHD 2
1,175
PHD 3
3,911
PHD 4
5,625
PHD 5
2,821
PHD 6
2,445
PHD 7
3,885
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Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

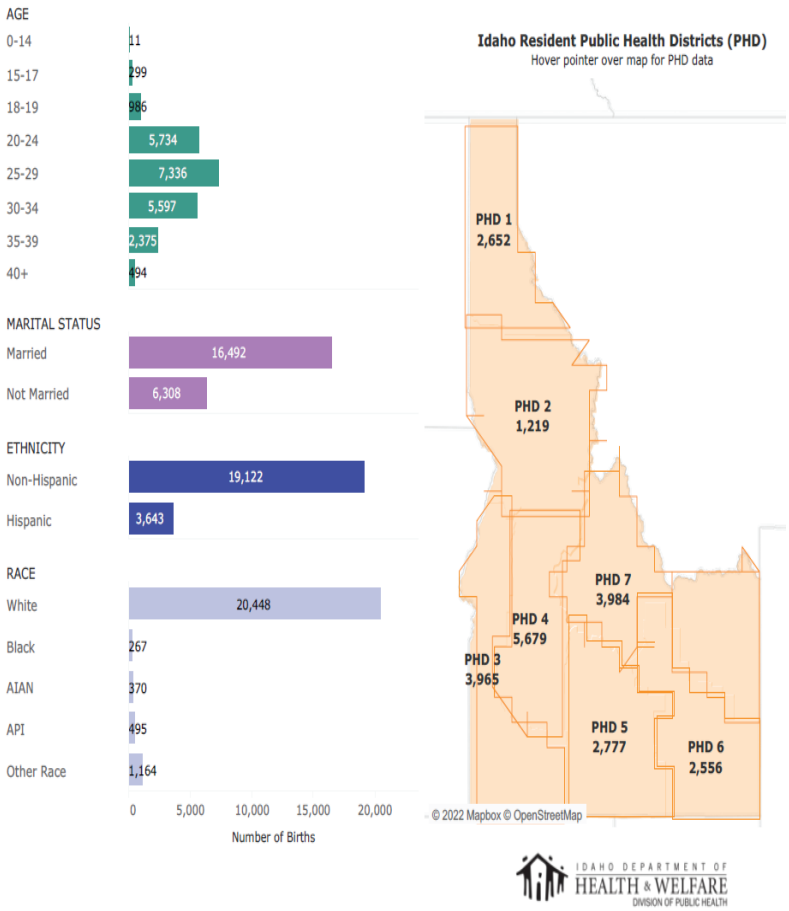
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2015	Use this filter to select Idaho (All) or PHD All

2015 All Idaho Resident Births: 22,832
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
733 3.2%	10,755 47.4%	5,734 25.2%	5,489 24.2%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
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15-17
299
18-19
986
20-24
5,734
25-29
7,336
30-34
5,597
35-39
2,375
40+
494
MARITAL STATUS
Married
16,492
Not Married
6,308
ETHNICITY
Non-Hispanic
19,122
Hispanic
3,643
RACE
White
20,448
Black
267
AIAN
370
API
495
Other Race
1,164
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,652
PHD 2
1,219
PHD 3
3,965
PHD 4
5,679
PHD 5
2,777
PHD 6
2,556
PHD 7
3,984
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DIVISION OF PUBLIC HEALTH

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

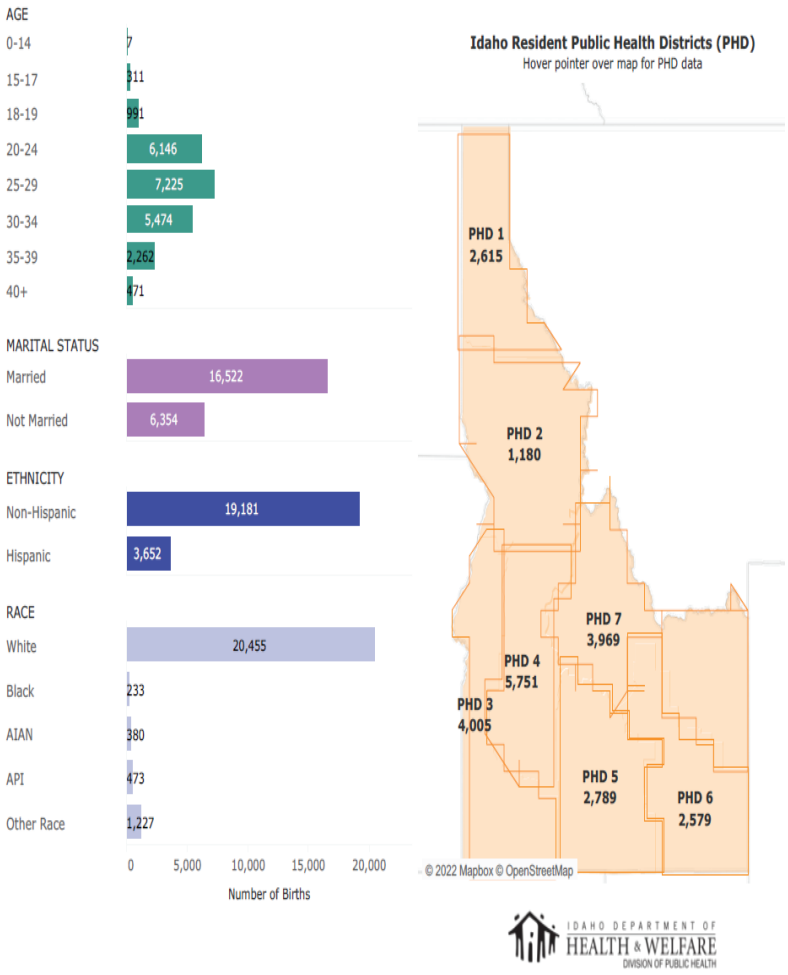
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2014	Use this filter to select Idaho (All) or PHD All

2014 All Idaho Resident Births: 22,888
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
817 3.6%	11,055 48.4%	5,643 24.7%	5,317 23.3%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.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0-14
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15-17
311
18-19
981
20-24
6,146
25-29
7,225
30-34
5,474
35-39
2,262
40+
471
MARITAL STATUS
Married
16,522
Not Married
6,354
ETHNICITY
Non-Hispanic
19,181
Hispanic
3,652
RACE
White
20,455
Black
233
AIAN
380
API
473
Other Race
1,227
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,615
PHD 2
1,180
PHD 3
4,005
PHD 4
5,751
PHD 5
2,789
PHD 6
2,579
PHD 7
3,969
© 2022 Mapbox © OpenStreetMap
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HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

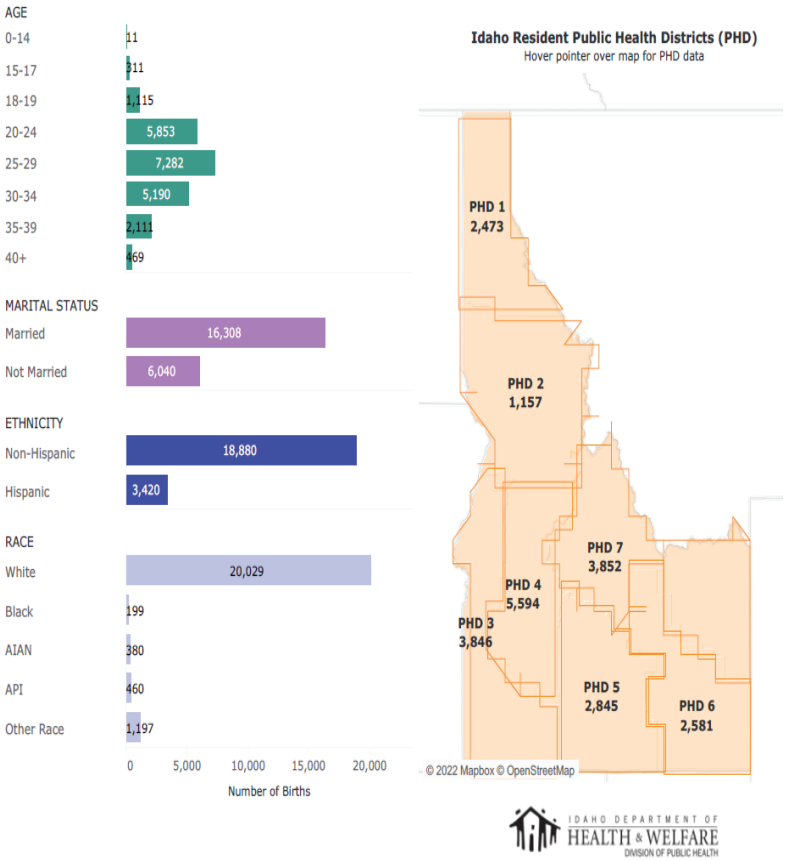
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2013	Use this filter to select Idaho (All) or PHD All

2013 All Idaho Resident Births: 22,348
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
764 3.4%	10,874 48.8%	5,585 25.1%	5,047 22.7%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
11
15-17
311
18-19
1,115
20-24
5,853
25-29
7,282
30-34
5,190
35-39
2,111
40+
469
MARITAL STATUS
Married
16,308
Not Married
6,040
ETHNICITY
Non-Hispanic
18,880
Hispanic
3,420
RACE
White
20,029
Black
199
AIAN
380
API
460
Other Race
1,197
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,473
PHD 2
1,157
PHD 3
3,846
PHD 4
5,594
PHD 5
2,845
PHD 6
2,581
PHD 7
3,852
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DIVISION OF PUBLIC HEALTH

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

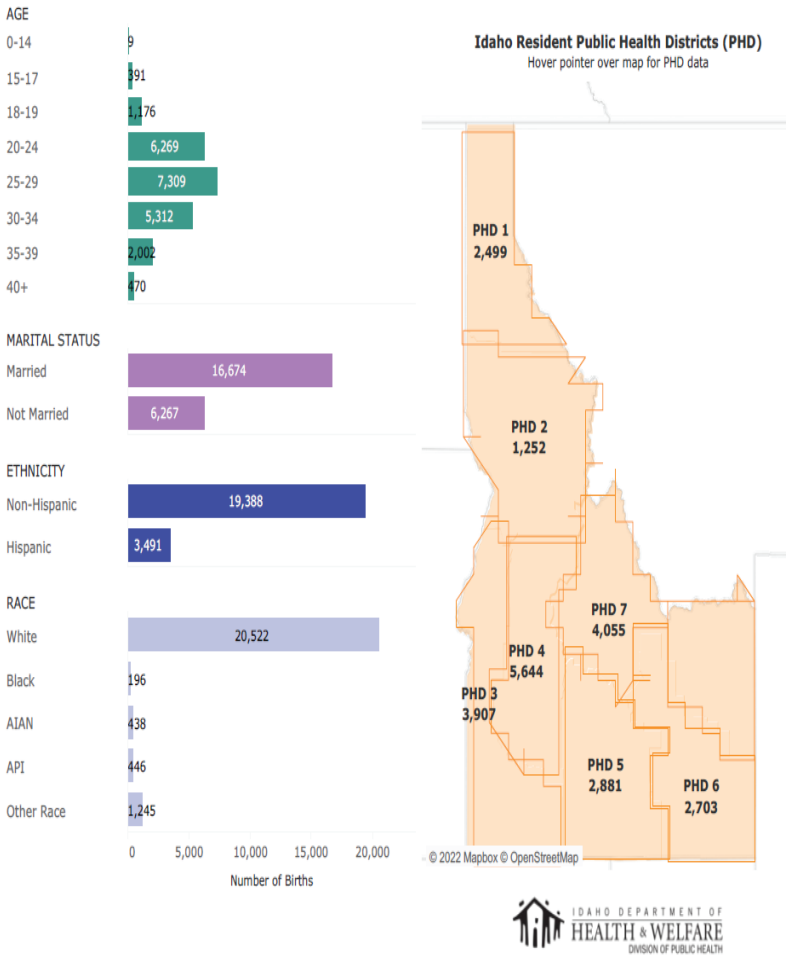
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2012	Use this filter to select Idaho (All) or PHD All

2012 All Idaho Resident Births: 22,941
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
770 3.4%	11,263 49.3%	5,663 24.8%	5,172 22.6%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.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0-14
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15-17
391
18-19
1,176
20-24
6,269
25-29
7,309
30-34
5,312
35-39
2,002
40+
470
MARITAL STATUS
Married
16,674
Not Married
6,267
ETHNICITY
Non-Hispanic
19,388
Hispanic
3,491
RACE
White
20,522
Black
196
AIAN
438
API
446
Other Race
1,245
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,499
PHD 2
1,252
PHD 3
3,907
PHD 4
5,644
PHD 5
2,881
PHD 6
2,703
PHD 7
4,055
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DIVISION OF PUBLIC HEALTH

Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

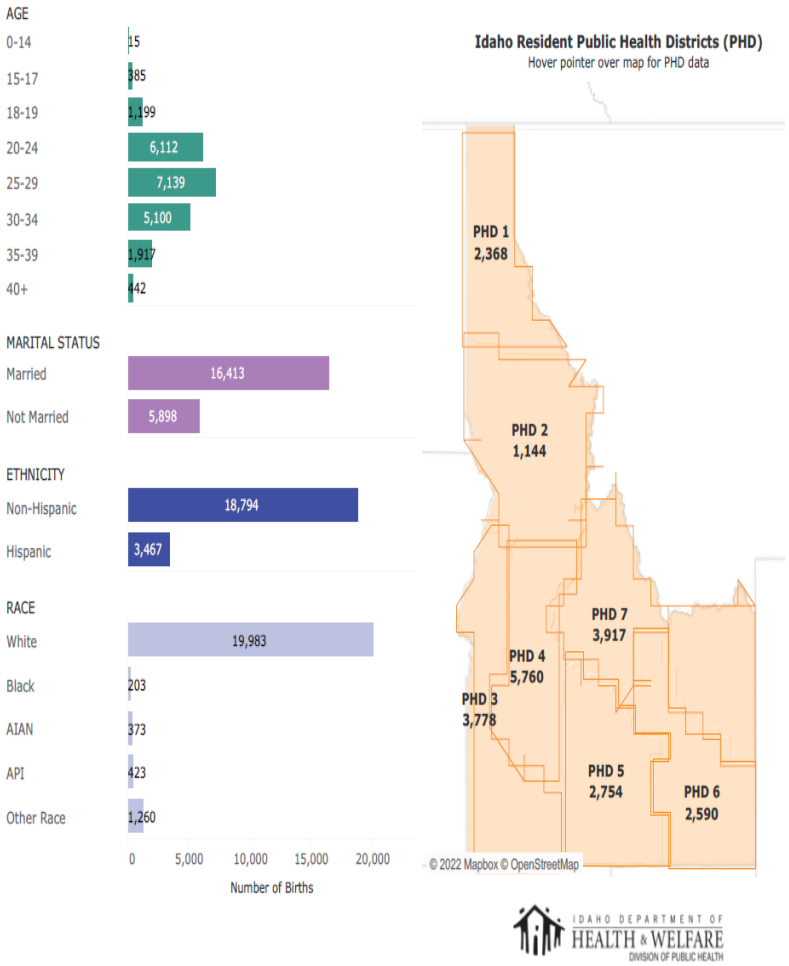
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2011	Use this filter to select Idaho (All) or PHD All

2011 All Idaho Resident Births: 22,311
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
745 3.3%	11,137 50.1%	5,522 24.8%	4,837 21.7%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.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0-14
15
15-17
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18-19
1,199
20-24
6,112
25-29
7,139
30-34
5,100
35-39
1,917
40+
442
MARITAL STATUS
Married
16,413
Not Married
5,898
ETHNICITY
Non-Hispanic
18,794
Hispanic
3,467
RACE
White
19,983
Black
203
AIAN
373
API
423
Other Race
1,260
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,368
PHD 2
1,144
PHD 3
3,778
PHD 4
5,760
PHD 5
2,754
PHD 6
2,590
PHD 7
3,917
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Idaho Vital Statistics Natality Dashboard

VS Natality– Introduction	VS Natality – Data Results, 2010-2020	VS Natality – Rate Trends, 2010-2020	VS Natality – Age Rate Trends, 2010-2020	VS Natality – Technical Notes

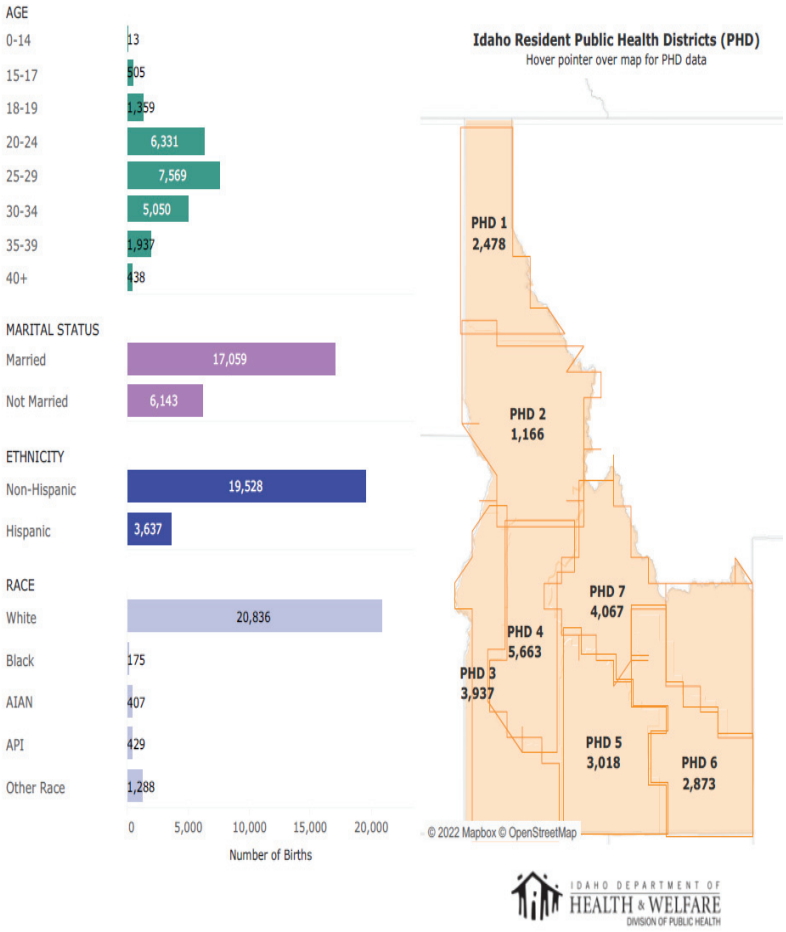
Birth, Infant and Demographic Data

Category	**Year**	**Location**
Use this filter to select category Maternal Pre-Pregnancy BMI	Use this filter to select year 2010	Use this filter to select Idaho (All) or PHD All

2010 All Idaho Resident Births: 23,202
Maternal Pre-Pregnancy BMI

Underweight	Normal Weight	Overweight	Obese
826 3.6%	11,256 48.7%	5,852 25.3%	5,167 22.4%

Directions for using table filter: click on category value in table above to filter value into bar graph and Idaho PHD map data below; click on category value in table a second time to de-activate filter.


AGE
0-14
13
15-17
505
18-19
1,359
20-24
6,331
25-29
7,569
30-34
5,050
35-39
1,937
40+
438
MARITAL STATUS
Married
17,059
Not Married
6,143
ETHNICITY
Non-Hispanic
19,528
Hispanic
3,637
RACE
White
20,836
Black
175
AIAN
407
API
429
Other Race
1,288
0
5,000
10,000
15,000
20,000
Number of Births
Idaho Resident Public Health Districts (PHD)
Hover pointer over map for PHD data
PHD 1
2,478
PHD 2
1,166
PHD 3
3,937
PHD 4
5,663
PHD 5
3,018
PHD 6
2,873
PHD 7
4,067
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DIVISION OF PUBLIC HEALTH

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Facsimile No. (208) 383-9516
joan@naylorhales.com

Attorneys for Defendant State of Idaho

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329-BLW **DECLARATION OF KRAIG WHITE, M.D.**

I, Kraig White, M.D., declare as follows:

1. I, Kraig White, M.D. am a board-certified family physician at Gritman Medical Center in Moscow, Idaho. For the last 6 years I have worked at this critical care access hospital as an emergency room physician where I have provided care in multiple life-threatening situations that have included obstetrical emergencies. The 11 years prior to working as an emergency room physician, I practiced broad spectrum family medicine that included operative obstetrics. I spent my first 4 years out of residency working with the most underserved through the National Health Service Corps. I completed my family medicine residency training in 2007 at McKay Dee Hospital with the University of Utah. I completed medical school training at the University of Washington in Seattle, WA. I have served on various hospital committees that have included Quality and Safety, Risk Management, Emergency Medicine, Obstetrics, and most recently I finished 9 years of serving on our hospital's board of

trustees where I ended by serving as the chairperson. I also have also enjoyed a lengthy history of serving as a clinical preceptor with the University of Washington School of Medicine.

2. I have reviewed the declaration submitted by Dr. Lee A. Fleisher, and the examples he sets forth in his declaration of situations where the conditions presented are of sufficient severity that in the absence of immediate medical attention would reasonably be expected to result in a) 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, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part. Dr. Fleisher concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

3. Specifically, Dr. Fleisher refers to a (hypothetical) patient with an ectopic pregnancy and who presents to an emergency department with bleeding, pelvic pain or severe abdominal pain. An ectopic pregnancy, if left untreated, will without exception, place the life of the pregnant woman in extreme jeopardy. Dr. Fleisher states as much: "An ectopic pregnancy in a fallopian tube is an emergency medical condition that places the patient's life in jeopardy because it will cause the fallopian tube to rupture and in the vast majority of cases cause significant and potentially fatal internal bleeding." (Fleisher Declaration at 6.) I agree with Dr. Fleisher that a patient who presents with significant internal bleeding resulting from a ruptured fallopian tube and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

4. The next example provided by Dr. Fleisher is of a (hypothetical) pregnant woman who presents to the emergency room with chest pain and severe shortness of breath as a result of severe heart failure related to long-standing pulmonary hypertension. I concur with Dr. Fleisher's observation that "[i]n some

circumstances, the appropriate stabilizing treatment for a patient suffering from severe heart failure is treatment of the heart and blood vessels through medications." (Fleisher Dec. at 8.) Dr. Fleisher then posits that "[i]n severe cases, the physician may determine that, despite other medical treatment, the patient continues to have worsening deterioration of blood oxygenation and maintenance of blood pressure." In my opinion, a pregnant patient who presents with continuing deterioration of blood oxygenation in spite of previous, unsuccessful, attempts to manage the condition, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

5. The third example given by Dr. Fleisher is a (hypothetical) patient who presents with nausea and shortness of breath resulting from high blood pressure—symptoms of pre-eclampsia, which in most cases will respond reasonably promptly to medications to control blood pressure. In this example, Dr. Fleisher states, accurately I believe, that "in some cases in which high blood pressure and/or the seizures of severe pre-eclampsia/eclampsia

cannot be controlled, termination of the pregnancy is medically necessary. In such cases, absent termination of the pregnancy, death or severe bodily dysfunction of the pregnant patient is the reasonably probable outcome." In my opinion, a pregnant patient who presents with high blood pressure and seizures attending either pre-eclampsia or eclampsia, where the high blood pressure and/or seizures have not responded to medication, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

6. Dr. Fleisher's fourth example is of a (hypothetical) patient who presents with a "life-threatening infection of the uterine contents." Here, the conditions set forth in the example are defined as "life-threatening." I agree with Dr. Fleisher's statement that "[t]he infection can progress to sepsis wherein multiple body organs and functions can start failing including the heart, lungs and blood pressure, which could lead to death." In my opinion, a pregnant patient who presents in a state of sepsis and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be

in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

7. Dr. Fleisher's fifth example is of a (hypothetical) patient who presents with vaginal bleeding as a result of placental abruption—where the placenta partially or completely separates from the inner wall of the uterus. I agree with Dr. Fleisher's statement that "[p]lacental abruption with uncontrolled and catastrophic bleeding is an emergency medical condition that places the patient's life in jeopardy or can cause serious impairment to bodily functions." Dr. Fleisher concludes that "[i]f bleeding will not stop, then a physician could conclude that the necessary stabilizing treatment for the uncontrolled and catastrophic bleeding includes removal of the fetus or the entire uterus . . . ." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Recognizing that this example is limited to situations where there is uncontrolled and catastrophic bleeding, if the conditions in this example have reached the point that it is not safe to

transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Fleisher, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

8. I have reviewed the declaration submitted by Dr. Emily Corrigan, and the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Corrigan present a life-threatening situation. Dr. Corrigan concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the examples provided by Dr. Corrigan present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

9. Dr. Corrigan's first example, Jane Doe 1, was diagnosed with preterm premature rupture of membranes ("PPROM"), or premature breaking open of the amniotic sac. I agree with Dr. Corrigan that PPROM "increases the risk of life-threatening intra-amniotic infection (chorioamnionitis) and also increases the risk that the fetus will not develop normally due to decrease in the amount of amniotic fluid." (Corrigan Declaration at 3.) I also agree with Dr. Corrigan that "[a]dministration of oral antibiotics and discharge home is not the medically accepted standard of care for suspected chorioamnionitis." (Corrigan Declaration at 4.)." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

10. Jane Doe 2 presented to an outlying hospital emergency department experiencing significant bleeding resulting from a placental abruption (separation of the placenta from the wall of the uterus before birth), which progressed to disseminated intravascular coagulation ("DIC"). I agree with Dr.

Corrigan that DIC "is a dangerous condition that creates a high risk of death for the mother due to the rapid loss of large volumes of blood." By the time Jane Doe came to Dr. Corrigan for treatment "[t]he risk of her death at that point was imminent and the fetus still had a detectible heart rate." (Corrigan Declaration at p.6.) The pregnancy was terminated by a dilation and evacuation ("D&E") procedure. In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

11. Jane Doe 3 was diagnosed with pleural effusions, sometimes called "water on the lungs," that were being caused by a case of pre-eclampsia with severe features. I agree with Dr. Corrigan that [w]hen [preeclampsia] occurs before 20-week's gestation, as it did for Jane Doe 3, it is typically severe and carries a high risk of maternal and fetal death." (Corrigan Declaration at p. 7.) The pregnancy was terminated by a D&E procedure. In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is

such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

12. I have reviewed the declaration submitted by Dr. Kylie Cooper, and the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Cooper present a life-threatening situation. Dr. Cooper concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the examples provided by Dr. Cooper present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until

stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

13. Dr. Cooper's first example is Jane Doe 1, who presented to the emergency department with severe range blood pressures and whose fetus had already been diagnosed with triploidy, a chromosomal abnormality that leads to multiple severe birth defects that are "not compatible with life." (Cooper Declaration at 3.) Jane Doe was also diagnosed with preeclampsia. I agree with Dr. Cooper that "[g]iven her severe illness placing her at risk for stroke, seizure, pulmonary edema, development of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

14. Dr. Cooper's second example, Jane Doe 2, had a pregnancy complicated by a host of conditions, including severe intrauterine growth restriction, abnormal amniotic fluid level, abnormal umbilical cord blood flow, elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Furthermore, Jane Doe 2's labs quickly deteriorated such that she required a platelet transfusion, had evidence of hemolysis, and was at risk for DIC ("a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary [and] edema."). (Cooper Declaration at 3-4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

15. Jane Doe 3 presented to the emergency room with acute onset severe abdominal pain, was noted to be hypertensive and her lab abnormalities were consistent with a diagnosis of HELLP syndrome. Also,

placental ultrasound was consistent with fetal triploidy, "a lethal fetal condition." Jane Doe 3's abdominal pain and rapidly rising liver enzymes were indicative of liver injury and her platelets were declining rapidly. I agree with Dr. Cooper's assessment that "[i]n the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, [and] pulmonary edema." (Cooper Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

16. I have reviewed the declaration submitted by Dr. Stacy T. Seyb, and the examples he sets forth in his declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Seyb present a life-threatening situation. Dr. Seyb concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the Emergency Medical Treatment and Labor Act ("EMTALA" 42

U.S.C. § 1395dd) requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the five examples provided by Dr. Seyb present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

17. Dr. Seyb's first example, Jane Doe 1, presented to the emergency department with fever, tender uterus, elevated heart rate and evidence of an intrauterine infection. The suspicion that her bag or water had ruptured 10 days earlier was confirmed by ultrasound that showed no fluid around the baby and confirmed that she had a condition termed Septic Abortion. I agree with Dr. Seyb's assessment that "[h]ad Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high." (Seyb Declaration at 3.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point

that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

18. In Jane Doe 2, Dr. Seyb describes a 35-year-old woman with severe range blood pressure and laboratory values that were consistent with pre-eclampsia with severe features. Also, ultrasound revealed a partial molar pregnancy. I concur with Dr. Seyb's assessment that "[t]he only medically acceptable action to preserve her life was termination of the pregnancy." (Seyb Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

19. Dr. Seyb's third example, Jane Doe 3, presented to the emergency department "after she

started bleeding very heavily per vagina." (Seyb Declaration at 4.) Jane Doe 3 was experiencing hypovolemic shock due to her blood loss, and although "[i]nitial resuscitation improved her condition, she continued to bleed in an uncontrolled manner." (Id.) I agree with Dr. Seyb's assessment that "[i]f left untreated the risks of life-threatening shock, even with blood replacement were very high." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

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

DATED this 16th day of August, 2022.

/s/ Kraig White, M.D.
KRAIG WHITE, M.D.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 16th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF RANDY RODRIQUEZ**

I, Randy Rodriquez, declare as follows:

1. I am the Hospital Administrator for State Hospital South in the Idaho Department of Health and Welfare's (IDHW) Division of Behavioral Health. My duties and responsibilities include the overall management and operation of the hospital. I have held this position since November 16, 2020. Before that, I was Human Services Field Program Manager, Clinical Supervisor and Clinician. I have worked at IDHW since 1998.

2. State Hospital South is a psychiatric hospital that provides skilled nursing and adult inpatient psychiatric care. It is Idaho's only state hospital that has entered into Medicare and Medicaid provider agreements to receive federal funding for the provision of care and services.

3. State Hospital South has no specialized capabilities or facilities related to the treatment of conditions that would require abortion, or that would require it to accept the transfer of a patient for an abortion.

4. State Hospital South is not licensed by the State of Idaho as an Emergency Room or Emergency Department.

5. State Hospital South does not have, nor does it hold itself out to the public as having, emergency facilities that provide care or treatment for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

6. Because State Hospital South is a psychiatric hospital, it would be outside the standard of care for medical providers at State Hospital South to perform an abortion as immediate stabilizing treatment. In the event a patient at State Hospital South were medically assessed to require an abortion as stabilizing treatment, the patient would have to be transferred to another facility.

7. I have reviewed the declaration of David R. Wright. Based on my knowledge and experience as the administrator of State Hospital South and the statement in paragraphs 10 through 12 of Mr. Wright's Declaration, State Hospital South does not have any obligations under the Emergency Medical Treatment and Labor Act that would result in it performing an abortion under any scenario.

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

DATED this 16th day of August, 2022.

/s/ Randy Rodriquez
RANDY RODRIQUEZ, Declarant

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 16th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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AND I FURTHER CERTIFY that on such date I served the foregoing on the following non-CM/ECF Registered Participant via email:

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UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

THE UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant, and SCOTT BEDKE, in his official capacity as Speaker of the House of Representatives of the State of Idaho; CHUCK WINDER, in his capacity	Case No. 1:22-cv-00329-BLW **DECLARATIONS IN SUPPORT OF IDAHO LEGISLATURE'S OPPOSITION TO THE GOVERNMENT'S MOTION FOR PRELIMINARY INJUNCTION**

as President Pro Tempore of the Idaho State Senate; and the SIXTY-SIXTH IDAHO LEGISLATURE,

Intervenor-Defendants.

The following declarations are filed in support of Idaho Legislature's Opposition to the Government's Motion for Preliminary Injunction, Dkt. 65:

1. Declaration of Tammy Reynolds, M.D. (Exhibit 1);
2. Declaration of Pam Harder (with Exhibits A and B) (Exhibit 2);
3. Declaration of Richard Scott French, M.D. (Exhibit 3); and
4. Declaration of Prosecuting Attorney Grant Loebs (Exhibit 4).

Dated this 17th day of August, 2022.

MORRIS BOWER & HAWS PLLC

By: */s/ Daniel W. Bower*
Daniel W. Bower

/s/ Monte Neil Stewart
Monte Neil Stewart

Attorneys for Intevenor-Defendants

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of August, 2022, I electronically filed the foregoing with the Clerk of the Court via the CM/ECF system, which

caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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American Public Health Association, American Medical Association

/s/ Daniel W. Bower
Daniel W. Bower

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW **DECLARATION OF TAMMY REYNOLDS, M.D.**

DECLARATION OF TAMMY REYNOLDS, M.D.

I, Dr. Tammy Reynolds, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn"). In my practice I regularly participate in and manage high risk pregnancies. I submit this declaration in support of the Idaho Legislature's Opposition to the United State's Motion for Preliminary Injunction. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto. In this respect, I note that I am not able to testify on August 22, 2022, but can testify remotely on August 23, 2022.

2. I was raised in Idaho Falls, Idaho, graduating from Idaho Falls High School; received my bachelors degree from the University of Utah and my medical degree from George Washington University in 2007; completed my residency in Obstetrics and Gynecology

at the University of Nevada School of Medicine in 2011; and since then have been in private practice with the largest Ob-Gyn group in Nevada, with more than 30 Ob-Gyn colleagues. Since the beginning of my residency in 2007 and continuously since, I have been involved with hundreds of emergency-room treatments of patients needing Ob-Gyn care. I have handled thousands of live births, and over the course of my career, I have treated thousands of pregnant women.

3. In my experience, the situations necessitating emergency procedures to save the life of the mother, that also might be deemed an abortion in the medical community, are rare. In my 11 years in private practice, I have only encountered one such event. In my opinion, any such event would be lawful under Idaho Code § 18-622 ("622 Statute") because the abortion would be "necessary to prevent the death of the pregnant woman." I have read and am familiar with the 622 Statute.

4. I understand that in this civil action the Government is claiming that there is a certain class of emergency medical conditions (i) where medically appropriate treatment of the mother will result in the death of the preborn child, (ii) where the federal Emergency Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA") requires that treatment, but (iii) where the 622 Statute prohibits it because it is not necessary to save the life of the mother. I am not aware of any term in the medical profession for this highly conceptual class of emergency medical conditions. Hereafter, I will refer to this conceptual class and the medical procedures allegedly falling within it collectively as "Relevant Abortions" to be

consistent with the prior filings of the Legislature's lawyers and to avoid confusion.

5. I have read and am familiar with EMTALA's language defining an emergency medical condition: "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 organ or part."

6. In my experience, I've never encountered nor have I ever been made aware of a Relevant Abortion. Relevant Abortions, if they even exist as a real-world medical event, would be exceedingly rare. Again, I have never encountered a situation where an emergency abortion was performed because otherwise the mother's bodily functions, organs, or parts risked serious impairment but her life was not at risk.

7. Further, in this context, I note that none of the Jane Doe cases described in the declarations filed in this civil action by Idaho doctors Cooper, Corrigan, and Seyb constitutes a Relevant Abortion. To the contrary, based on the plain language of those descriptions, each case involved an emergency medical procedure to save the life of the mother. Meaning, each case involved a lawful medical procedure under the 622 Statute. Indeed, in my judgment and based on my experience, each case presented a situation where no informed, competent

professional would second-guess the legality of the procedure.

8. I read ¶ 12 of Dr. Corrigan's declaration as an effort to portray the 622 Statute as the cause of increased risk for the patient. I disagree with that conclusion. In my opinion, the increased risk to Jane Doe #1 in Dr. Corrigan's declaration resulted from two closely related acts of medical malpractice by the treating physician referenced there: one, not correctly identifying that the PPROM diagnosis meant that there was a serious risk to the life of the mother and, two, misunderstanding the scope of the Idaho abortion statutes. In my judgment, part of a treating Ob-Gyn physician's duty of care is possession of accurate knowledge of the language and real-world application of the jurisdiction's laws regulating abortion.

9. In my opinion, the 622 Statute's language about abortions necessary to prevent the death of the mother provides a clear and workable standard for Idaho medical professionals to effectively, and quickly, provide emergency medical procedures necessary to save the life of the mother without fear of prosecution. Those Idaho medical professionals will be able to do so without violating EMTALA in any real way because, as I discuss above, although Relevant Abortions may be theoretically possible, nothing in the declarations of the Idaho doctors, coupled with nothing from my own experience, suggests the existence of Relevant Abortions in Idaho.

10. Accordingly, it is my opinion that attending Idaho physicians can determine, in their good faith medical judgment, whether the mother's condition is

such that an emergency medical procedure is necessary to avoid the mother's death and when it is not. It is also, therefore, my opinion that these physicians may proceed without the kinds of subjective "fears" and "chillings" suggested in the declarations of the three Idaho doctors.

11. Regarding Dr. Fleisher's declaration, I have just had the opportunity to read the declaration of Richard Scott French, M.D. In my opinion, his testimony is medically sound and valid.

12. Termination of an ectopic pregnancy is not an abortion and therefore not prohibited by the 622 Statute. Any effort to *redefine* abortion to include treatment of ectopic pregnancies is medically baseless and, in my judgment, inexcusable.

13. The following conditions may constitute a medical emergency under the Idaho statutes that necessitate an emergency abortion to save the life of the mother:

a. A case of severe pre-eclampsia in the mother prior to 20 weeks of gestation or eclampsia;

b. A severe case of PPROM (preterm premature rupture of membranes) leading to infection and serious risk of sepsis;

c. A severe case of catastrophic, uncontrolled, and/or severe vaginal bleeding caused by placental abruption; and/or

d. A long-standing pulmonary hypertension or a massive pulmonary embolism, exacerbated by complications during pregnancy.

14. Neither I nor, in my opinion, any practicing Ob-Gyn would reasonably fear criminal prosecution under the 622 Statute in any of the above-listed circumstances because they necessitate early delivery (if possible) or an emergency medical procedure necessary to preserve the life of the mother. In circumstances where the mother's life is in danger, a reasonable and competent medical professional would not delay life-saving care due to the fear of legal repercussions under the 622 Statute because the circumstances where emergency medical procedures are necessary to save the life of the mother are obvious.

15. The doctor-declarants' comments about "fears" and "chillings" of doctors already in Idaho and of Ob-Gyn doctors considering relocating to Idaho do not ring true to me, for all the reasons I have given above. They also mention a concern about a shortage of Ob-Gyns. The general shortage of Ob-Gyns is appreciated throughout the country, especially in rural areas.

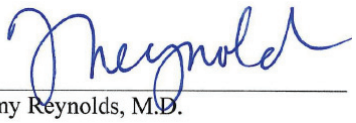
16. Regarding the declaration that Idaho is a "hotbed" for surrogacy, once a pregnant woman presents and is correctly diagnosed as being in a medical emergency that threatens the life of the mother, how the pregnancy started does not alter the work, responsibility, or judgment thereafter of the treating medical professionals

17. I have not been paid consideration in any form for my work in making this declaration and will not be paid for my future testimony for a hearing on the preliminary injunction, whether in-person or remotely, in this civil action, other than

reimbursement of actual expenses such as for travel. I am making this declaration out of my personal commitment to the best practices of my profession, including their interaction with duly enacted abortion laws.

I declare under penalty of perjury under the laws of the State of Idaho and of the United States that the foregoing is to the best of my knowledge true and correct.

Date: Monday, August 15, 2022



Tammy Reynolds, M.D.

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW **DECLARATION OF PAM HARDER**

DECLARATION OF PAM HARDER

I, Pam Harder, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a Research Analyst Supervisor with the Idaho Department of Health and Welfare Bureau of Vital Statistics ("DHW").

2. I am authorized to compile data reported to the DHW.

3. There are certain statutory reporting requirement associated with performing an abortion in Idaho. These reports are made by physicians to the DHW through the State of Idaho Report of Induced Termination of Pregnancy ("Form"). *See attached Exhibit A.*

4. Pursuant to Idaho Code § 18-506 any physician who performs or induces or attempts to perform or induce an abortion must report such action to the Idaho Department of Health and Welfare. Included in the required information is the following:

a. "If a determination of probable postfertilization age was not made, the basis of the determination that a medical emergency existed" (I.C. § 18-506(b)); and

b. "If the probable postfertilization age was determined to be twenty (20) or more weeks, the basis of the determination that the pregnant woman had a condition that so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function ... ." (I.C. § 18-506(c)).

5. This information, if applicable, is reported by the attending physician in question 20 of the Form.

6. Furthermore, Idaho Code § 18-609G(l)(b) mandates the reporting of whether an abortion was performed following a medical emergency that made the abortion immediately necessary and without consent from a parent, guardian, or conservator in circumstances where the patient is under 18 years of age-with the specific diagnosis included.

7. This information, if applicable, is reported by the attending physician in question 19b of the Form.

8. I certify that I have compiled all of the data reported to the Idaho Department of Health and Welfare on questions 19b and 20 of the Idaho Report of Induced Termination of Pregnancy per year for the years 2007 to 2021 for question 19b and years 2013 to 2021 for question 20. Those are all the years that the answers to these questions have been required by the

Idaho legislature to be collected by the DHW. I further certify that the compilation is true and accurate. *See attached Exhibit B.*

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 16th day of August 2022, in Boise, Idaho.

August 16, 2022
Date

Pamela Harder
Digitally signed by Pamela Harder
DN: cn=Pamela Harder, c=US, o=Idaho Dept of Health and Welfare, ou=BVRHS, email=Pam.Harder@dhw.idaho.gov
Date: 2022.08.16 16:12:02 -06'00'

Pam Harder

Harder Declaration Exhibit A

State of Idaho
REPORT OF INDUCED TERMINATION OF PREGNANCY

State File No. _____

<table>
<tr><td colspan="2">1. Facility Name (if not clinic or hospital, give address)</td><td colspan="2">2. City, Town, or Location of Pregnancy Termination</td><td>3. County of Pregnancy Termination</td></tr>
<tr><td colspan="2">4. Patient's Identification Code</td><td>5. Age Last Birthday
(if under 18, you must complete item #19)</td><td>6. Married? (At termination, conception, or any time in between)
□ YES
□ NO</td><td>7. Date of Pregnancy Termination (Mo, Day, Yr)</td></tr>
<tr><td>8a. Residence-State</td><td>8b. County</td><td>8c. City, Town, or Location</td><td>8d. Inside City Limits?
□ YES
□ NO</td><td>8e. Zip Code (First five digits only)</td></tr>
<tr><td colspan="2">9. Of Hispanic Origin? (Specify No or Yes-if yes, specify Cuban, Mexican, Puerto Rican, etc.)
□ NO □ YES
Specify:_____</td><td>Race – American Indian, Black, White, Japanese, etc. (Specify below)</td><td colspan="2">11. Education (specify only highest grade completed)
Elementary/Secondary (0-12)
College (1-4 or 5+)</td></tr>
<tr><td colspan="3">12. Date Last Normal Menses Began</td><td colspan="2">14. Previous Pregnancies (Complete each section)</td></tr>
</table>

			Live Births	Other Terminations
13a. Clinical Estimate of Gestation (Weeks) *(See question #20 for additional information)*	14a. Now Living	14b. Now Dead	14c. Spontaneous (Include fetal deaths)	14d. Induced (Do not include this termination)
13b. Method of determining Gestational Age □ Ultrasound □ Pelvic Exam □ Other (specify) □ None	Number _____ □ None	Number _____ □ None	Number _____ □ None	Number _____ □ None

15. TERMINATION PROCEDURES		
15a. Procedure that Terminated Pregnancy *(Check only one)*	15b. Additional Procedures Used for this Termination, If Any (Check all that apply)	Was there a complication with this Abortion, As Defined By Idaho Code §39-9503(02) □ No □ Yes
(1) □ ……../Suction Curettage…	….. □ (1)	If Yes, you must complete and submit the
(2) □ …..Medical (Nonsurgical) *(Specify medications below)*…...	….. □ (2)	

(3) □ .....Dilation and Evacuation (D&E).....	..... □ (3)	Abortion Complications Reporting Form to the Bureau of Vital Records and Health Statistics within 90 days.
(4) □ .....Inter-Uterine Instillation (Saline or Prostaglandin).....	..... □ (4)	
(5) □ ...Sharp Curettage (D&C)	..... □ (5)	
(6) □ .....Hysterotomy/ Hysterectomy.....	..... □ (6)	
(7) □... Other (Specify)_____	..... □ (7)	
□		

Patient Educational Materials Provided? □ YES □ NO	Name of Attending Physician *(Type/Print)*	Name of Person Completing Report *(Type/Print)*

IF PATIENT IS UNDER 18 YEARS OF AGE, COMPLETE EITHER 19A. OR 19B.

19a. TERMINATION PERFORMED FOLLOWING PHYSICIAN'S RECEIPT OF: *(Check only one)*

(1) □ Written informed consent of a parent, guardian or conservator and the minor

(2) □ Written informed consent of emancipated minor for herself

(3) □ Written informed consent of minor for herself pursuant to court order granting minor right to self-consent

(4) □ Court order which includes finding that abortion is in best interests of minor, despite absence of parental consent

(5) □ Certification from minor that pregnancy resulted from rape or sexual conduct with minor by the minor's parent, stepparent, uncle, grandparent, sibling, adoptive parent, legal guardian, or foster parent

OR

19b. TERMINATION PERFORMED FOLLOWING MEDICAL EMERGENCY: *(Specify diagnosis below)*

_____

IF DETERMINATION OF POSTFERTILIZATION AGE WAS 20 WEEKS OR GREATER, OR UNKNOWN, COMPLETE ITEM 20

20. MEDICAL CONDITION THAT NECESSITATED THE ABORTION AT 20 OR GREATER WEEKS POSTFERTILIZATION:

(1) □ Patient had a condition that so complicated her medical condition as to necessitate the abortion of this pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions

(2) □ It was necessary to preserve the life of an unborn child

(3) □ Determination of probably postfertilization age was not made. Provide the basis of the determination that a medical emergency existed: (specify below)

_____

Harder Declaration Exhibit B

Idaho Abortion Reporting (RESPONSE)

In April 2000, the question "If patient is under 18 years of age, complete either 19a or 19b" was added to the Idaho Report of Induced Termination of Pregnancy. However, data on Informed consent was required to be collected by legislation beginning March 27, 2007.

Question 19b is specifically "Termination performed following medical emergency". From March 27, 2007 through December 31, 2021, there has been one induced termination reported in which the patient was under 18 years of age and the termination performed was for medical emergency. The report was in 2013. There have been none reported in 2022; however, 2022 data are preliminary and are based on records filed as of 7/21/2022. From March 27, 2007 through records filed-to-date in 2022, there have been 886 abortions to teens under the age of 18 in Idaho.

On January 1, 2013, the question "If determination of Postfertilization age was 20 weeks or greater, or unknown complete Item 20" was added to the Idaho Report of Induced Termination of Pregnancy. From January 1, 2013 through December 31, 2021 there have been 5 induced terminations in Idaho at 20 weeks or greater postfertilization. The five terminations occurred in 2013 (1 report), 2016 (1 report), 2019 (1 report), and 2021 (2 reports). The medical condition that necessitated the abortion at 20 or greater weeks postfertilization was:

1) Patient had a condition that so compilated her medical condition as to necessitate the abortion

of this pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions (1 report in 2016).

2) It was necessary to preserve the life of unborn child (1 report 2013)

Box was not checked, but medical condition was written in (1 report in 2021)
Question 20 was left blank (1 report in 2019 and 1 report in 2021).

There have been none reported to date in 2022; however, 2022 data are preliminary and are based on records filed as of 7/21/2022.
From January 1, 2013 through records filed to-date in 2022, there have been 13,392 abortions in Idaho to patients of all ages.

Note: 20 weeks or greater postfertilization is equal to 22 weeks or greater clinical estimation of gestation.

There is no other report that I know of that involves abortions performed for emergency reasons.

Pam Harder
Research Analyst Supervisor
Health Statistics Section
Bureau of Vital Records and Health Statistics
Division of Public Health

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF RICHARD SCOTT FRENCH, M.D.**

I, Dr. Richard Scott French, declare as follows:

1. I graduated from Harbor-UCLA Emergency Medicine Residency in June 1986. After completing my residency in Emergency Medicine, I joined the faculty of Stanford University Medical School as a full-time assistant professor in the Department of Surgery, Division of Emergency Medicine, in July 1986.

2. Since that time, I have held full-time teaching faculty positions at Stanford University Medical School and University of North Carolina Medical School.

3. I have also held several part-time clinical faculty teaching appointments, including at the University of Washington, Oregon Health Systems University, University of Alabama, and Emory University.

4. In my teaching capacities, I have given presentations to medical students, interns, and residents on normal and abnormal labor and delivery,

and all pregnancy complications including ectopic pregnancies, trauma in pregnancy, pre-eclampsia/ HELLP, sepsis, uterine abruption, placental abruption, diagnosis and treatment protocols. I have also taught medical students, interns, and residents on the principles of immunology, and preventive measures for immunological diseases, as well as diagnosis and treatment.,

5. I have practiced Emergency Medicine in northern Idaho and in Boise, and performed consults on Emergency Department protocols in southern Idaho

6. I have been either an attending physician in multiple Emergency Departments, and/or the Medical Director, and/or supervising the Emergency Department physicians and medical director. I also managed EMS medical systems and set up protocols for obstetric patients in Idaho and California. The states where I have practiced Emergency Medicine include Idaho, California, Oregon, Washington, Hawaii, Alabama, Florida, North Carolina, Georgia, Montana, Louisiana, and Mississippi.

7. I have been a Regional Medical Director for three separate large national medical groups, and was involved in managing Emergency Departments, Hospitalists, and urgent care clinics in several states.

8. I have extensive prior experience in population management and disease management, and with the Emergency Medical Treatment and Labor Act ("EMTALA" 42 U.S.C. § 1395dd) as Chief Medical Officer of a large health plan in California, which included hospitals with tertiary Obstetric capabilities.

9. I have reviewed the declarations submitted by Dr. Lee A. Fleisher, Dr. Emily Corrigan, Dr. Kylie Cooper, Dr. Stacy T. Seyb and the cases they present. In my opinion, the examples of pregnancy-related medical emergencies in these declarations are presented in a way that creates a false conflict/false dichotomy between the life and health of the mother and the life and health of the unborn child and appear to *assume* that under Idaho Code § 18-622, physicians will give the health and welfare of the mother less consideration than the health and welfare of the unborn child. In my experience, in the emergency situations presented in these examples and anticipated by EMTALA, the subordination of the mother's life and health in favor of the unborn child by a physician has not and will not occur. Further, these same physicians would never interpret Idaho Code 18-622 to mean that the mother's health and welfare are secondary to the baby. Every physician understands the Hippocratic Oath of "do no harm", and physicians certainly understand that the baby's health is dependent upon the mother's health. This is why in the tragic and rare circumstances whereby the mother dies, then a post- mortem C-section is promptly performed. Since there is no chance to save the mother, then the focus turns to the baby's health.

10. In fact, EMTALA is designed and intended simply to facilitate the transfer of patients to facilities that have the capacity to treat them – it is not a statute that mandates any particular type of treatment, but rather "stabilizing treatment" until the patient can be transferred. Many of the cases presented assume that every hospital has the capability to take care of high-risk pregnancy cases.

Unfortunately, this capability and availability of resources is only available in larger cities, just as only a very few hospitals can perform emergency heart surgery in a rural state such as Idaho. One of the life-saving aspects of EMTALA is that it helps those physicians in rural areas transfer care of certain patients to a hospital that has the capability to provide appropriate treatment. The scenarios presented in these declarations *imply* that in extreme emergency situations, the physician may be confused as to whether his or her first duty is to abort babies or save the life of the mother before transferring her to an appropriate hospital. Many tertiary care hospitals will refuse a transfer unless the patient is "adequately stabilized," and "adequately stabilized" is often at the discretion of the receiving hospital. Fortunately, to the best of my knowledge, refusal of transfer has not been a problem with the tertiary care hospitals in Idaho. In the case of a high-risk pregnant woman, the most appropriate action to save the mother's life is to send to the closest hospital with the appropriate resources and personnel for the care of a critically ill pregnant woman .

11. In some of the most dire cases, it may not be possible to stabilize the pregnant patient prior to transfer to a tertiary care hospital. Then the Emergency Physician must call an obstetrician if available, and if none are available, he or she would be calling in a surgeon.

12. As former full-time and part-time teaching faculty member and Medical Director in multiple Emergency Departments, I have designed, implemented, and taught protocols for these same Emergency Departments that deal with all the life-

threatening cases related to pregnancy. These protocols included diagnosis and treatment of ectopic pregnancies, septic shock, stroke, serious or life-threatening vaginal bleeding, traumatic injuries, cardiovascular emergencies, and other emergencies that threaten the life and health of the mother. In these emergency situations, the primary focus is on preserving the health, welfare, and life of the mother, and any procedure will be focused on treating the mother, not on the potential death of the child.

13. A real-world example that was not included in the declarations I have reviewed, but sadly I have also witnessed, and is the case of a pregnant woman with a gunshot wound to the chest or abdomen and her vital signs are deteriorating. The trauma surgeon would perform an emergency thoracotomy in order to stop the bleeding at the source. In such a case, the trauma surgeon's first thought is, "I must stop the source of the bleeding." It is *never*, "I must perform an abortion to save this woman's life." This is a matter of fact, even though the emergency thoracotomy commonly will include cross clamping of the aorta, which will most likely end the life of the unborn child. When the surgeon dictates the operation note, abortion will not be listed as a procedure. Instead, if the mother survives and the child dies, there will be a post-mortem c-section of the baby.

14. In other words, the intent of the procedure is to save the life of the mother; it is an unintended consequence of the procedure that the baby dies. It appears thatDr. Fleisher is recommending that we redefine all maternal life-saving procedures as an "abortion," but this is a gross and misleading

deception with dire consequences for the health of women.

15. The Idaho law as written in no way precludes this life-saving procedure or other similar procedures in the same or similar circumstances. As stated in Section 18-622(4):

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

16. I can find no literature, and the physician declarations do not cite any studies, where abortion is the first line treatment for any medical emergency. Although precipitous delivery is necessary in cases of pre-eclampsia and HEELP, the "life-saving" abortion that results in the death and dismemberment of a fetus in the uterus can cause an entire cascade of reactions that would in fact worsen many of the scenarios that are presented as life-saving.

17. I have reviewed the declaration of Dr. Lee A. Fleisher, and he uses the example of an ectopic pregnancy as a life-threatening scenario whereby an abortion is necessary to save the life of the mother. I agree that a life-saving procedure is necessary, but the life-saving surgery is not considered an abortion. Idaho Law does not prohibit *any* life-saving surgery, even if it results in the death of the unborn child.

18. I would question the competence of an obstetrician who said they were going to perform an abortion on a patient bleeding out from a ruptured

ectopic pregnancy. Any competent surgeon would *first* find the source of the bleeding and take whatever steps were necessary to stop it, even if halting the bleeding of the mother resulted in the death of the developing baby.

19. In the case of a hypotensive patient due to a ruptured ectopic pregnancy, the patient will die without finding the bleeding source from the ruptured ectopic pregnancy, and ligating (suturing) and/or removing the bleeding blood vessels. The surgery required to stop the bleeding at the source may require removing the ruptured tube and/or bleeding ovary. Clearly, this procedure is not in the same class or category as an abortion, since an abortion does not include ligating bleeding arteries and removing the mother's fallopian tube (transports the egg) and/or ovary.

20. In fact, as long as the mother is conscious, an attempt at getting informed consent must be documented. Calling this life-saving procedure an abortion is not only disingenuous but would be a gross deception for the mother. The mother would think that an abortion had been performed, when in fact she had had a major, life-saving surgical procedure that also resulted in the death of the developing child. In explaining the procedure to a conscious mother, the obstetrician/surgeon would need to state this as a risk, and of course let her know that if the procedure were not performed then she would likely die.

21. The life threat of an ectopic pregnancy is covered in 18-622(4) that specifies the health of the woman is of primary importance:

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

22. Another example that Dr. Fleisher uses is where a pregnant individual presents with chest pain, shortness of breath, is pregnant, and has severe heart failure secondary to long-standing pulmonary hypertension. Clearly, this is a worst-case scenario for the mother and the emergency physician, even if the physician is at a high functioning tertiary care hospital with a high-risk obstetric team, interventional cardiology, a cardiovascular anesthesiologist, pulmonologist, intensivist, and other highly specialized equipment and capabilities. The mortality of such a patient is most likely greater than 50% no matter what you do, and the physician would want to choose carefully what is the most appropriate first action. I have been in situations like this, and the first thing any competent physician would do is to consult with each of the physicians to determine what is the best course of action *to save the life of the mother, and if possible, also save the life of the child*. Making terminating the pregnancy the primary objective could in fact be the worst first thing to do for the sake of the health of the mother. But it is also an unavoidable truth that if the mother does not survive, the child will also certainly not survive.

23. The vast majority of hospitals in Idaho would be unable to care for such a complicated pregnant patient without a high-risk obstetric team, a cardiologist, cardiac anesthesiologist, pulmonologist

and other support staff. Thus, if the patient is too unstable to transport and the transferring hospital is unable to provide the proper medications or treatments necessary to "stabilize" the patient, two provisions of EMTALA would appear to apply. First, the hospital's obligation to provide screening and stabilizing treatment to patients with an emergency medical condition is limited to such screening and treatment that is "within the staff and facilities available at the hospital." (42 U.S.C. § 1395dd(b)(1)(a).) Thus, hospitals are able to transfer unstable patients without violating EMTALA where the hospital does not have the facilities or staff needed to stabilize the critically ill pregnant patient. Second, EMTALA prohibits the transfer of unstable patients, unless "based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer." (42 U.S.C. 1395dd(c)(1)(A)(ii).) Clearly, where the hospital does not have the facilities or staff to stabilize the patient, the benefits of transferring the patient outweigh the increased risks that would attend transfer.

24. In my opinion, Dr. Fleisher's conclusion that Idaho law prohibits treatment of pre-eclampsia, under the extreme and rare circumstances presented in his example, by providing treatment that is both necessary to stabilize the patient and also results in the loss of the developing child's life, is inaccurate. Pre-eclampsia, as described in Dr. Fleisher's example, would always be a life-threatening complication for

the mother, and is particularly dangerous where it progresses into the often fatal HELLP syndrome.

25. Dr. Fleisher's fourth example is of a hypothetical patient who presents with a "life-threatening infection of the uterine contents." This hypothetical case in a "clinical vacuum" demonstrates the importance of having all the pertinent clinical information so as to come to a correct diagnosis before initiating appropriate treatment. For example, the treatment for sepsis is entirely different for uncontrolled vaginal bleeding, which is different than the treatment of an ectopic pregnancy.

26. While the example Dr. Fleisher gives describes someone who arrives with a "diagnosis,"in reality, an emergency physician will see a woman arriving at the ER with pain, fever, vaginal bleeding, abdominal pain, and/or myriad other complaints. The first order of business is always to have stat vital signs. A patient with normal vital signs (blood pressure, heart rate, oxygenation, and temperature) will require less emergent action, and allows for a more comprehensive diagnostic work up than a patient who has abnormal and dangerous vital signs.

27. Obviously, the treatment called for will depend upon the results of the patient's vitals and subsequent diagnostic work up. However, surgical intervention will only be necessary to stabilize the patient if other stabilizing treatments have failed – such as administering IV fluids, possible transfusion of blood if there is significant hemorrhage, providing blood pressure support, and giving antibiotics. Any surgical procedure deemed necessary at that point

would not be considered an abortion, but rather life-saving surgery.

28. Dr. Fleisher's fifth example is of a (hypothetical) patient who presents with vaginal bleeding as a result of placental abruption – where the placenta partially or completely separates from the inner wall of the uterus. I agree with Dr. Fleisher's statement that "[p]lacental abruption with uncontrolled and catastrophic bleeding is an emergency medical condition that places the patient's life in jeopardy or can cause serious impairment to bodily functions." Thus, an immediate C-section is performed if the baby is at a certain gestational age, not an abortion (dismemberment of body parts). With placental abruption, time is of the essence, and the patient may quickly die without an immediate C-section.

29. Dr. Fleisher concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under the EMTALA requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that a life-saving surgery would more likely than not result in the

termination of the pregnancy. However, the life-saving surgery is not an abortion, and the language in the Idaho statue permits such life-saving surgeries/procedures.

30. I have reviewed the declaration submitted by Dr. Emily Corrigan, including the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Corrigan present a life-threatening situation. Dr. Corrigan concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under EMTALA requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A).

31. It is my opinion that every one of the examples provided by Dr. Corrigan present a life-threatening situation and are not prohibited under the Idaho Law.

As stated in Section 18-622(4):

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

32. Dr. Corrigan's first example, Jane Doe 1, was diagnosed with preterm premature rupture of membranes ("PPROM"), or premature breaking open of the amniotic sac. I agree with Dr. Corrigan that PPROM "increases the risk of life-threatening intraamniotic infection (chorioamnionitis) and also increases the risk that the fetus will not develop normally due to decrease in the amount of amniotic fluid." (Corrigan Declaration at 3.) I also agree with Dr. Corrigan that "[a]dministration of oral antibiotics and discharge home is not the medically accepted standard of care for suspected chorioamnionitis." (Corrigan Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given.

33. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. However again, the procedure performed would not be an abortion, but rather a dilation and evacuation(D&E). In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman, but here again, the termination of the pregnancy is not the intent of the surgery. The intent of the surgery is to remove infected tissues that will lead to overwhelming sepsis and death of the mother. Further, I see nothing in the Idaho law that

would preclude this life-saving procedure. Labelling as an abortion the heroic life-saving surgery that involved removal of infected fetal tissue which would certainly lead to the death of the baby an abortion is a gross deception of the obstetrician's superior skill and judgement.

34. Dr. Corrigan's example of Jane Doe 1 demonstrates how EMTALA was designed to work without any conflict between it and Idaho law, and where the transferring physician and hospital are unable to properly care for the patient, the patient was promptly and appropriately transferred to the tertiary care hospital for definitive care.

35. Jane Doe 2 presented to an outlying hospital emergency department experiencing significant bleeding resulting from a placental abruption (separation of the placenta from the wall of the uterus before birth), which progressed to disseminated intravascular coagulation ("DIC"). I agree with Dr. Corrigan that DIC "is a dangerous condition that creates a high risk of death for the mother due to the rapid loss of large volumes of blood." By the time Jane Doe came to Dr. Corrigan for treatment "[t]he risk of her death at that point was imminent and the fetus still had a detectible heart rate." The pregnancy was terminated by a dilation and evacuation ("D&E") procedure.

36. Labelling as an abortion the life-saving surgery that saves the mother's life by removing the ruptured placenta is again a gross deception of the obstetrician's superior skill and judgement. Further, the baby can't survive a ruptured placenta, despite the still detectable heartbeat, so the baby was doomed

to die due to the ruptured placenta. Thus, it is an abhorrent distortion to claim that this life-saving procedure was an abortion. Clearly again, the Idaho statute does not preclude saving the mother's life, and the baby was tragically going to die with or without surgery, just as in the case of an ectopic pregnancy.

37. In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. It must be stated yet one more time that the intent of the surgery was to save the mother's life, and the baby was not going to survive an abruption of the placenta, the source of blood and oxygen.

38. Jane Doe 3 was diagnosed with pleural effusions, sometimes called "water on the lungs," that were being caused by a case of pre-eclampsia with severe features. I agree with Dr. Corrigan that "[w]hen [preeclampsia] occurs before 20-week's gestation, as it did for Jane Doe 3, it is typically severe and carries a high risk of maternal and fetal death." The pregnancy was terminated by a D&E procedure. In my opinion, a pregnant patient who presents with

the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment was given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman. In short, in the scenario described by Dr. Corrigan, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman.

39. Here again, the intent of the surgery was to save the mother's life, as the baby would not survive if the mother is dead. Idaho law as written is not in conflict with the lifesaving procedure performed on the mother.

40. I have reviewed the declaration submitted by Dr. Kylie Cooper, including the examples she sets forth in her declaration of situations where termination of the pregnancy was necessary. It is my opinion that every one of the three examples provided by Dr. Cooper present a life-threatening situation that would require termination of the pregnancy in order to preserve the life of the mother. Dr. Cooper concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under EMTALA requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the examples provided by Dr. Cooper present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

41. In short, in the scenarios described by Dr. Kylie Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman, and I see nothing in the Idaho law that would conflict with that judgment. As stated in Section 18-622(4):

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

42. Dr. Cooper's first example is Jane Doe 1, who presented to the emergency department with severe range blood pressures and whose fetus had already been diagnosed with triploidy, a chromosomal abnormality that leads to multiple severe birth defects that are "not compatible with life." (Cooper Declaration at 3.) Jane Doe was also diagnosed with preeclampsia. I agree with Dr. Cooper that "'[g]iven her severe illness placing her at risk for stroke,

seizure, pulmonary edema, development of HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets), urgent termination of pregnancy was the recommended treatment to stop her disease progression to preserve her health and life." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment were given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman.

43. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. The intent of the surgery is to save the mother's life, and if the mother dies the baby dies.

44. Dr. Cooper's second example, Jane Doe 2, had a pregnancy complicated by a cluster of adverse life threatening fetal and maternal conditions, including severe intrauterine growth restriction, abnormal amniotic fluid level, abnormal umbilical cord blood flow, elevated blood pressures and lab abnormalities consistent with a diagnosis of HELLP syndrome. Furthermore, Jane Doe 2's labs quickly deteriorated such that she required a platelet transfusion, had evidence of hemolysis, and was at risk for DIC ("a life-threatening emergency related to the body's inappropriate consumption of blood-clotting factors

leading to systemic bleeding, liver hemorrhage and failure, kidney failure, stroke, seizure, pulmonary [and] edema."). (Cooper Declaration at 3-4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment were given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman.

45. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. The intent of the surgery/procedure was to save the life of the mother, not to perform an abortion. In addition, given the nature of the baby's unfortunate abnormalities, the baby would not likely have survived with or without the procedure, particularly in addition to the unfortunate adverse effects of the pregnancy on the mother, further compromising the survivability of the baby. I do not see where Idaho law also would be in conflict with the heroic efforts of the obstetrician

46. Jane Doe 3 presented to the emergency room with acute onset severe abdominal pain, was noted to be hypertensive and her lab abnormalities were consistent with a diagnosis of HELLP syndrome. Also, placental ultrasound was consistent with fetal triploidy, "a lethal fetal condition." Jane Doe 3's

abdominal pain and rapidly rising liver enzymes were indicative of liver injury and her platelets were declining rapidly. I agree with Dr. Cooper's assessment that "[i]n the setting of pre-viable HELLP syndrome she was at risk for DIC, liver hemorrhage and failure, kidney failure, stroke, seizure, [and] pulmonary edema." (Cooper Declaration at 4.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment were given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman.

47. In short, in the scenario described by Dr. Cooper, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. As noted by Dr. Cooper, the baby had a fatal condition, and the intent of the surgery was to prevent the death of the mother. As has been previously discussed, HELLP syndrome is a highly lethal condition, and requires the expert care that was given by Dr. Cooper in an appropriate tertiary care facility. Idaho law as written does not conflict with the life-saving surgery performed.

48. I have reviewed the declaration submitted by Dr. Stacy T. Seyb, including the examples he sets forth in his declaration of situations where termination of the pregnancy was necessary. It is my

opinion that every one of the three examples provided by Dr. Seyb present a life-threatening situation. Dr. Seyb concludes that in each of these examples, termination of the pregnancy may be the type of treatment needed to stabilize the patient, which under EMTALA requires the hospital "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 the facility." 42 U.S.C. § 1395dd(e)(3)(A). It is my opinion that every one of the three examples provided by Dr. Seyb present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy would be necessary to save the life of the pregnant woman.

49. In short, in the scenarios described by Dr. Stacy T. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman, and I see nothing in the Idaho law that would prohibit such treatment from being given. As stated in Section 18-622(4):

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

50. Dr. Seyb's first example, Jane Doe 1, presented to the emergency department with fever, tender uterus, elevated heart rate and evidence of an intrauterine infection. The suspicion that her bag or water had ruptured 10 days earlier was confirmed by ultrasound that showed no fluid around the baby and confirmed that she had a condition termed Septic Abortion. I agree with Dr. Seyb's assessment that "[h]ad Jane Doe 1 not received both antibiotics and termination of the fetus to allow removal of the infected tissue, the chance of her progressing to severe sepsis and dying was very high." (Seyb Declaration at 3.) In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment were given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman.

51. In the scenario described by Dr. Seyb, I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. The baby was already dead from the septic abortion(miscarriage), and the infected fetal tissues would casue the death of the mother if not removed. Here again, to describe this as an abortion procedure is a gross mischaracterization of the heroic life-saving surgery performed by

Dr. Sayb, and does not conflict with Idaho law as written.

52. In Jane Doe 2, Dr. Seyb describes a 35-year old woman with severe range blood pressure and laboratory values that were consistent with pre-eclampsia with severe features. Also, ultrasound revealed a partial molar pregnancy.

53. The following is UpToDate description of a molar pregnancy:

> A molar pregnancy is not even a viable pregnancy, so the procedure performed would have been a D&E, not an abortion. Hydatidiform mole (HM) was first described by Hippocrates around 400 BCE as "dropsy of the uterus." Since that time, HM (also referred to as molar pregnancy or mole) has been of clinical and research interest. Molar pregnancy is part of a group of diseases classified as gestational trophoblastic disease (GTD), which originate in the placenta and have the potential to locally invade the uterus and metastasize. The pathogenesis of GTD is unique because the maternal tumor arises from gestational rather than maternal tissue [1].

54. Thus, even though there was a baby, there was also a partial molar pregnancy that would likely compromise the viability of the baby. In addition, the partial molar pregnancy was causing severe pre-eclampsia, threatening the life of the mother and the baby. Thus, clearly the intent of the surgery was to save the life of the mother, and the baby's probability of survival even without all the complications was

probably close to zero. Yet again, to describe this as an abortion procedure is a gross mischaracterization of the heroic life-saving surgery performed by Dr. Sayb, and does not conflict with Idaho law as written

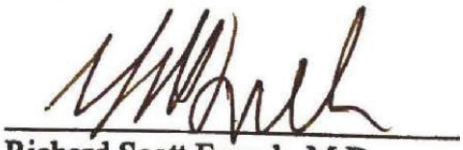
55. Dr. Seyb's third example, Jane Doe 3, presented to the emergency department "after she started bleeding very heavily per vagina." (Seyb Declaration at 4.) Jane Doe 3 was experiencing hypovolemic shock due to her blood loss, and although "[i]nitial resuscitation improved her condition, she continued to bleed in an uncontrolled manner." (Id.) I agree with Dr. Seyb's assessment that "[i]f left untreated the risks of life-threatening shock, even with blood replacement were very high." In my opinion, a pregnant patient who presents with the specific conditions described in this example, and whose condition is such that it is not safe to transfer the patient until stabilizing treatment is given, would be in a life-threatening situation if no treatment were given. Thus, if the conditions in this example have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that termination of the pregnancy was necessary to save the life of the pregnant woman.

56. In the scenario described by Dr. Seyb, the pregnant woman was very close to death from hypovolemic shock due to blood loss from a 19 week gestation pregnancy. Dr. Seyb's heroic management included the initial resuscitation with fluid and blood, but unfortunately the resuscitation could not keep up with the bleeding. As is the case of life-threatening bleeding, the bleeding must be stopped at the source. Unfortunately, in this case, the source was the

pregnancy. I could in good faith make the medical judgment that terminating the pregnancy was necessary to prevent the death of the pregnant woman. Yet again, the life of the mother was at stake, and Idaho law as written is not in conflict with the life saving procedure.

57. I submit this declaration in support of Idaho Legislature's Opposition to the Government's Motion for Preliminary Injunction. Unless otherwise state, the facts set forth herein are true of my own personal knowledge, and if called to testify as a witness in this matter, I could and would testify competently thereto.

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



Richard Scott French, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW **DECLARATION OF PROSECUTING ATTORNEY GRANT LOEBS**

DECLARATION

I, Grant Loebs, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I have served as the Prosecuting Attorney for Twin Falls County since 1997.

2. I am familiar with The Emergency Medical Treatment and Labor Act ("EMTALA") that generally requires "stabilizing treatment" to incoming patients, including pregnant patients, experiencing an "emergency medical condition." *See* 42 U.S.C. § l 395dd(b)(1). Similarly, I am familiar with the obligation of hospital emergency departments to comply with EMTALA as a result of receiving Medicare.

3. I am also familiar with Idaho abortion law, Idaho Code § 18-622, set to take effect August 25, 2022.

4. In my opinion, Idaho Code § 18-622 ("622 Statute") as written does not preclude life-saving

procedure or other similar procedures when required under EMTALA. As stated in Section 18-622(4):

> Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

5. Assuming a serious medical condition requires an emergency medical procedure under EMT ALA, and that such procedure ends the life of the pre-born child, in the exercise of my prosecutorial discretion I would not second-guess the judgments and decisions of the attending medical professionals and would not consider prosecuting anyone under the 622 Statute in such a case. Unless I had proof beyond a reasonable doubt that the procedure was performed in bad faith and that the emergency was fabricated to evade the 622 Statute under the guise of EMTALA, no charges would be filed under the 622 Statute.

6. I have reviewed the various circumstances and scenarios presented by Dr. Corrigan (Dkt. 17-6), Dr. Cooper (Dkt. 17-7) and Dr. Seyb (Dkt. 17-8) in their respective August 8, 2022, declarations.

7. I would not prosecute any health care professional based on facts like those set forth in those declarations, and I believe no Idaho prosecuting attorney would do so. Indeed, it is as though the scenarios set forth in the affidavits of Drs. Corrigan, Cooper, and Seyb were specifically designed to illustrate cases where prosecution would NOT be pursued.

8. Under Idaho Code § 18-622, medical professionals (physicians, physician's assistants, pharmacists, nurses, and anesthesiologists) would NOT be committing a criminal act when they perform or assist in performing an abortion necessary to prevent the death of the pregnant woman. Therefore, as an elected prosecutor, I would not pursue prosecution in such situations.

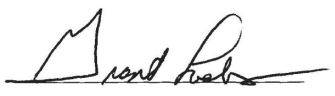
9. Under Idaho Code § 18-622, medical professionals (physicians, physician's assistants, pharmacists, nurses, and anesthesiologists) would NOT be committing a criminal act when they perform or assist in performing procedures to stabilize the health of a mother which accidentally result in the death of a pre-born child. Therefore, as an elected prosecutor, I would not pursue prosecution in such situations.

10. Medical professionals should not hesitate or delay in providing stabilizing life care due to a fear of prosecution under the 622 Statute.

11. I believe that the opinions I have stated above regarding prosecutorial discretion and the application of the 622 Statute are shared by all prosecuting attorneys in Idaho.

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

August 17, 2022
Date



UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant, and THE IDAHO LEGISLATURE, Defendant-Intervenor.	Case No. 1:22-cv-00329-BLW **MEMORANDUM DECISION AND ORDER**

Before the Court is the issue of whether to hold an evidentiary hearing before ruling on the United States' motion for a preliminary injunction. (Dkt. 17) For the reasons discussed below, the Court will not conduct an evidentiary hearing. Instead, the scheduled hearing on August 22, 2022 will only include argument.

BACKGROUND

The United States and the State of Idaho initially agreed that the Court did not need to conduct an evidentiary hearing on the motion for a preliminary injunction because it involved only legal issues. But then the Idaho Legislature asked to intervene to present a factual opposition. The Court partially granted that motion, allowing the Legislature to offer

evidence about the factual issues underlying the United States' motion.

After partially granting permissive intervention, the Court held an informal status conference to discuss the length and content of the upcoming motion hearing. At that time the Legislature made what was essentially a request for an evidentiary hearing. They argued that without live evidence, the Court could not make credibility determinations or resolve factual disputes in the parties' declarations (which, at that point, had not been fully submitted to the Court). The Court has now reviewed all the declarations.

DISCUSSION

A district court does not need to hold an evidentiary hearing before ruling on a preliminary injunction. In fact, the Ninth Circuit has "rejected any presumption in favor of evidentiary hearings, especially if the facts are complicated." *Kenneally v. Lungren*, 967 F.2d 329, 335 (9th Cir. 1992) (quoting *United States v. Oregon*, 913 F.2d 576, 582 (9th Cir. 1990)). Even more, the Ninth Circuit explicitly declined to follow a rule that would require "presenting oral testimony when the pleadings and affidavits are conflicting." *Int'l Molders' & Allied Workers' Local Union No. 164 v. Nelson*, 799 F.2d 547, 555 (9th Cir. 1986). *See also Stanley v. Univ. of S. Cal.*, 13 F.3d 1313, 1326 (9th Cir. 1994) ("[T]he refusal to hear oral testimony at a preliminary injunction hearing is not an abuse of discretion if the parties have a full opportunity to submit written testimony and to argue the matter.").

Instead, the Ninth Circuit has given district courts general principles to guide the exercise of discretion: "Where sharply disputed [] facts are simple and little time would be required for an evidentiary hearing, proceeding on affidavits alone might be inappropriate. . . . But an evidentiary hearing should not be held when the magnitude of the inquiry would make it impractical." *Nelson*, 799 F.2d at 555. Courts should also consider "general concepts of fairness, the underlying practice, the nature of the relief requested, and the circumstances of the particular case[]." *Id.*

The Court finds that this case is poorly suited to an evidentiary hearing on several grounds. In the Court's assessment, the declarations on file provide a sufficient basis to make an informed decision. Equally important, the bulk of the purported factual dispute is actually a legal dispute—the meaning of Idaho Code § 18-622 and its overlap with EMTALA, 42 U.S.C. § 1395dd, are legal questions, not factual ones.

What is more, to the extent there is a factual dispute, it centers around subjective medical assessments—in what circumstances physicians can determine "in [their] good faith medical judgment" that abortion is "necessary to prevent the death of the pregnant woman." Idaho Code § 18-622. That is precisely the kind of complex factual dispute that is impractical to resolve at an evidentiary hearing at this point in the litigation. Moreover, the large magnitude of that inquiry would require a very lengthy evidentiary hearing. Given that the Court already has a mere two days to rule on the motion after the scheduled argument, holding a long

evidentiary hearing creates an additional, untenable burden on the Court.

As a result, the Court finds that it is appropriate to rule on the United States' motion without holding an evidentiary hearing or hearing live testimony.

ORDER

IT IS ORDERED that the Legislature's request for an evidentiary hearing is **DENIED**.

DATED: August 17, 2022

B. Lynn Winmill
U.S. District Court Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329

SUPPLEMENTAL DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties. The following statements are provided as a supplement to the prior written testimony that I submitted in relation to this case on August 8, 2022.

1. I have reviewed the Declarations of Dr. Richard Scott French (the "French Declaration"), ECF 75-1, and Dr. Kraig White (the "White Declaration"), ECF 66-1. Both the French Declaration and the White Declaration discuss my prior declaration, including my testimony explaining that the appropriate stabilizing treatment for some emergency medical conditions experienced by pregnant patients is

termination of pregnancy. French Decl. ¶¶ 17-29; White Decl. ¶¶ 2-7.

2. Both Dr. French and Dr. White agree with my prior statements that termination of pregnancy is the necessary and appropriate medical treatment for pregnant patients under the circumstances discussed. As Dr. French explains: "[E]very one of the five examples provided by Dr. Fleisher present a life-threatening situation. Thus, if the conditions described in each of these examples have reached the point that it is not safe to transfer the patient until stabilizing treatment is given, it would be my good faith medical opinion that a life-saving surgery would more likely than not result in the termination of the pregnancy." French Decl. ¶ 29. Dr. White similarly agrees. White Decl. ¶¶ 2-7.

3. The only point of disagreement with my prior testimony appears to be Dr. French's interpretation of the Idaho statute that is challenged in this case. Dr. French states that "life-saving surgery is not an abortion, and the language in the Idaho statute permits such life-saving surgeries/procedures." French Decl. ¶ 29. Dr. French's interpretation is inconsistent with my reading of the Idaho statute, which defines abortion to mean "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." Idaho Code § 18-604(1). While I agree that the statutory definition of "abortion" in the Idaho Code covers some procedures that would not be characterized as an abortion *in the medical community*, the language of the Idaho statute appears to cover any medical

treatment that requires intentional termination of a pregnancy regardless of the circumstances.

4. Additionally, it appears that Dr. French and Dr. White believe that the Idaho statute does not threaten criminal liability when termination of the pregnancy occurs in response to a "life-threatening" condition. French Decl. ¶¶ 29-30; White Decl.¶ 2. From a medical perspective, I do not believe "life-threatening," which generally implies only a *risk* of death, necessarily has the same meaning as the Idaho law's affirmative defense—"necessary to prevent . . . death"—which generally implies avoiding a certainty (or at least very high probability) of death.

5. Regardless, I do not believe "life-threatening" fully encompasses all potential emergency medical conditions for which a pregnant patient might be entitled to stabilizing treatment under EMTALA. Specifically, the State's declarations do not address situations in which termination of pregnancy is necessary to protect a patient's health, or to ensure that a pregnant patient will not suffer a serious impairment to their bodily functions or serious dysfunction of any bodily organ or part, but where the patient's life is likely not in danger at that point in time. As explained in my prior declaration, many pregnancy conditions pose serious risks to the patient's health that are appropriately stabilized through termination of pregnancy, even though a physician may not be able to establish or know that termination of pregnancy is "necessary to prevent the death of the woman" at that time. In those instances, termination of pregnancy would be necessary to protect the patient's health, even though death is not immediately threatened.

6. For example, I previously discussed the scenario of a patient who comes to an emergency department with preterm premature rupture of membranes ("PPROM"), which is a premature breaking open of the amniotic sac that increases the risk of severe intra-amniotic infection. If PPROM is diagnosed, the patient faces serious risk of infection which could impair the function of any number of organs or bodily functions. As an example, developing significant infection in the uterus could seriously impair the patient's reproductive organs if the condition is allowed to deteriorate. Providing stabilizing treatment in the form of termination of pregnancy at the point of diagnosis would be an appropriate means to preserve the patient's reproductive organs at that time. If stabilizing treatment were withheld at that point in time, the infection could only worsen and treatment at a later point would present significantly higher risk of complications, potentially requiring a hysterectomy and/or harming their future fertility. If a patient is diagnosed with PPROM before severe infection occurs, a patient may not immediately face a life-threatening risk. However, immediate treatment through termination of pregnancy may be necessary because delaying treatment would allow the condition to progress, thereby threatening other bodily organs and functions, including but not limited to future fertility. Under those circumstances, the patient and physician may decide that termination of pregnancy may be the appropriate stabilizing treatment to protect the patient from organ dysfunction or other bodily impairment, even though the stabilizing

treatment is not yet in response to a life-threatening circumstance.

7. In general, medical risk to individual patients exists along a continuum, and there are no medical "bright lines" specifying when exactly a condition becomes "life-threatening" or "necessary to prevent the death" of the pregnant patient. Even in situations where it is unclear whether the patient's life is in immediate danger, it may be apparent that the patient's condition will continue to deteriorate absent stabilizing treatment through termination of pregnancy. Under those circumstances, terminating the pregnancy to avoid the patient's health falling into serious jeopardy, bodily functions being seriously impaired, or organs becoming seriously dysfunctional (rather than waiting to see if and/or when the patient's condition worsens to the point that they are about to die) may be the appropriate recommendation from the physician as medically necessary and is what EMTALA requires.

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

Executed this 18th day of August, 2022 in Philadelphia, PA.

Lee A. Fleisher, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **REPLY DECLARATION OF DR. EMILY CORRIGAN**

REPLY DECLARATION OF DR. EMILY CORRIGAN IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Emily Corrigan, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist ("Ob-Gyn") physician at Saint Alphonsus Regional Medical Center in Boise, Idaho and I previously submitted a declaration in this case. I have now reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. As with my first declaration, unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

The State's Physician Declarations Do Not Reflect Relevant Personal Experience or Risk.

2. To begin, my overall reaction having reviewed the declarations of Drs. White, Reynolds and French is that none of them face the same risk of criminal prosecution for violating Idaho Code § 18-622 as myself, Dr. Seyb, Dr. Cooper, and most other Idaho physicians and nurses who must comply with EMTALA while treating critically-ill pregnant patients.

3. Although Dr. Reynolds says she was raised in Idaho, after she completed her residency in Nevada she chose to continue practicing medicine there where I understand abortion to be legal. *See* Dr. Reynolds Decl. ¶ 2. She does not indicate in her declaration any intention to return to Idaho to help either patients in Idaho or her physician colleagues deal with these new laws, which have no effect on her living and practicing in Nevada. If anything, her declaration is evidence of Idaho's dire OB/GYN shortage as compared to more urban areas like Las Vegas where she trained, has practiced ever since, and is part of a very large group of physicians. The OB/GYN residency program in Nevada will continue to produce six new OB/GYN physicians per year to supply their workforce. Idaho hospitals will have to convince OB/GYN physicians from out of state to move here and practice under the stressful circumstances created by Idaho Code § 18-622 and our already understaffed OB/GYN Departments.

4. Dr. French does not state in his declaration where he currently is practicing medicine but he speaks of his time in Idaho in the past tense only. *See*

Dr. French Decl. ¶¶ 5, 6. His online Doximity profile indicates that he is currently practicing in Hawaii. Abortion healthcare is not currently under legal threat in Hawaii.

5. Dr. White says that he is practicing in Moscow, Idaho, a town that is only 8 miles from Pullman, Washington. Pullman Regional Hospital features a level IV trauma center, so any high-risk patient that Dr. White encounters could quickly and easily be transferred to a hospital in a state where abortion is legal.

6. Additionally, Dr. White says that he is working as a Family Medicine Physician in the Emergency Department at a small hospital. In my experience, if a pregnant patient is having a significant complication, the Emergency Department provider requests a consultation from an OB/GYN who then assumes management of the patient.[1] Reading his declaration, I noted that while Dr. White says that in the last 6 years he has treated "life-threatening situations that have included obstetrical emergencies," he does not say whether he has ever personally made the decision to terminate a patient's pregnancy to stabilize her condition. Also, complex obstetric patients are usually transferred from a critical access hospital to a tertiary care center before a decision is made regarding an emergency abortion. As such, there is nothing in his declaration to suggest that Dr. White has ever faced the situations that Drs.

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[1] Patients with emergency pregnancy-related conditions are frequently triaged and treated in a hospital's labor & delivery department, which is considered part of the "emergency department" for purposes of EMTALA.

Seyb, Cooper, and I have faced many times in our careers, that we described in our declarations, and that is at the crux of the conflict between federal and state law if Idaho Code § 18-622.

The State's Physician Declarations Are Wrong About "Necessary to Prevent Death"

7. Each of the State's physician declarations suggests that termination of the pregnancy was necessary to save the pregnant patient's life in each of the cases I discussed. Having not treated those patients or studied their files, those physicians do not speak from experience and are simply wrong. There are several reasons why.

8. First, it is medically impossible to say that death was the guaranteed outcome for Jane Doe 1, 2, and 3 if we had not terminated their pregnancies when we did. None of their conditions *necessarily* would have ended in death. Jane Doe 1 could have developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but could still be alive. Jane Doe 2 possibly would have developed kidney failure requiring lifelong dialysis or hypoxic brain injury but escaped death. Jane Doe 3 was at risk for stroke and severe lung injury but may have survived her illness. Each of these women potentially would have had to live the remainder of their lives with significant disabilities and chronic medical conditions as a result of their pregnancy complication. If I was asked if the abortion was necessary to prevent the death of the patient in each of those cases, I could not necessarily

say yes with absolute certainty. I do not believe that any physician could. That said, in each case, abortion was necessary to stabilize the patient's health.

9. While the State's physician declarations speak in terms of absolutes, medicine does not work that way in most cases. Death may be a possible or even probable outcome, but different outcomes may also be possible or probable. This is why doctors frequently refuse to answer the question, "What are my chances?" I frequently tell my patients that I do not possess a "crystal ball" that informs me of exactly what the future holds for them, I can only make an educated guess based on my training and experience. We can provide empirical data on how many patients survived a particular condition, if that data was collected and verified (usually through peer review). But we can only rarely predict with certainty a particular outcome. This is why we follow the standard of care—something that is knowable and is consistent with our obligations under EMTALA. And this is also why the Idaho law will have a chilling effect on physicians in treating pregnant patients facing health emergencies.

10. Second, the State's physician declarations simply assume that their interpretation of the Idaho law is the correct one, ignoring that the law does not define when a procedure would be deemed "necessary to prevent the death of the pregnant woman." For those of us faced with the obligation to comply with that law and left only with an affirmative defense, we must ask: Is any risk of death sufficient? Must the risk be greater than 50%? 75%? Or must the physician wait until the patient's heart has stopped beating to provide the termination and begin resuscitative

efforts? Idaho Code § 18-622 does not say. What we can say is that a physician's good-faith belief that it was necessary is *not* enough, as it appears the law does not have any sort of good-faith exception. Just because one physician says he or she believes termination is "necessary" to prevent the pregnant patient's death does not mean all physicians would agree, and certainly does not guarantee all prosecutors, judges, and jurors untrained in medicine would agree. Instead, a physician must rely on hope that a judge or jury would interpret what is "necessary" in the same way as the physician.

11. Third, even if death is eventually the necessary outcome absent termination of a pregnancy, the Idaho law tells physicians to wait until death is near-certain and in the meantime the patient will experience pain and complications that may have lifelong disabling consequences. Even if a patient is ultimately provided the medically necessary care, Idaho Code § 18-622 will delay that care until a debate determines whether it is truly "necessary to prevent the death of the pregnant woman." In my view, the State's physician declarations unrealistically downplay the reason physicians will wait until they are sure an abortion is necessary to prevent death. A physician administering an emergency abortion in Idaho would be risking their professional license, livelihood, personal security, and freedom. Our malpractice insurance may not cover us for performing an act that some may view as a crime. Of course, we may hesitate to provide the same care after the Idaho law is effective—the law is designed for that very purpose.

12. Fourth, the State's physician declarations ignore that it is not only physicians who perform abortions who may be exposed to serious risk. Idaho law also exposes nurses and others who assist doctors to criminal and license-suspension risk. As a result, there will be some cases where even if a physician may be comfortable proceeding, she may have no nurse or other staff to assist because of the fear that this law has instilled in healthcare workers in Idaho. That too will undermine patient care, causing harm to patients and increasing the risk associated with the abortion being performed.

13. Just because out-of-state doctors do not fear prosecution under Idaho Code § 18-622 does not mean that those of us who actually do practice in Idaho feel the same way. I have said to the administration at my hospital that the OB/GYN Physicians in Idaho are "bracing for the impact" of this law, as if it is a large meteor headed towards Idaho. The OB/GYN and Maternal Fetal Medicine physicians who work at tertiary care hospitals in Boise feel this trepidation most acutely because we receive the most complex cases from other hospitals in the state that have fewer resources. Dr. Cooper, Dr. Seyb, and I are all part of this group of physicians that is most at risk from the implications of this law. There are no declarations submitted in support of this law from any physician with this level of current and intimate knowledge of the risks and challenges we are facing. If this law goes into effect, there will be serious negative consequences for patients and healthcare workers alike. While the pregnant people of Idaho will likely suffer serious physical and emotional trauma or even death as a result of this law, the OB/GYN physicians

who practice here will face the untenable situation of making decisions for the care of critically ill patients while facing an impossible choice between complying with either state or federal law but not both.

The Prosecutor's Declaration Provides Little to No Comfort.

14. I reviewed the declaration from Prosecuting Attorney Grant Loebs. A declaration from one prosecutor in Twin Falls County does not provide me with any comfort that I would not be criminally prosecuting for terminating a patient's pregnancy where required by EMTALA but not 100% necessary to prevent imminent death to the patient. Idaho has lots of prosecutors. They may have different views of how to exercise their discretion. Some may even think that they have an obligation to enforce the law in Idaho and may disagree that it was passed only to send a message. And other prosecutors who haven't even been elected yet may have still other views of the law. The consequences of a criminal prosecution are so serious, even if I could present a defense, that Idaho Code § 18-622 is necessarily going to change how emergency medical care is administered in Idaho, even if one prosecutor promises he doesn't plan to enforce it.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 8th day of August 2022, in Boise, Idaho.

8/18/22
Date

Emily Corrigan, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **DECLARATION OF DR. AMELIA HUNTSBERGER**

DECLARATION OF DR. AMELIA HUNTSBERGER IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Amelia Huntsberger, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I am a board-certified Obstetrician-Gynecologist (Ob/Gyn) physician at Bonner General Health, a critical access hospital in Sandpoint, Idaho. Bonner General Health is a small, rural hospital that provides Labor and Delivery services. The nearest Neonatal Intensive Care Unit (NICU) is 45 miles from Sandpoint.

2. In 2008, I graduated from the University of Washington School of Medicine which is the regional medical school for Washington, Idaho, Wyoming, Montana and Alaska. I completed my residency in Obstetrics and Gynecology at the University of

Michigan in Ann Arbor in 2012. I am board certified in General Obstetrics and Gynecology since 2015.

3. I was invited to join the Idaho Perinatal Project advisory board in 2018. Improving pregnancy outcomes by reducing maternal and infant morbidity and mortality is the mission of the Idaho Perinatal Project. I am a member of the Idaho Maternal Mortality Review Committee. I am currently the Idaho Section Chair of the American College of Obstetricians & Gynecologists.

4. I moved to Sandpoint, Idaho in 2012 and began working as an Ob/Gyn at Bonner General Health.

5. I grew up in a rural area and feel patients in rural areas deserve high quality, compassionate health care just like patients in more populated areas. Serving a rural community has been my goal since I was a medical student.

6. I have reviewed declarations prepared by Kraig White, M.D., Tammy Reynolds, M.D., Richard Scott French, M.D., and Prosecuting Attorney Grant Loebs, which I understand were submitted by Idaho in this case. I submit this declaration in response. The facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

Abortion Is Sometimes Medically Necessary Even When It Is *Not* Necessary to Prevent the Mother's Death.

7. The physician declarations from Drs. White, Reynolds, and French seem to suggest that whenever abortion is medically necessary, it is necessary to

prevent the mother's death. That is simply not the case.

8. At Bonner General Health, we do not perform purely "elective abortion." However, I have personally treated patients whose health condition requires abortion as stabilizing care—even if those patients were not necessarily facing death in the absence of an abortion.

9. A relatively common example of this is ectopic pregnancy. Not every patient with an ectopic pregnancy will die without an abortion. But terminating an ectopic pregnancy is the standard of care to prevent serious risks to the mother, including internal bleeding, injury to the fallopian tube or other organs in the abdominal cavity, impaired fertility, and in some cases, death.

10. I have reviewed the declaration of Dr. Reynolds stating that termination of ectopic pregnancy is not an abortion. While Dr. Reynolds may not consider the termination of ectopic pregnancy to be abortion, she does not acknowledge how Idaho law defines abortion. Unlike Dr. Reynolds, who practices in Las Vegas, Nevada, I practice medicine in Idaho. I have reviewed Idaho law and it defines abortion as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean the use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization or the implantation of a fertilized ovum within the uterus." An ectopic

pregnancy is a "clinically diagnosable pregnancy" even if the fetus is not viable, and Idaho law has no exceptions for lethal anomalies. There are various means to terminate an ectopic pregnancy, all of which are intended to cause the death of the fetus and all of which are performed with knowledge that they will cause the death of the fetus.

11. For example, I treated a patient in her mid-30s who presented to the hospital with spotting and pelvic pain. An ultrasound showed an ectopic pregnancy with a fetal heartbeat. Free fluid, presumed to be blood, was seen on the pelvic ultrasound. I counseled the patient about the risks, benefits, and alternatives available to her and she elected and consented to undergo laparoscopy with removal of the ectopic pregnancy. At the time of surgery, there was 750 mL of blood in her abdomen despite normal blood pressure and pulse. A patient with stable vital signs like this one is experiencing a health emergency—her health is in "serious jeopardy" within the meaning of EMTALA. However, a patient with stable vital signs may not appear to be near death. If I had let her condition deteriorate before performing a life-saving abortion, however, she would have faced increased pain, risk of further hemorrhage inside the abdomen, anemia, possible development of disseminated intravascular coagulopathy (DIC), need for blood transfusion and other blood products. She also could have died had we waited too long and been unable to manage the complications that may have arisen. Ectopic pregnancy is a potentially life-threatening diagnosis. The timeline for it to develop into an acutely life-threatening condition is difficult to precisely predict, even for a medical expert.

Stabilizing treatment with abortion as defined by Idaho law was necessary to prevent a life-threatening situation from evolving.

Waiting Until Abortion Is Necessary to Prevent the Patient's Death Will Cause Serious Harm.

12. With ectopic pregnancies and pregnancy of unknown location, waiting until an abortion is necessary to prevent death is harmful and dangerous. In some ectopic pregnancies and pregnancies of unknown location, treatment with methotrexate may be offered. Methotrexate is a chemotherapy drug used to kill rapidly dividing cells (which therefore targets pregnancy). Methotrexate can be used to "intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child" (the Idaho definition of abortion). If we must wait until a patient's death is imminent to terminate her ectopic pregnancy or pregnancy of unknown location, we can no longer use methotrexate and must provide surgical intervention. Surgical intervention carries its own risks, including potential loss of a fallopian tube, damage to nearby abdominal structures (like bladder, bowel, uterus, ovary, ureter and/or blood vessels), infection, bleeding and potential loss of the patient's ability to become pregnant naturally in the future.

13. I have personally treated patients who sadly experienced this outcome. One patient had the devastating experience of having both tubes removed for separate instances of ruptured ectopic pregnancy. As a result, she has no option for spontaneous

pregnancy and would require in vitro fertilization (IVF) or adoption to grow her family. Appropriate use of methotrexate when the patient first presents with ectopic pregnancy, if successful (which it typically is), may avoid the need for surgical intervention and increase likelihood of successful future pregnancy. The total abortion ban will cause doctors to hesitate before using methotrexate, putting their patients' health and fertility at risk.

14. Another example shows the consequences of delaying an abortion. This patient was a female in her 40s with 3 living children who presented to the hospital via ambulance with heavy vaginal bleeding. She reported that she was approximately 14 weeks gestation. She had been experiencing very heavy bleeding at home. She initially declined care including bloodwork, pelvic ultrasound and/or Ob/Gyn consultation in the ER. She was not unstable at this time, and I could not say an abortion was necessary at that time to prevent her death. However, she continued bleeding profusely in the ER until she was unable to stand due to hemorrhage causing symptomatic anemia. After a syncopal episode, she agreed to be seen by an Ob/Gyn and I was emergently called. She was pale and unable to sit up in bed due to her anemia at the time of my evaluation. She was bleeding heavily from the vagina making visualization during pelvic exam very difficult. I removed products of pregnancy from the open cervix in the ER, however, very brisk bleeding continued and she was counseled to undergo emergent D&C in the Operating Room (OR) for a second trimester incomplete abortion. I reviewed the risks, benefits and alternatives of D&C (dilation and curettage- a

procedure to remove the products of pregnancy from the uterus) in addition to the risks, benefits and alternatives of blood transfusion and she consented to both. I took her to the OR for D&C. She was hypotensive and tachycardic; she was unstable at that time. She received 2 liters of IV fluids, transfusion of 3 units of packed red blood cells in the OR, another unit of packed red blood cells in the Recovery Room immediately following her surgical procedure. She received 2 units of fresh frozen plasma given her large volume blood loss. I had to order platelets from Spokane, Washington, which did not arrive until several hours later via taxi and were transfused into the patient. She stayed in the hospital for 2 days. She received another transfusion of 2 units of blood for ongoing symptomatic anemia prior to her discharge home.

15. I provide these details regarding this patient's case because her case shows what can happen when we delay an abortion that would otherwise be the recommended medical intervention. In this case, the patient chose to delay the abortion but if Idaho Section 622 takes effect, physicians in Idaho will be forced to wait until the abortion is necessary to prevent death of the patient. Patients may experience serious complications, have negative impact on future fertility, require additional hospital resources including blood products, and some patients may die.

The Idaho Law Will Have Serious Negative Effects on Medical Care in Idaho.

16. While Drs. White, Reynolds and French suggest that the law is clear to them, it certainly is not clear to me. The goal in medicine is to effectively

identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. One impact on medical care may be a reluctance to use effective, evidence-based treatments like methotrexate for ectopic pregnancy or pregnancy of unknown location.

17. Most rural hospitals in Idaho, like my own institution, were not offering "elective terminations" of pregnancies prior to the *Dobbs* decision. Yet those of us who treat pregnant patients are deeply worried about what these abortion laws will mean for the practice of routine reproductive care given the Legislature's broad definition of "abortion."

18. In rural areas, patients may live 30-60 miles or more away from medical care. There is less access to specialty care, less blood stocked in the blood bank, less access to other blood products. At the critical access hospital where I work, we don't have platelets in the blood bank as previously described. If necessary, platelets come via taxi from a neighboring state and may take hours to arrive. Most rural hospitals do not have interventional radiology (can provide additional treatment option for maternal hemorrhage), Maternal Fetal Medicine expert (high risk pregnancy doctor), nor a dedicated Critical Care doctor that manages the Intensive Care Unit (ICU). Rural hospitals, like my own, may not have dialysis capabilities. As per EMTALA, some patients will need to be transferred to a hospital that can offer a higher level of care. If there is bad weather, it is not possible to use a helicopter and then a patient will travel by ambulance 45 to 60 miles away depending on which

hospital accepts the patient and/or which hospital has the resources that the patient needs. We work with the resources that we have to the best of our ability, but we don't have the same staff, equipment and resources as larger and/or urban centers. For rural patients in particular, delaying medical care until we can say an abortion is necessary to prevent death is dangerous. Patients will suffer pain, complications, and could die if physicians comply with Idaho law as written when it conflicts with EMTALA.

19. I hope that the Court takes into consideration how physicians actually practicing in Idaho and treating Idahoans perceive the law and its effect of criminalizing evidence-based medical care. A doctor practicing in Las Vegas or Honolulu does not have the same experience and does not face the same potentially life-altering dilemma that we will face if this law is allowed to take effect.

20. I have also reviewed the declaration of the attorney, Mr. Loebs, and it does not make me feel any better about how the law will negatively affect patients and physicians in Idaho. How can I trust that every prosecutor in the State has exactly the same beliefs, much less every *future* prosecutor? If the law allows prosecution, it is not reassuring that I can simply rely on the good faith of prosecutors. A prosecutor may believe that they have an obligation to enforce the law as it is written. I have a career and a family of my own so I cannot just hope that all prosecutors will exercise discretion in exactly the same way as Mr. Loebs.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best

of my knowledge true and correct. Executed this 18th day of August 2022, in Sandpoint, Idaho.

8/18/2022
Date

Amelia Huntsberger, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329 **SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D.**

SUPPLEMENTAL DECLARATION OF KYLIE COOPER, M.D. IN SUPPORT OF THE UNITED STATES' MOTION FOR A PRELIMINARY INJUNCTION

I, Kylie Cooper, being first duly sworn under oath, state and depose upon personal knowledge as follows:

1. I have read the briefs submitted by the State of Idaho and the Idaho Legislature and the supporting Declarations. I submit this supplemental declaration in support of the Motion for Preliminary Injunction filed by the United States in the above-captioned matter. Unless otherwise stated, the facts set forth herein are true of my own personal knowledge, and if called as a witness to testify in this matter, I could and would testify competently thereto.

2. As stated in my Declaration (Dkt.17-7), pregnancy is not always straight forward and complication free. If I terminate a "clinically diagnoseable pregnancy" the affirmative defense available to me under Idaho Code § 18-622 requires

me to prove that in my medical judgment and based on the facts known to me, the termination was necessary to prevent the death of the pregnant woman. The vast majority of patients do not present at death's door. For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense.

3. My patient Jane Doe I is just one of countless patients whom I have treated with a diagnosis of preeclampsia with severe features. Medical standard of care dictates that expectant management, or continued observation without treatment of a pregnancy with a diagnosis of preeclampsia with severe features is contraindicated in the setting of a fetus not expected to survive including those at a pre-viable gestational age. The reason for this is because preeclampsia with severe features places a patient at risk for both acute and long-term complications and the clinical course involves progressive deterioration of the maternal and fetal condition. Patients with preeclampsia with severe features may present with varying symptoms. For some it is severe hypertension, for others it is evidence of kidney or liver damage on laboratory assessment. Others present with severe intractable headache pulmonary edema and some at the extreme end of the spectrum with HELLP syndrome (hemolysis, elevated liver enzymes, low platelets). The definitive medical treatment for pre-viable preeclampsia with severe features is termination of pregnancy. The medical

rationale to treat preeclampsia with severe features once it has been diagnosed is not always to prevent death; in the majority of cases it is to avoid further deterioration, physical harm, and threat to future fertility and long-term health.

4. Maternal death remains relatively uncommon which is due to contemporary and evidence based medical practices and protocols which we use to treat the patient in an appropriate and timely manner rather than waiting until they experience the anticipated and severe complications of their illness.

5. Preterm pre-labor rupture of membranes (PPROM) is a circumstance in which the amniotic sac has ruptured too early. I have treated countless patients with PPROM and for some patients this occurs in the pre-viable or peri-viable time frame. This condition carries a multitude of risks including intra-amniotic infection, endometritis, placental abruption, and retained placenta. It can also lead to maternal sepsis, acute kidney injury, hemorrhage, need for blood transfusion, and hysterectomy. Maternal deaths due to infection do occur. The clinical presentation of PPROM can vary. In addition to abnormal leakage of amniotic fluid, some may also experience bleeding from an abruption or labor. For others, they may present with signs and symptoms of intraamniotic infection. In the pre-viable and peri-viable setting the chance of pregnancy loss is very high. The clinical course for patients with PPROM can be unpredictable. They may be stable at one moment and bleeding profusely or demonstrating systemic signs of infection the next. Having PPROM places them at risk for hemorrhage which can be

further compounded by an intraamniotic infection or sepsis. Hemorrhage, if significant and unresponsive to first line therapies can necessitate a hysterectomy which would eliminate future fertility. The treatment for intraamniotic infection or hemorrhage related to PPROM is to remove the products of conception from the uterus. It is my opinion these are the types of scenarios where the condition may not meet the "necessary to prevent the death of the pregnant woman" requirement for the affirmative defense under I.C. § 18-622 but I would be required under EMTALA to stabilize a condition that without immediate medical attention would place the patient's health in jeopardy.

6. I have read the declarations of Dr. White and Dr. Reynolds. As a maternal-fetal medicine physician I provide direct care for high-risk pregnant patients and also serve as a subspecialist consultant for other medical providers. In my role as a subspecialist physician I am consulted regularly and from around the state of Idaho by a variety of physicians including generalist OB/Gyn, family practice, and emergency medicine for assistance in managing pregnant patients and pregnancy complications. As a subspecialist physician at a tertiary care center who receives pregnancy related patient transports regularly from around the state, I frequently see conditions that threaten the health of the patient. The three examples in my initial declaration were all cared for within the past year. Even if it is just one patient's health being severely impacted or life lost related to the inability of her medical providers to care for her, that is unacceptable.

7. Dr. Reynolds states that "any effort to redefine abortion to include treatment of ectopic pregnancies is medically baseless and, in my judgment, inexcusable." Idaho Code § 18-622 defines an abortion as the termination of a "clinically diagnosable pregnancy". Medically speaking, the healthcare community would not classify treatment of an ectopic pregnancy as an abortion. This statute was not written using medically accepted definitions or terminology. Therefore, providers are left with the plain language of the law and because an ectopic pregnancy is a clinically diagnosable pregnancy this leads to provider fear of prosecution for providing the evidence-based and medically indicated treatment for those patients. Dr. Reynolds, who practices in Nevada, states that Idaho physicians, "may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors" and "[t]he doctor-declarants' comments about 'fears' and 'chillings' of doctors already in Idaho and of Ob-Gyn doctors considering relocating to Idaho do not ring true to me." As a physician who is practicing in Idaho and through my personal interactions with health care providers around the state as well as through my positions with ACOG, the Idaho Perinatal Project advisory board, and the Idaho Coalition for Safe Reproductive Healthcare, provider fear and unease is real and widespread.

8. I have read the declaration of Dr. French who states "the 'life-saving' abortion that results in the death and dismemberment of a fetus in the uterus can cause an entire cascade of reactions that would in fact worsen many of the scenarios that are presented as life-saving." Surgical abortion is a safe treatment. The

risk of death associated with childbirth is 14 times higher than that with abortion. For those complications related directly to the pregnancy itself such as HELLP syndrome, preeclampsia with severe features, severe hemorrhage, and intraamniotic infection, this safe surgical procedure is the definitive treatment that will stop the progression and reduce risks of bodily harm.

9. I have read the declaration of Mr. Loebs. A single prosecutor, from a different jurisdiction from where I practice medicine stating that he would not prosecute a physician based on a few patient examples does not alleviate my fear of criminal prosecution. Similarly, his speculation that all prosecuting attorneys in Idaho would interpret these scenarios the same way he does gives me no security. Implicit in prosecutorial discretion, is the fact that each prosecutor will decide for themselves whether to prosecute these cases, leaving medical providers unable to predict or know how each prosecuting attorney will proceed.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is to the best of my knowledge true and correct. Executed this 19th day of August 2022, in Boise, Idaho.

8/19/22
Date

Kylie Cooper
Kylie Cooper MD

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW MEMORANDUM DECISION AND ORDER

INTRODUCTION

Pregnant women in Idaho routinely arrive at emergency rooms experiencing severe complications. The patient might be spiking a fever, experiencing uterine cramping and chills, contractions, shortness of breath, or significant vaginal bleeding. The ER physician may diagnose her with, among other possibilities, traumatic placental abruption, preeclampsia, or a preterm premature rupture of the membranes. In those situations, the physician may be called upon to make complex, difficult decisions in a fast-moving, chaotic environment. She may conclude that the only way to prevent serious harm to the patient or save her life is to terminate the pregnancy—a devastating result for the doctor and the patient.

So the job is difficult enough as it is. But once Idaho Code § 18-622 goes into effect, the physician may well find herself facing the impossible task of attempting to simultaneously comply with both federal and state law. A decades-old federal law

known as the Emergency Medical Treatment and Labor Act (EMTALA) requires that ER physicians at hospitals receiving Medicare funds offer stabilizing treatment to patients who arrive with emergency medical conditions. But when the stabilizing treatment is an abortion, offering that care is a crime under Idaho Code § 18-622—which bans *all* abortions. If the physician provides the abortion, she faces indictment, arrest, pretrial detention, loss of her medical license, a trial on felony charges, and at least two years in prison. Yet if the physician does not perform the abortion, the pregnant patient faces grave risks to her health—such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, hypoxic brain injury, or even death. And this woman, if she lives, potentially may have to live the remainder of her life with significant disabilities and chronic medical conditions as a result of her pregnancy complication. All because Idaho law prohibited the physician from performing the abortion.

Granted, the Idaho statute offers the physician the cold comfort of a narrow affirmative defense to avoid conviction. But only if she convinces a jury that, in her good faith medical judgment, performing the abortion was "necessary to prevent the death of the pregnant woman" can she possibly avoid conviction. Even then, there is no certainty a jury will acquit. And the physician cannot enjoy the benefit of this affirmative defense if she performed the abortion merely to prevent serious harm to the patient, rather than to save her life.

Back to the pregnant patient in the emergency department. The doctor believes her EMTALA obligations require her to offer that abortion right now. But she also knows that all abortions are banned in Idaho. She thus finds herself on the horns of a dilemma. Which law should she violate?

Fortunately, the drafters of our Constitution had the wisdom to provide a clear answer in Article VI, Paragraph 2 of the Constitution—the Supremacy Clause. At its core, the Supremacy Clause says state law must yield to federal law when it's impossible to comply with both. And that's all this case is about. It's not about the bygone constitutional right to an abortion. This Court is not grappling with that larger, more profound question. Rather, the Court is called upon to address a far more modest issue—whether Idaho's criminal abortion statute conflicts with a small but important corner of federal legislation. It does.

As such, the United States has shown it will likely succeed on the merits. Given that—and for the reasons discussed in more detail below—the Court has determined it should preserve the status quo while the parties litigate this matter. The Court will therefore grant the United States' motion. During the pendency of this lawsuit, the State of Idaho will be enjoined from enforcing Idaho Code § 18-622 to the extent that statute conflicts with EMTALA-mandated care.

BACKGROUND

A. The Emergency Medical Treatment and Labor Act

Congress enacted EMTALA in 1986 with the overarching purpose of ensuring that all patients receive adequate emergency medical care—regardless of the patient's ability to pay and regardless of whether the patient qualifies for Medicare. *See Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001) (citation omitted). Under that Act, when a patient arrives at an emergency department and requests treatment, the hospital must provide an appropriate screening examination "to determine whether or not an emergency condition" exists. 42 U.S.C. § 1395dd(a). An "emergency medical condition" is defined to include:

> (A) 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 organ or part; . . .

42 U.S.C. § 1395dd(e)(1).[1] If a hospital determines that a patient has an emergency medical condition, it must examine the patient and provide stabilizing treatment at the hospital, although a transfer is permitted under certain circumstances. 42 U.S.C. § 1395dd(b)(1). Under EMTALA, stabilizing an emergency medical condition generally means providing medical treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during" a discharge or transfer to another facility. 42 U.S.C. § 1395dd(e).

EMTALA applies to every hospital that has an emergency department and participates in Medicare. *See* 42 U.S.C. § 1395cc(a)(1)(I). And a participating hospital that fails to comply with EMTALA's screening requirement, stabilizing treatment, or transfer provisions may be subject to civil monetary penalties up to $119,942 per violation. 42 U.S.C. § 1395dd(d)(1)-(2); 42 C.F.R. §1003.500 (2017). Likewise, treating physicians who violate EMTALA face civil monetary penalties of up to $119,942 per violation and exclusion from Medicare and state health care programs. 42 U.S.C. § 1395dd(d)(1); 42 C.F.R. §1003.500.

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[1] Sub-part (B) defines an emergency medical condition as it relates to "a pregnant woman having contractions," but that subsection is not relevant to the issues before the Court.

B. Idaho's Criminal Abortion Law[2]

Idaho Code § 18-622 is set to take effect on August 25, 2022. It provides that "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion." Idaho Code § 18-622(2). Abortion is defined as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." § 18-604(1). Pregnancy, in turn, is defined as "the reproductive condition of having a developing fetus in the body and commences at fertilization." § 18-604(11).

Criminal abortion is a felony punishable by at least two, and up to five, years' imprisonment. § 18-622(2). In addition, "any health care professional who performs or attempts to perform or who assists in performing or attempting to perform an abortion" faces professional licensure suspension for a minimum of six months upon a first offense and permanent revocation for subsequent offenses. *Id.*

The statute provides two affirmative defenses. As relevant here, an accused physician may avoid

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[2] Idaho has enacted a series of statutes criminalizing abortion. The statute at issue here—and referred to at times as the "criminal abortion law" or the "Total Abortion Ban"—is codified at Idaho Code § 18-622. Not at issue is the later-enacted *Fetal Heartbeat Preborn Child Protection Act*, codified at Idaho Code § 18-8801 to 18-8808. According to Idaho Code § 18-8805, if Idaho Code § 18-622 becomes enforceable, the penalties specified in the Heartbeat Act will be superseded by §18-622. *See* Idaho Code § 18-8805(4).

conviction by proving, by a preponderance of the evidence, that:

> (1) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman; and
>
> (2) The physician performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman.

Idaho Code § 18-622(3)(a)(ii) and (iii).

C. Facts

Idaho has roughly 22,000 births per year. Not surprisingly then, some patients will experience serious, pregnancy-related complications that qualify as an "emergency medical condition" under EMTALA. *See generally Fleisher Dec.* ¶ 12, Dkt. 17-3; *Corrigan Dec.* ¶¶ 9-30, Dkt. 17-6; *Cooper Dec.* ¶¶ 6-12, Dkt. 17-7; *Seyb Dec.* ¶¶ 4-13, Dkt. 17-8.

One relatively straightforward example is a patient who presents at an emergency department with an ectopic pregnancy. *Id.* ¶ 13. Accounting for about 2% of all reported pregnancies, ectopic pregnancies occur when an embryo or fetus grows outside of the uterus, most frequently in a fallopian

tube. *Ex. B. to Fleisher Dec.*, Dkt. 17-4, at 91. It is undisputed that an ectopic pregnancy in a fallopian tube is an emergency medical condition that places the patient's life in jeopardy. Left untreated it will cause the fallopian tube to rupture and, in the majority of cases, cause significant and potentially fatal internal bleeding. *See, e.g.*, *White Dec.* ¶ 3, Dkt. 66-1. Likewise, the parties do not dispute that the appropriate treatment for an ectopic pregnancy is either "emergency surgery and removal of the involved fallopian tube, including the embryo or fetus, or administration of a drug to cause embryonic or fetal demise." *Fleisher Dec.* ¶ 13, Dkt. 17-3. Still, though, during oral argument, the State conceded that the procedure necessary to terminate an ectopic pregnancy is a criminal act, given the broad definitions used in Idaho's criminal abortion statute.

In addition to ectopic pregnancies, there are many other complications that may arise during pregnancy—all of which may place the patient's health in serious jeopardy or threaten bodily functions. Despite the risks such conditions present, it is not always possible for a physician to know whether treatment for any particular condition, at any particular moment in time, is "necessary to prevent the death" of the pregnant patient, which is the prerequisite to their relying on the affirmative defense offered by the criminal abortion statute. *See Fleisher Dec.* ¶¶ 13-21, Dkt. 17-3. Some examples include the following scenarios:

- A patient arrives at an emergency room with nausea and shortness of breath, leading to a diagnosis of preeclampsia. Preeclampsia can

quickly progress to eclampsia, with the onset of seizures.

- A woman arrives at an emergency room with an infection after the amniotic sac surrounding the fetus has ruptured. That condition can progress into sepsis, at which point the patient's organs may fail.
- A patient arrives at the hospital with chest pain or shortness of breath, which leads the physician to discover elevated blood pressure or a blood clot.
- A patient arrives at the emergency room with vaginal bleeding caused by a placental abruption. Placental abruption is when the placenta partly or completely separates from the inner wall of the uterus. It can lead to catastrophic or uncontrollable bleeding. If the bleeding is uncontrollable, the patient may go into shock, which could result in organ disfunction such as kidney failure, and even cardiac arrest.

Id. ¶¶ 15-22.

Idaho physicians have submitted declarations describing specific patients who have presented with these types of complications and have required abortions.[3] Each of these conditions unquestionably

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[3] *See Corrigan Dec.* ¶¶ 9-30, Dkt. 17-6 (describing three patients who required abortions after experiencing, respectively, (1) severe infection due to premature rupture of the membranes; (2) placental abruption which other medications and blood products failed to mitigate; and (3) preeclampsia with pleural

qualifies as an "emergency medical condition" under EMTALA. Accordingly, if future patients with similar conditions presented at Medicare-funded hospitals, they would be entitled to the emergency care required by EMTALA—which will often include an emergency abortion.

The impact of Idaho's criminal abortion statute on the emergency care dictated by EMTALA is substantial. The United States has submitted declarations from four physicians practicing in Idaho who say that if Idaho Code § 18-622 goes into effect, they believe "there will be serious and negative consequences for patients and healthcare workers alike." *Corrigan Supp. Dec.* ¶ 13, Dkt. 86-3. Dr. Emily Corrigan, a board-certified Obstetrician-Gynecologist practicing at a Boise hospital, explains why this is so. First, she speaks specifically as to three recent patients—all of whom presented with emergency medical conditions and required an abortion. She says that for each of these patients, it was "medically impossible to say that death was the guaranteed outcome." *Id.* ¶ 8. Regarding Jane Doe 1, for example, she says that this patient "could have developed severe sepsis potentially resulting in catastrophic injuries such as septic emboli necessitating limb

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effusions and high blood pressure); *Cooper Dec.* ¶¶ 6-11, Dkt. 17-7 (describing three patients who required abortions after experiencing, respectively, (1) preeclampsia with severe features, (2) HELLP syndrome, and (3) lab abnormalities consistent with a diagnosis of HELLP syndrome); *Seyb Dec.* ¶¶ 7-13, Dkt. 17-8 (describing three patients who required abortions after experiencing, respectively, (1) a septic abortion, (2) preeclampsia with severe features, and (3) heavy vaginal bleeding).

amputations or uncontrollable uterine hemorrhage ultimately requiring hysterectomy but [she] could still be alive." *Id.* Jane Does 2 and 3 were in similar situations—they could have survived, but each "potentially would have had to live the remainder of their lives with significant disabilities and chronic medical conditions as a result of their pregnancy complication." *Id.*.

More broadly, Dr. Corrigan says that "while the State's physician declarations speak in terms of absolutes," in her view, "medicine does not work that way in most cases. Death may be a possible or even probable outcome, but different outcomes or conditions may also be probable. That is why doctors frequently refuse to answer the question, 'What are my chances?'" *Id.* ¶ 9.

Dr. Corrigan also points out that if Idaho Code § 18-622 goes into effect, patient care will be delayed. *Id.* ¶ 11. She says that, under Idaho's law, physicians must "wait until death is near-certain and in the meantime, the patient will experience pain and complications that may have lifelong disabling consequences." *Id.* Ultimately then, from her perspective, "[a] physician administering an emergency abortion in Idaho would be risking their professional license, livelihood, personal security, and freedom." *Id.*

Compliance with the EMTALA standards is significant to this state's health care system. In Idaho, there are thirty-nine hospitals that receive Medicare funding and provide emergency services. *Wright Dec.* ¶ 8, Dkt. 17-9. Between 2018 and 2020, these hospitals' emergency departments received

approximately $74 million in federal Medicare funding, which was conditioned on compliance with EMTALA. *Shadle Dec.* ¶ 6, Dkt. 17-10.

LEGAL STANDARD

The United States asks for a preliminary injunction to enjoin Idaho from enforcing its criminal abortion law to the extent it conflicts with EMTALA-mandated care. "A preliminary injunction is 'an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Fraihat v. United States Immigration & Customs Enf't*, 16 F.4th 613, 635 (9th Cir. 2021) (citation omitted).

To obtain relief, the United States must establish that: (1) it is likely to succeed on the merits; (2) it is likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in its favor; and (4) an injunction is in the public interest. *Winter v. NRDC*, 555 U.S. 7, 24 (2008). As to the last two factors, "[w]here the government is a party to a case in which a preliminary injunction is sought, the balance of the equities and public interest factors merge." *Padilla v. Immigration & Customs Enf't*, 953 F.3d 1134, 1141 (9th Cir. 2020).

"A district court has considerable discretion in granting injunctive relief and in tailoring its injunctive relief." *United States v. AMC Entm't, Inc.*, 549 F.3d 760, 768 (9th Cir. 2008). Generally, a court must ensure that the relief is "tailored to eliminate only the specific harm alleged" and not "overbroad." *E.&J. Gallo Winery v. Gallo Cattle Co.*, 967 F.2d 1280, 1297 (9th Cir. 1992). "[I]njunctive relief should be no more burdensome to the defendant than necessary to

provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979). And in the context of enjoining a state statute subjected to an as-applied challenge, the Supreme Court has said, "Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem. We . . . enjoin only the unconstitutional applications of a statute while leaving other applications in force." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328-29 (2006).

ANALYSIS

The key substantive question this Court must address is whether Idaho Code § 18-622 conflicts with certain requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. But before turning to that question, the Court will resolve three threshold issues: (1) whether the United States has a cause of action; (2) whether the United States has standing; and (3) whether the United States has mounted a facial or an as-applied attack to the challenged statute.

A. Cause of Action

The United States has the unquestioned authority to sue. It has asked this Court, sitting in equity, to partially enjoin the enforcement of Idaho Code § 18-622 because of its direct conflict with a federal statute. Such a Supremacy Clause claim fits squarely within causes of action the Supreme Court has recognized. As the Supreme Court explained in *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-

empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question." *Id.* at 96 n.14; *see also Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 326 (2015) ("[W]e have long recognized, if an individual claims federal law immunizes him from state regulation, the court may issue an injunction upon finding the state regulatory actions preempted."). Here, the United States has a cause of action because it seeks to halt Idaho's allegedly unconstitutional encroachment on EMTALA; it is not seeking to enforce federal law against would-be violators. This case is therefore distinct from the line of cases where plaintiffs challenge state administrative action taken under a particular statute, as opposed to challenging the validity of the state statute itself. *See*, *e.g.*, *Armstrong*, 575 U.S. at 324.

In a somewhat related argument, the State, in its briefing, attempted to raise[] serious concerns that EMTALA's required stabilizing treatment, as interpreted by the United States and expressed in this litigation, is invalid as coercive spending clause legislation." *State Br.*, Dkt. 66, at 19 n.10 (citing *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575-87 (2012)). To the extent this "concern" is an argument, it is not sufficiently developed here. *Cf. Indep. Towers of Wash. v. Washington*, 350 F.3d 925, 930 (9th Cir. 2003) ("We require contentions to be accompanied by reasons."). The State cannot challenge the constitutionality of a 35-year-old federal statute in a passing footnote. More importantly, deciding that question would "run contrary to the fundamental principle of judicial restraint that courts should

neither 'anticipate a question of constitutional law in advance of the necessity of deciding it' nor 'formulate a rule of constitutional law broader than is required by the precise facts to which it is to be applied.'" *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 450 (2008) (quoting *Ashwander v. TVA*, 297 U.S. 288, 346-47 (1936) (Brandeis, J., concurring)).

B. Standing

To establish standing, the United States must demonstrate that it has suffered an injury in fact that is fairly traceable to Idaho's actions and that will likely be redressed by a favorable decision from the Court. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).

Here, United States alleges at least three types of harm. First, the United States' sovereign interests are harmed when its laws are violated. *See Vt. Agency of Nat. Res. v. United States ex rel Stevens*, 529 U.S. 765, 771 (2000); *United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011), *rev'd in part on other grounds*, 567 U.S. 387 (2012). Second, if Idaho Code § 18-622 goes fully into effect, pregnant patients throughout Idaho will be denied EMTALA-mandated care. As a general principle, the United States may sue to redress widespread injuries to the general welfare. *In re Debs*, 158 U.S. 564, 584 (1895). Third, the United States has alleged that Idaho's law deprives it of the benefits of its bargain in that it has provided Medicare funding to hospitals within Idaho, and that funding was conditioned on those hospitals' compliance with EMTALA.

From there, the standing analysis is simple. The harms the United States alleges are traceable to

Idaho's actions in enacting and, soon, enforcing Idaho Code § 18-622. And the remedies sought here would redress the injury. The United States thus has established standing.

C. Facial versus As-Applied

"As a general matter, a facial challenge is a challenge to an entire legislative enactment or provision," *Hoye v. City of Oakland*, 653 F.3d 835, 857 (9th Cir. 2011), and a successful facial challenge "invalidates the law itself." *Italian Colors Restaurant v. Becerra*, 878 F.3d 1165, 1175 (9th Cir. 2018). An as-applied challenge, on the other hand, "challenges only one of the rules in a statute, a subset of the statute's applications, or the application of the statute to a specific circumstance." *Hoye*, 653 F.3d at 857. Thus, "a successful as-applied challenge invalidates only the particular application of the law." *Italian Colors*, 878 F.3d at 1175 (internal quotation and citation omitted).

Ultimately, though, "[t]he label is not what matters." *Doe v. Reed*, 561 U.S. 186, 194 (2010) (acknowledging that plaintiffs' claim had characteristics of both an as-applied and facial challenge). Rather, the "important" inquiry is whether the "claim and the relief that would follow . . . reach beyond the particular circumstances of the[ ] plaintiffs." *Id.* In other words, the distinction between the two types of challenges mainly goes to the breadth of the remedy.

Here, a quick skim of the United States' complaint reveals an as-applied challenge. In its prayer for relief, the United States asks the Court to issue a declaratory judgment stating that "Idaho Code

§ 18-622 violates the Supremacy Clause and is preempted and therefore invalid *to the extent that it conflicts with EMTALA*." *Compl.* ¶ 16, Dkt. 1 (emphasis added). The complaint repeats that limiting language in the prayer for injunctive relief. *Id.* And in moving for a preliminary junction, the United States once again—and repeatedly—clarified that it is seeking a limited form or relief. *See*, *e.g.*, *Mtn.*, Dkt. 17-1, at 8.

The State acknowledges this limiting language but nevertheless argues that the United States is bringing a facial challenge, based on the United States' argument that there is a conflict in *all* instances in which both EMTALA and Idaho Code § 18-622 apply. The State says this isn't so because, at times, the two statutes can operate harmoniously.

The Court does not find the State's argument persuasive because it has failed to properly account for the staggeringly broad scope of its law, which has been accurately characterized by this Court and the Idaho Supreme Court as a "Total Abortion Ban." *See Planned Parenthood Great Nw. v. Idaho*, --- P.3d ---, 2022 WL 3335696, at *1 (Idaho Aug. 12, 2022). As will be discussed more fully below, Idaho Code § 18-622 doesn't just criminalize EMTALA-mandated abortions; it criminalizes all abortions. So, in that sense, the United States has mounted a textbook, as-applied challenge focusing only on a particular application of the statute in a particular context. After all, Idaho Code § 18-622 will take effect on August 25, 2022, regardless. The United States is not trying to stop that. The only question this Court is addressing is whether the statute must include a

carve-out for EMTALA-mandated care. The United States has mounted an as-applied challenge.

Moreover, even if the Court were to construe the challenge as a facial one—focusing only on the subset of abortions EMTALA requires—the United States is still likely to succeed on the merits of its claim. As explained below, even within that subset there will always be a conflict between EMTALA and Idaho Code § 18-622.

D. Likelihood of Success on the Merits

With these threshold questions resolved, the Court turns to whether the United States is entitled to a preliminary injunction. The first question—whether the United States is likely to succeed on the merits—is the most important. *California v. Azar*, 950 F.3d 1067, 1083 (9th Cir. 2020). To resolve that question, the Court is guided by the Supremacy Clause and basic preemption principles.

1. The Supremacy Clause & Preemption

The Supremacy Clause provides that federal law "shall be the supreme Law of the Land." U.S. Const. art. VI, cl. 2. "Congress may consequently pre-empt, *i.e.*, invalidate, a state law through federal legislation." *Oneok, Inc. v. Learjet, Inc.*, 575 U.S. 373, 376 (2015).

In EMTALA, Congress indicated its intent to displace state law through an express preemption provision, which says EMTALA preempts state law only "to the extent that the [state law] requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f). The Ninth Circuit has construed EMTALA's "directly conflicts" language as

referring to two types of preemption—impossibility preemption and obstacle preemption. *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993). Impossibility preemption occurs, straightforwardly, "where it is impossible for a private party to comply with both state and federal law." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000). And obstacle preemption exists where state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 373.

2. Impossibility Preemption

Here, it is impossible to comply with both statutes. As already discussed, when pregnant women come to a Medicare-funded hospital with an emergency medical condition, EMTALA obligates the treating physician to provide stabilizing treatment, including abortion care. But regardless of the pregnant patient's condition, Idaho statutory law makes that treatment a crime. Idaho Code § 18-622(2). And where federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws. Full stop.

The statute's affirmative defense does not cure the impossibility. An affirmative defense is an excuse, not an exception. The difference is not academic. The affirmative defense admits that the physician committed a crime but asserts that the crime was justified and is therefore legally blameless. And it can only be raised after the physician has already faced indictment, arrest, pretrial detention, and trial for every abortion they perform. *See generally United States v. Sisson*, 399 U.S. 267, 288 (1970) (indictments

need not anticipate affirmative defenses). So even though accused healthcare workers might avoid a conviction, the statute still makes it impossible to provide an abortion without also committing a crime.

Moreover, even taking the affirmative defense into account, the plain language of the statutes demonstrates that EMTALA requires abortions that the affirmative defense would not cover. When an abortion is the necessary stabilizing treatment, EMTALA directs physicians to provide that care if they reasonably expect the patient's condition will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious jeopardy to the patient's health. 42 U.S.C. § 1395dd(3)(1). In contrast, the criminal abortion statute admits to no such exception. It only justifies abortions that the treating physician determines are *necessary* to prevent the patient's death. Idaho Code § 18-622(a)(ii) (emphasis added). According to the dictionary, the word "necessary" means something is "needed" or "essential." *See Necessary*, Black's Law Dictionary (11th ed. 2019). And the Idaho Supreme Court has said that "[w]hen engaging in statutory interpretation," it "begins with the dictionary definitions of disputed words or phrases contained in the statute." *Idaho v. Clark*, 484 P.3d 187, 192 (Idaho 2021). Thus, an abortion is only justified under the statute if the treating physician can persuade the jury that she made a good faith determination that the patient would have died if the abortion had not been performed.

EMTALA is thus broader than the affirmative defense on two levels. First, it demands abortion care to prevent injuries that are more wide-ranging than

death. Second, and more significantly, it calls for stabilizing treatment, which of course may include abortion care—when harm is probable, when the patient could "reasonably be expected" to suffer injury. In contrast, to qualify for the affirmative defense, the patient's death must be imminent or certain absent an abortion. It is not enough, as the Legislature has argued, for a condition to be life-threatening, which suggests only the *possibility* of death. *See Life-Threatening*, Black's Law Dictionary (11th ed. 2019) ("illness, injury, or danger that *could* cause a person to die") (emphasis added).

Finally, as the Court discusses further below, when the defense is put up against the realities of medical judgments, its scope is tremendously ambiguous. Although this makes it difficult to determine whether some abortions would qualify for both the affirmative defense and be mandated by EMTALA, that question is ultimately immaterial to the Court's determination that it is impossible for physicians to comply with both statutes.

Seeking to skirt the conflict between federal and state law, the Legislature advances three main points. First, the Legislature submits declarations from two physicians who offer up opinions as to what Idaho Code § 18-622 means. They say that terminating a pregnancy to save the life of the pregnant woman is *never* considered an abortion under Idaho law. *French Dec.* ¶¶ 14, 17, Dkt. 71-5; *Reynolds Dec.* ¶ 12, Dkt. 71-1. But as already discussed, on its face, the Idaho law criminalizes *all* procedures *intended* to terminate a pregnancy, even if necessary to save the patient's life or to preserve her health. *See* Idaho Code § 18-604(1). And it should go

without saying that Idaho law controls the inquiry on this point—not the medical community. Indeed, if anything, this argument crystallizes the conflict between Idaho law and EMTALA: Idaho law criminalizes as an "abortion" what physicians in emergency medicine have long understood as both life- and health-preserving care.

The Legislature's primary example of ectopic pregnancies as falling outside the statutory prohibition further reveals the fallacy of their argument: Idaho law expressly defines "pregnancy" as "having a developing fetus in the body" and commencing at fertilization. Idaho Code § 18-604(11). This plain language, which refers to "the body," rather than the uterus, and "fertilization" rather than implantation, evinces the Legislature's intent to include ectopic pregnancies within the statutory definition of "pregnancy." *See Worley Highway Dist. v. Kootenai Cnty.*, 576 P.2d 206, 209 (Idaho 1978). As such, termination of an ectopic pregnancy falls within the definition of an "abortion." The Legislature cannot avoid the effect of its chosen statutory language by relying on the medical community's definition of what is (and what is not) an abortion.

The Legislature next says that terminations of ectopic pregnancies—or any other, similar lifesaving procedures—do not fall within the scope of the statute because such terminations are "covered" by the exemption of Idaho Code § 18-622(4). *See French Dec.* ¶ 15, Dkt. 71-5. This sub-section exempts from the statute's prohibitions medical treatment provided to pregnant women that results in the "*accidental* death" or "*unintentional* injury" to the fetus. Idaho Code § 18-622(4). But certain pregnancy-related

conditions, such as ectopic pregnancy, require pregnancy termination to preserve a patient's health or save her life—and the "death" or "injury" to the "unborn child" in that situation will be neither accidental nor unintentional. *See Cooper Dec.* ¶ 3, Dkt. 17-6; *Fleisher Dec.* ¶ 13, Dkt. 17-3; *Seyb Dec.* ¶ 6, Dkt. 17-8. It is therefore nonsensical to classify it as such, simply because the pregnancy was terminated to save the life or health of the mother.

Second, during oral argument, the Legislature acknowledged the "conceptual textual conflicts" between § 18-622 and EMTALA but entreated the Court to ignore the Idaho statute's text and focus instead on "what happens in the real world." Even if the Court accepted this invitation to ignore what the law says, the Legislature's speculations about how the law will work in practice are belied by the actual, "real-life" experience of medical professionals in Idaho who regularly treat women in these situations. They conclude that emergency care normally provided to pregnant patients will be made criminal by the plain language of § 18-622, which will, in turn, hinder their ability to provide that care if the law goes into effect. *See Corrigan Dec.* ¶¶ 31-35, Dkt. 17-6; *Cooper Dec.* ¶ 12, Dkt. 17-7; *Seyb Dec.* ¶ 13, Dkt. 17-8. As one Idaho physician testified, OB/GYN physicians in Idaho have been "bracing for the impact of this law, as if it is a large meteor headed towards Idaho." *Supp. Cooper Dec.* ¶ 13, Dkt. 86-3. More fundamentally, if the law does not mean what it says, why have it at all?

In short, given the extraordinarily broad scope of Idaho Code § 18-622, neither the State nor the Legislature have convinced the Court that it is

possible for healthcare workers to simultaneously comply with their obligations under EMTALA and Idaho statutory law. The state law must therefore yield to federal law to the extent of that conflict.

3. Obstacle Preemption

Moreover, even if it were theoretically possible to simultaneously comply with both laws, Idaho law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Crosby*, 530 U.S. at 373. To be sure, the Supreme Court has cautioned that "a high threshold must be met if a state law is to be pre-empted for conflicting with the purposes of a federal Act." *Chamber of Commerce of the United States v. Whiting*, 563 U.S. 582, 607 (2011) (citation and quotation omitted). Nevertheless, that threshold is met when it is plain that "Congress made 'a considered judgment' or 'a deliberate choice' to preclude state regulation" because "a federal enactment clearly struck a particular balance of interests that would be disturbed or impeded by state regulation." *In re Volkswagen "Clean Diesel" Mktg., Sales Practices, & Prods. Liab. Litig.*, 959 F.3d 1201, 1212 (9th Cir. 2020) (quoting *Arizona*, 567 U.S. at 405).

"The first step in the obstacle preemption analysis is to establish what precisely were the purposes and objectives of Congress in enacting" the statute at issue. *Chamber of Commerce v. Bonta*, 13 F.4th 766, 778 (9th Cir. 2021). For nearly four decades, EMTALA has served as the bedrock for the emergency-care safety net. Congress enacted EMTALA primarily because it was "concerned that medically unstable patients are not being treated

appropriately" including in "situations where treatment was simply not provided." H.R. Rep. No. 99-241, Pt. I, at 27 (1985). Congress's clear purpose was to establish a bare minimum of emergency care that would be available to all people in Medicare-funded hospitals. *See Arrington v. Wong*, 237 F.3d 1066, 1073-74 (9th Cir. 2001).

Congress chose to use "federal sanctions" to ensure that emergency screening and treatment was available for "all individuals for whom care is sought." H.R. Rep. No. 99-241, Pt. III, at 4-5 (1985). But Congress was mindful that overly severe sanctions might lead "some hospitals, particularly those located in rural or poor areas, [to] decide to close their emergency rooms entirely rather than risk the . . . penalties that might ensue." *Id.* at 6. Notably, Congress took care to avoid sanctions that would "result in a decrease in available emergency care, rather than an increase in such care, which appears to have been the major goal of [EMTALA]." *Id.*

Here, Idaho's criminal abortion statute, as currently drafted, stands as a clear obstacle to what Congress was attempting to accomplish with EMTALA. As discussed below, Idaho's criminal abortion law will undoubtedly deter physicians from providing abortions in some emergency situations. That, in turn, would obviously frustrate Congress's intent to ensure adequate emergency care for all patients who turn up in Medicare-funded hospitals.

a. **Idaho Code § 18-622 Deters Abortions**

It goes without saying that all criminal laws have some deterrent effect. But the structure of Idaho's criminal abortion law—specifically that it provides

for an affirmative defense rather than an exception—compounds the deterrent effect and increases the obstacle it poses to achieving the goals of EMTALA.

For one, the process of enduring criminal prosecution and licensing authority sanctions has a deterrent effect, regardless of the outcome. As Dr. Corrigan aptly explained, "[h]aving to defend against such a case would be incredibly burdensome, stressful, costly." *Corrigan Dec.* ¶ 10, Dkt. 17-6. By criminalizing all abortions, Idaho guarantees that physicians will have to accept this hardship every time they perform an abortion. The result is reluctance to perform abortions in any circumstances.

The uncertain scope of the affirmative defense intensifies that result. Providers who might be willing to depend on the affirmative defense do not have the clarity to do so because of the statute's ambiguous language and the complex realities of medical judgments.

Consider what a defendant-physician needs to prove to avail herself of the affirmative defense. The core of the affirmative defense at issue requires the defendant-physician to show she determined "the abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2). In that sense, the defense is objective—either the defendant-physician made the determination, or she did not. Yet the nature of that determination—how imminent a patient's death must before an abortion is necessary—is inscrutable.

Applying the standard to another medical context shows its ambiguity. Say a sovereign adopted a law that allowed oncologists to provide cancer treatment

"only when necessary to prevent death." Under that standard, oncologists would likely feel comfortable providing care to a patient with a stage four terminal cancer diagnosis. But what about a patient with stage one cancer? On the one hand, treatment may be lawful because the patient has a condition that, left untreated, will eventually, almost certainly cause death. On the other hand, the patient is not in danger of dying soon, so perhaps the oncologist needs to withhold treatment until the cancer progresses to the point where treatment is more obviously necessary to prevent death.

Idaho physicians treating pregnant women face this precise dilemma. As Dr. Cooper puts it, "For those patients who are clearly suffering from a severe pregnancy related illness and for which there is a clear indicated treatment, but death is not imminent, it is unclear whether I should provide the appropriate treatment because the circumstances may not justify the affirmative defense." *See Cooper Supp. Dec.* ¶ 2, Dkt. 86-5. In other words, when, precisely, does the "necessary-to-prevent-death" language apply? Healthcare providers can seldom know the imminency of death because medicine rarely works in absolutes. *Corrigan Supp. Dec.* ¶ 9, Dkt. 86-3. Instead, physicians treat patients whose medical risks "exist along a continuum" without bright lines to specify "when exactly a condition becomes 'life-threatening' or 'necessary to prevent the death' of the pregnant patient." *Fleisher Supp. Dec.* ¶ 7, Dkt. 86-2; *see also Seyb Dec.* ¶ 13, Dkt. 17-8 (explaining that "'prevent the death of the pregnant woman'" standard is not useful because "this is not a dichotomous variable"). Faced with these limitations, physicians

provide care by making "educated guess[es] . . . . [b]ut we can only rarely predict with certainty a particular outcome." *Corrigan Supp. Dec.* ¶ 9, Dkt. 86-3. Because medical needs present on a spectrum, in a given moment of decision, "[d]eath may be a possible or even probable outcome, but different outcomes may also be possible or probable." *Id.*

But the affirmative defense is only available to physicians once they make that often "medically impossible" determination that "death [i]s the guaranteed outcome." *Corrigan Supp. Dec.* ¶ 8; *see also ACEP et al Amicus Br.*, Dkt. 62 at 6 (describing the affirmative defense as "a legislatively imagined but medically nonexistent line"); *Fleisher Dec.* ¶ 12, Dkt. 17-3 ("[I]n some cases where the patient's health is unambiguously threatened, it may be less clear whether there is also a certainty of death without stabilizing treatment—and a physician may not ever be able to confirm whether death would result absent immediate treatment.").

In short, against the backdrop of these uncertain, medically complex situations, the affirmative defense is an empty promise—it does not provide any clarity. The upshot of this uncertainty is that even those providers willing to risk prosecution if they were confident in the availability of the affirmative defense will be deterred from providing emergency abortion care under EMTALA, where the availability of the defense is so uncertain.

And the Legislature cannot step in and say there is no obstacle to providing EMTALA-mandated care—that these Idaho healthcare workers may comfortably forge ahead and provided emergency abortions—

based on its assertion that Idaho prosecutors would not enforce the law as written.[4] The Legislature supports this argument with a single declaration from a single county prosecutor, who said he "would not prosecute any health care professional based on facts like those set forth in [the United States'] declarations, and that he "believe[s] no Idaho prosecuting attorney would do so." *Loebs Dec.* ¶ 7, Dkt. 71-6. But Idaho prosecutors have a statutory duty "to prosecute *all* felony criminal actions." Idaho Code § 31-2604(2) (emphasis added). And this one prosecutor lacks the authority to bind the other forty-three elected county prosecutors, let alone grand juries or citizens who might independently seek to initiate criminal proceedings, or any of the disciplinary boards that might pursue license revocation proceedings. *Cf.* Idaho Code § 19-1108 (grand juries); *Idaho v. Murphy*, 584 P.2d 1236, 1241 (Idaho 1978) (citizen complaints); § 18-622(2).

One prosecutor's promise to refrain from enforcing the law as written, therefore, offers little solace to physicians attempting to navigate their way around both EMTALA and Idaho's criminal abortion

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[4] The Legislature also submitted a declaration from a Nevada doctor who opines that the standard laid out in Idaho Code § 18-622 "provides a clear and workable standard" and that "physicians may proceed without the kinds of subjective 'fears' and 'chillings' suggested in the declarations of the three Idaho doctors.'" *Reynolds Dec.* ¶¶ 9-10, Dkt. 71-1. The Court does not find this assertion persuasive. At best, it's a difference of opinion—some doctors will be chilled; some won't. On balance, and based on the factual record before it, the Court finds that if Idaho Code §18-622 goes into effect, physicians practicing in Idaho are likely to be deterred from providing EMTALA-mandated care, including emergency abortions.

laws—and whose "professional license, livelihood, personal security, and freedom" are on the line. *Corrigan Supp. Dec.* ¶ 11, Dkt. 86-3 ("Our malpractice insurance may not cover us for performing an act that some may view as a crime."). Indeed, the Ninth Circuit has expressly rejected the argument that courts may uphold a law merely because the enacting authority promises to enforce it only to the extent it is consistent with federal law. *United States v. City of Arcata*, 629 F.3d 986, 992 (9th Cir. 2010) (holding officials' "promise of self-restraint does not affect our consideration of the ordinances' validity" under preemption doctrine). Physicians performing health- or life-saving abortions should not be left to "the mercy of *noblesse oblige*." *Powell's Books, Inc. v. Kroger*, 622 F.3d 1202, 1215 (9th Cir. 2010) (citation omitted) ("We may not uphold the statutes merely because the state promises to treat them as properly limited.").

b. **Deterring Abortions is an Obstacle to EMTALA**

The clear and intended effect of Idaho's criminal abortion law is to curb abortion as a form of medical care. This extends to emergency situations, obstructing EMTALA's purpose. Idaho's choice to impose severe and sweeping sanctions that decrease the overall availability of emergency abortion care flies in the face of Congress's deliberate decision to do the opposite.

The primary obstacle is delayed care. Under the status quo, physicians "rely upon their medical judgement or best practices for handling pregnancy complications." *Seyb Dec.* ¶ 13, Dkt. 17-8. But because

of the criminal abortion statute, "providers will likely delay care for fear of criminal prosecution and loss of licensure." *Id.*; *see also Cooper Supp. Dec.* ¶ 7, Dkt. 86-5 ("provider fear and unease is real and widespread"). The incentive to do so is obvious—delaying care so that the patient gets nearer to death and thus closer to the blurry line of the affirmative defense. Providers may also delay care to allow extra time to consult with legal experts. *See*, *e.g.*, *Corrigan Dec.* ¶¶ 25, Dkt. 17-6.

Delayed care is worse care. "The goal in medicine is to effectively identify problems and treat them promptly so patients are stabilized *before* they develop a life-threatening emergency. The Idaho law requires doctors to do the opposite—to wait until abortion is necessary to prevent the patient's death. *See Huntsberger Dec.* ¶ 12, Dkt. 86-4. Rather than providing the stabilizing treatment that EMTALA calls for, Idaho subjects women in medical crisis to periods of "serious physical and emotional trauma" as they wait to get nearer and nearer to death. *Corrigan Supp. Dec.* ¶ 13, Dkt. 86-3.

The wait for care is troubling enough on its own. Even worse, delayed care worsens patient outcomes. As a result of delay, "[p]atients may experience serious complications, have negative impacts on future fertility, require additional hospital resources including blood products, and some patients may die." *Huntsberger Dec.* ¶ 15, Dkt. 86-4. A recent study of maternal morbidity in Texas confirms this. When a pregnant woman with specific pregnancy complications was treated with "the standard protocol of terminating the pregnancy to preserve the pregnant patient's life or health," the rate of serious

maternal morbidity was 33 percent. *California et al Amicus Br.*, Dkt. 59 at 21.[5] That rate reached 57 percent, nearly doubling, when providers used "an expectant-management approach," meaning the physician provided "observation-only care until serious infection develops or the fetus no longer has cardiac activity." *Id.*

These delays in providing care frustrate EMTALA in two ways. First, delays frustrate Congress's intent to eliminate situations where treatment was simply not provided by providing for basic emergency treatment. Second, the worsened patient outcomes offend EMTALA's core purpose of ensuring that the most vulnerable people were not left to suffer catastrophic outcomes because of indifference from physicians—or, in this case, obstacles created by the State.

Another effect of Idaho's criminal abortion law is that it will likely make it more difficult to recruit OB/GYNs, who are on the front lines of providing abortion care in emergency situations. Because Idaho does not have in-state training for the specialty, all OB/GYNs must be recruited to come here. *Seyb Dec.* ¶ 14, Dkt. 17-8. But if these newly trained physicians "can practice in a state without these conflicts and risks, it is only natural that they would be deterred from practicing here." *Id.* By extension, OB/GYNs who are already practicing here may choose to leave

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[5] Citing Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, Am. J. Obstetrics & Gynecology (forthcoming 2022) (internet).

or to change the nature of their practice. *See*, *e.g.*, *Corrigan Dec.* ¶ 32, Dkt. 17-6. In both cases, the end result is fewer providers performing health and life-saving abortions. This, again, is an obstacle to EMTALA because it disrupts Congress's careful balance to avoid overly severe sanctions that could lead to providers deciding not to provide emergency care.

In sum, cutting back on emergency abortion care quantitatively and qualitatively is a plain obstacle to EMTALA, which Congress enacted to ensure that all individuals—including pregnant women—have access to a minimum level of emergency care.

E. Likelihood of Irreparable Harm

Having concluded that that the United State is likely to succeed on the merits of its claims, the Court turns to whether the United States has shown it is likely to suffer irreparable harm in the absence of an injunction.

The United States has met that burden, as Supremacy Clause violations trigger a presumption of irreparable harm when the United States is a plaintiff. *See generally United States v. Arizona*, 641 F.3d 339, 366 (9th Cir. 2011), *rev'd in part on other grounds*, 567 U.S. 387 (2012) ("[A]n alleged constitutional infringement will often alone constitute irreparable harm.") (citation omitted). As one court has explained, "The United States suffers injury when its valid laws in a domain of federal authority are undermined by impermissible state regulations." *United States v. Alabama*, 691 F.3d 1269, 1301 (11th Cir. 2012).

And so it is here. If Idaho's criminal abortion statute is allowed to go fully into effect, federal law will be significantly frustrated—as discussed in detail above. Most significantly, allowing the criminal abortion ban to take effect, without a cutout for EMTALA-required care, would inject tremendous uncertainty into precisely what care is required (and permitted) for pregnant patients who present in Medicare-funded emergency rooms with emergency medical conditions. *See generally United States v. South Carolina*, 840 F. Supp. 2d 898, 925 (D.S.C. 2011) (finding irreparable harm where state immigration law "could create a chaotic situation in immigration enforcement"). The net result—discussed further in the next section—is that these patients could suffer irreparable injury in the absence of an injunction.

F. The Balance of Equities and the Public Interest

The next question is whether the balance of equities tips in the United States' favor and whether an injunction is in the public interest. As noted above, because the United States is a party, these two factors merge. The key consideration here is what impact an injunction would have on non-parties and the public at large. *Bernhardt v. L.A. Cnty.*, 339 F.3d 920, 931 (9th Cir. 2003).

Looking first to the public at large, in the most general sense, "preventing a violation of the Supremacy Clause serves the public interest." *United States v. California*, 921 F.3d 865, 893-94 (9th Cir. 2019) (citing *Arizona*, 641 F.3d at 366). As the Ninth Circuit has explained, "it is clear that it would not be

equitable or in the public's interest to allow the state to violate the requirements of federal law, especially when there are no adequate remedies available. In such circumstances, the interest of preserving the Supremacy Clause is paramount." *Arizona*, 641 F.3d at 366 (cleaned up, citations omitted).

Next, based on the various declarations submitted by the parties, the Court finds that allowing the Idaho law to go into effect would threaten severe, irreparable harm to pregnant patients in Idaho. Speaking of patients, although the parties and the Court have often focused mainly on the actions and competing interests of doctors, prosecutors, legislators, and governors, we should not forget the one person with the greatest stake in the outcome of this case—the pregnant patient, laying on a gurney in an emergency room facing the terrifying prospect of a pregnancy complication that may claim her life. One cannot imagine the anxiety and fear she will experience if her doctors feel hobbled by an Idaho law that does not allow them to provide the medical care necessary to preserve her health and life. From that vantage point, the public interest clearly favors the issuance of a preliminary injunction.

In that regard—and as discussed at some length above—the United States has submitted declarations from physicians explaining that there are any number of pregnancy-related complications that require emergency care mandated by EMTALA but that are forbidden by Idaho's criminal abortion law. Idaho physicians have treated such complications in the past, and it is inevitable that they will be called upon to do so in the future. Not only would Idaho Code § 18-622 prevent emergency care mandated by EMTALA,

it would also discourage healthcare professionals from providing *any* abortions—even those that might ultimately be deemed to have been necessary to save the patient's life—given the affirmative-defense structure already discussed. Finally, if the abortion ban laid out in the Idaho statute goes into effect, the capacity of hospitals in neighboring states that do not prohibit physicians from providing EMTALA-mandated care (Washington and Oregon, for example)—would be pressured as patients may choose to cross state lines to get the emergency care they are entitled to receive under federal law. *See* Dkt. 45-1, at 16-17.

Turning to the other side of the equitable balance sheet, the State of Idaho will not suffer any real harm if the Court issues the modest preliminary injunction the United States is requesting. In fact, as a practical matter, the State (and, to a much greater extent, the Legislature) argue that physicians who perform the types of emergency abortions at issue here won't violate Idaho law anyway; therefore, by their own reasoning, they will suffer no harm if enforcement of § 18-622 is enjoined on this limited basis. And although the State has argued that in the wake of *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), the public interest lies in allowing states to regulate abortions, *Dobbs* did not overrule the Supremacy Clause. Thus, even when it comes to regulating abortion, state law must yield to conflicting federal law. As such, the public interest lies in favor of enjoining the challenged Idaho law to the extent it conflicts with EMTALA.

ORDER

IT IS ORDERED that:

1. Plaintiff's motion for a preliminary injunction (Dkt. 17) is **GRANTED**.

2. The Court hereby restrains and enjoins the State of Idaho, including all of its officers, employees, and agents, from enforcing Idaho Code § 18-622(2)-(3) as applied to medical care required by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. Specifically, the State of Idaho, including all of its officers, employees, and agents, are prohibited from initiating any criminal prosecution against, attempting to suspend or revoke the professional license of, or seeking to impose any other form of liability on, any medical provider or hospital based on their performance of conduct that (1) is defined as an "abortion" under Idaho Code § 18-604(1), but that is necessary to avoid (i) "placing the health of" a pregnant patient "in serious jeopardy"; (ii) a "serious impairment to bodily functions" of the pregnant patient; or (iii) a "serious dysfunction of any bodily organ or part" of the pregnant patient, pursuant to 42 U.S.C. § 1395dd(e)(1)(A)(i)-(iii).

3. This preliminary injunction is effective immediately and shall remain in full force and effect through the date on which judgment is entered in this case.

DATED: August 24, 2022

B. Lynn Winmill
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-329

SECOND SUPPLEMENTAL DECLARATION OF LEE A. FLEISHER, M.D.

I, Lee A. Fleisher, M.D., of the Centers for Medicare & Medicaid Services (CMS), declare that the following statements are true and correct to the best of my knowledge and belief, and that they are based on my personal knowledge as well as information provided to me in the ordinary course of my official duties. The following statements are provided as a supplement to the prior written testimony that I submitted in relation to this case on August 8, 2022.

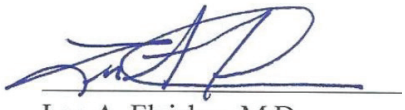
1. In my first declaration submitted in this case, in paragraph 36, I reported the number of claims that were made to Medicaid and the Children's Health Insurance Program ("CHIP") for ectopic pregnancies within the State of Idaho for the years 2018 through 2021. As stated in that paragraph, those numbers were 98 for 2018; 72 for 2019; 103 for 2020; and 108 for 2021.

2. Those numbers are accurate with respect to the overall number of *claims* submitted to Medicaid/CHIP for ectopic pregnancies. In the course of further analyzing this data after my initial declaration was submitted, however, HHS determined that the initial data did not fully de-duplicate beneficiaries who had multiple claims related to a single pregnancy. In some cases, particularly for services delivered in a hospital setting, a single episode of care can generate multiple claims from different providers involved in rendering care (for instance, one claim from the hospital, and a wholly separate medical claim from the physician performing a procedure).

3. HHS thereafter sought to fully de-duplicate the claims data, such that each Medicaid/CHIP beneficiary is counted only once per year regardless of how many claims for a pregnancy termination are found for the beneficiary. This de-duplicated data would more accurately reflect the discrete number of ectopic pregnancies within the State of Idaho for Medicaid/CHIP beneficiaries, as opposed to the overall number of claims submitted in connection with ectopic pregnancies.

4. I am informed that HHS has determined, based on the fully de-duplicated data, that the number of discrete ectopic pregnancies reflected in Medicaid/CHIP claims data are as follows: 66 in 2018; 48 in 2019; 76 in 2020; and 73 in 2021.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 15 day of September, 2022 in Philadelphia, PA.



Lee A. Fleisher, M.D.

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant, SCOTT BEDKE, in his official capacity as Speaker of the House of Representatives of the State of Idaho; CHUCK WINDER, in his capacity as President Pro Tempore of the Idaho State Senate; and the SIXTY-SIXTH IDAHO LEGISLATURE, Intervenor-Defendants	Case No. 1:22-cv-00329-BLW **MEMORANDUM DECISION AND ORDER**

INTRODUCTION

Idaho Code § 18-622 makes it a felony for anyone to perform or attempt to perform or assist with an abortion. Idaho Code § 18-622(2). The law, which the Idaho Supreme Court refers to as the "Total Abortion Ban," criminalizes *all* abortions, without exception – offering only the "cold comfort" of two narrow affirmative defenses. *Memorandum Decision and Order dated August 24, 2022*, p. 1, Dkt. 95. As relevant here, an accused physician may avoid

conviction when the physician determines in her good faith medical judgment that the abortion is necessary to prevent the death of a pregnant woman. *Id.* § 18-622(3). The affirmative defense does not protect a physician who performs an abortion "merely" to prevent serious harm to the patient, rather than to save her life. Nor does the affirmative defense insulate the physician from criminal *prosecution* under any circumstances. Instead, it shifts the burden of proof from the prosecution to the criminal defendant to prove at trial that the abortion was necessary to prevent the death of the mother – in a sense, presuming the defendant guilty until she proves herself innocent.

The Total Abortion Ban, even before it went into effect, has engendered various legal challenges in both federal and state court. In this Court, the United States sued to enjoin the ban to the extent it conflicted with the federal Emergency Medical Treatment and Labor Act ("EMTALA"), which requires hospitals that accept Medicare funds to offer stabilizing treatment—including, in some cases, treatment that would be considered an abortion—to patients who present at emergency departments with emergency medical conditions. Because the Total Abortion Ban criminalizes medical care that federal law requires hospitals to offer, this Court enjoined Idaho Code § 18-622 to the extent it conflicts with EMTALA. *See Memorandum Decision and Order, dated August 24, 2022* ("*August 24, 2022 Injunction*"). Rather than appealing this decision the State of Idaho and the Idaho Legislature have filed motions for reconsideration, which are now pending before the Court. (Dkt. 97 & 101).

Parallel to this litigation, a challenge to the constitutionality of the ban under the Idaho Constitution proceeded separately before the Idaho Supreme Court. *Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky. v. State ("Planned Parenthood")*, Idaho Supreme Court Docket No. 49817-2022 (Idaho June 27, 2022) (Petition for Writ of Prohibition). On January 5, 2023, while the motions for reconsideration remained pending, the Idaho Supreme Court issued its decision in *Planned Parenthood*, upholding the constitutionality of the Total Abortion Ban under the Idaho Constitution. *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132 (2023). The Idaho Supreme Court also construed the scope of Idaho's Total Abortion Ban in rendering its decision.

After the Idaho Supreme Court issued its decision in *Planned Parenthood*, both the State and the Legislature requested to file supplemental briefing in support of their motions for reconsideration. This Court granted their request. Now, in addition to their arguments raised in their initial round of briefing, both the State and the Legislature argue that the *Planned Parenthood* decision eliminated any conflict between EMTALA and the Total Abortion Ban, obviating any need for the preliminary injunction entered in this case. *See* Dkts. 126, 127. As explained below, the Court will deny the motions for reconsideration.

ANALYSIS

1. Motion to Reconsider Standard

"Reconsideration is an extraordinary remedy, to be used sparingly in the interests of finality and

conservation of judicial resources." *Adidas Am., Inc. v. Payless Shoesource, Inc.*, 540 F. Supp. 2d 1176, 1179 (D. Or. 2008) (quoting *Kona Enterprises, Inc. v. Estate of Bishop*, 229 F.3d 877, 890 (9th Cir. 2000)) (internal quotation marks omitted); *see also Carroll v. Nakatani*, 342 F.3d 934, 945 (9th Cir. 2003). A motion to reconsider should therefore be granted only if the moving party can show an intervening change in controlling law, new evidence has become available, or the district court committed clear error, or the initial decision was manifestly unjust. *See Cachil Dehe Band of Wintun Indians of Colusa Indian Community v. California*, 649 F.Supp.2d 1063, 1069-70 (E.D. Cal. 2009) (citing *Sch. Dist. No. 1J Multnomah County, Or. v. ACandS, Inc.*, 5 F.3d 1255, 1263 (9th Cir. 1993)).

"Motions for reconsideration are generally disfavored, and, in the absence of new evidence or change in the law, a party may not use a motion to reconsider to present new arguments or evidence that could have been raised earlier." *Adidas*, 540 F. Supp. 2d at 1180 (citing *Fuller v. M.G. Jewelry*, 950 F.2d 1437, 1442 (9th Cir. 1991)). "Motions to reconsider are also not vehicles permitting the unsuccessful party to 'rehash' arguments previously presented." *Cachil Dehe Band*, 649 F. Supp. 2d at 1069–70 (quoting *United States v. Navarro*, 972 F.Supp. 1296, 1299 (E.D.Cal.1997), *rev'd on other grounds*, 160 F.3d 1254 (9th Cir. 1998) (internal quotation marks omitted)). "Ultimately, a party seeking reconsideration must show more than a disagreement with the Court's decision, and recapitulation of the cases and arguments considered by the court before rendering its original decision fails to carry the moving party's

burden." *Id.* (quoting *United States v. Westlands Water Dist.*, 134 F. Supp. 2d 1111, 1131 (E.D.Cal. 2001). (internal quotation marks omitted)).

2. The Legislature and State Fail to Meet the Demanding Standard for Reconsideration in their Initial Briefing.

The Legislature and the State's motions fail to meet the demanding standard the Ninth Circuit has set for succeeding on reconsideration. In their original round of briefing on their motions to reconsider, the Legislature and the State do not identify an intervening change in controlling law or newly discovered evidence. Instead, they argue that this Court "committed clear error or made a decision that was manifestly unjust" when it granted the United States' motion for preliminary injunction. But then the Legislature and the State simply proceed in rehashing arguments previously presented or in making additional arguments that they could have raised earlier.

To the extent the Legislature and the State merely express their disagreement with the Court's decision and recapitulate the cases and arguments considered by the Court before rendering its initial decision, they have failed to carry their heavy burden on reconsideration. The Court will therefore deny their motions to reconsider on any of the grounds raised in their initial round of briefing. To the extent, however, the Idaho Supreme Court decision in *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132 (2023), somewhat altered the legal landscape since the Court issued its preliminary injunction, it merits some discussion.

3. The *Planned Parenthood* Decision Did Not Negate the Fundamental Principles Underpinning the Court's Preliminary Injunction.

In their supplemental briefing, the Legislature and the State suggests the Idaho Supreme Court's decision in *Planned Parenthood* amounts to an intervening change of controlling law, warranting reconsideration of the Court's preliminary injunction order. They argue the Idaho Supreme Court "defined the scope of Idaho Code § 18-622 in at least two ways that conflict with this Court's interpretation of that law," upending this Court's analysis finding a conflict between the Total Abortion Ban and EMTALA. *See Id's Supp. Br.*, Dkt. 127. The Court disagrees.

In its preliminary injunction decision, the Court concluded that the Total Abortion Ban conflicts with EMTALA under principles of both impossibility and obstacle preemption. *August 24, 2022 Injunction*, pp. 19-34, Dkt. 95. First, the Court determined that, by virtue of the Total Abortion Ban's affirmative defense structure, "it is impossible to comply with both laws" because "federal law requires the provision of care and state law criminalizes that very care." *Id.* at 19. Second, this Court found that "the plain language of the statutes demonstrates that EMTALA requires abortions that the affirmative defense would not cover." *Id.* at 20. And third, this Court concluded that "Idaho's criminal abortion law will undoubtedly deter physicians from providing abortions in some emergency situations," which "would obviously frustrate Congress's intent to ensure adequate

emergency care for all patients who turn up in Medicare-funded hospitals." *Id.* at 26.

In the *Planned Parenthood* decision, the Idaho Supreme Court confirmed that: (1) Idaho Code § 18-622 criminalizes *all* abortions, 522 P.3d at 1152 ("Unlike Idaho's historical abortion laws, which provided an exception to 'save' or 'preserve' the life of the woman, the Total Abortion Ban makes all 'abortions' a crime."); (2) the affirmative defense covers a narrower set of circumstances than those in which EMTALA requires a hospital to offer stabilizing treatment, *id.* at 1196 (noting Idaho Code § 18-622 "does *not* include the broader 'medical emergency' exception for abortions" contained in Idaho Code § 18-8804(1)); and (3) a provider's invocation of the affirmative defense may still be challenged at trial, after the provider has been charged, arrested, and potentially detained, and thus will continue to deter the provision of medically necessary abortions, *id.* (noting "a physician who performed an "abortion' …could be charged, arrested, and confined until trial *even if* the physician initially claims they did it to preserve the life of the mother….[and] "[o]nly later, at trial, would the physician be able to raise the affirmative defenses available in the Total Abortion Ban").

In other words, the Idaho Supreme Court's decision in *Planned Parenthood* confirms each of the fundamental principles that underpinned this Court's decision enjoining Idaho Code § 18-622 to the extent it conflicts with EMTALA; it therefore does not provide a basis for this Court to reconsider its decision. By contrast, the aspects of the Idaho Supreme Court's decision on which the State and

Legislature focus—i.e., that the affirmative defense is subjective rather than objective, and that the Total Abortion Ban does not apply to ectopic or other nonviable pregnancies—do not fundamentally alter this Court's preemption analysis.

The Idaho Supreme Court held that the necessary-to-prevent-death affirmative defense "does not require *objective* certainty" nor "a particular level of immediacy" before the abortion can be "necessary" to prevent a pregnant woman's death. *Planned Parenthood*, 522 P.3d at 1203. Thus, according to the State, because the affirmative defense is "subjective" rather than objective, "there is no conflict" between the Total Abortion Ban and EMTALA because the ban "does not require a 'medically impossible' determination that a pregnant woman is certain to die without an abortion," and neither does it promote delays or worsened patient outcomes by encouraging physicians to wait to provide care until a pregnant woman is nearer to death. *Id. Supp. Br.*, pp. 1-2, Dkt. 127.

First, this argument ignores – as the Idaho Supreme Court decision makes clear – that "the Total Abortion Ban makes all 'abortions' a crime," and "a physician who perform[s] an 'abortion'… [can] be charged, arrested, and confined until trial *even if* the physician initially claims they did it to preserve the life of the mother." *Planned Parenthood*, 522 P.3d at 78 (emphasis in original). "Only later, at trial, would the physician be able to raise the affirmative defenses available under the Total Abortion Ban…to argue it was a *justifiable* abortion that warrants acquittal and release." *Id.* This is true regardless of whether the affirmative defense is "subjective" or "objective." It

also remains true that EMTALA requires physicians to offer medical care that state law criminalizes. Thus, the Idaho Supreme Court's decision, as consistent with this Court's holding, confirmed – rather than eliminated – the conflict between EMTALA and the Total Abortion Ban: Because "federal law requires the provision of care and state law criminalizes that very care, it is impossible to comply with both laws" and the state law is preempted. *August 24, 2022 Injunction*, p. 19, Dkt. 95.

Second, this argument ignores a second key rationale undergirding this Court's preliminary injunction decision: the affirmative defense applies to a narrower scope of conduct than EMTALA covers. *August 24, 2022 Injunction*, p. 20, Dkt. 95. A physician may only assert the affirmative defense at trial when "the abortion was necessary to prevent the death of the pregnant woman." I.C. § 18-622(3)(a)(ii). But EMTALA requires providing stabilizing care not just when the patient faces death, but also when a patient faces serious health risks that may stop short of death, including permanent and irreversible health risks and impairment of bodily functions. 42 U.S.C. § 1395dd(e)(1)(A). As the Court explained in its decision, the pregnant patient may face grave risks to her health, "such as severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, or hypoxic brain injury" – but if the pregnant patient does not face death, the ban's affirmative defense offers no protection to a physician who performs an abortion. *August 24, 2022 Injunction*, pp. 2-3, 20, Dkt. 95. The Idaho Supreme Court confirmed as much when it noted that the Total

Abortion Ban "does not include the broader 'medical emergency' exception for abortions present in [another Idaho abortion statute]." *Planned Parenthood*, 522 P.3d at 1196. The lack of such an exception, or even affirmative defense, is yet another reason that a conflict exists between EMTALA and § 18-622. *August 24, 2022 Injunction*, p. 20, Dkt. 95. Again, the subjective nature of the affirmative defense does not change this result, given that the *Planned Parenthood* decision did not expand the scope of the defense to include health-threatening conditions.

Likewise, the Idaho Supreme Court's narrowing the scope of the Total Abortion Ban to exclude ectopic and other "non-viable pregnancies" did not eliminate the conflict between Idaho law and EMTALA. In *Planned Parenthood*, contrary to this Court's interpretation, the Idaho Supreme Court applied a "limiting judicial construction, consistent with apparent legislative intent" to conclude that § 18-622 does not "contemplate ectopic pregnancies" or other "non-viable pregnancies." *Id.* at 1202-1203. Both the State and the Legislature argue that this limiting construction eliminates any conflict between EMTALA and the Total Abortion Ban by pointing to the United States' examples involving ectopic pregnancies. *Leg.'s Supp. Br.*, p. 2, Dkt. 126, *Id. Supp. Br.*, pp. 7-8, Dkt. 127. But this Court's decision finding a conflict between § 18-622 and EMTALA did not rest on its conclusion that the ban encompasses ectopic pregnancies.

In its decision enjoining the Total Abortion Ban, this Court pointed to "many other complications," in addition to ectopic pregnancy, that "may place the

patient's health in serious jeopardy or threaten bodily functions." *August 24, 2022 Injunction*, p. 8, Dkt. 95. As noted by the Court in its decision, "[s]ome examples include the following scenarios":

- A patient arrives at an emergency room with nausea and shortness of breath, leading to a diagnosis of preeclampsia. Preeclampsia can quickly progress to eclampsia, with the onset of seizures.
- A woman arrives at an emergency room with an infection after the amniotic sac surrounding the fetus has ruptured. That condition can progress into sepsis, at which point the patient's organs may fail.
- A patient arrives at the hospital with chest pain or shortness of breath, which leads the physician to discover elevated blood pressure or a blood clot.
- A patient arrives at the emergency room with vaginal bleeding caused by a placental abruption. Placental abruption is when the placenta partly or completely separates from the inner wall of the uterus. It can lead to catastrophic or uncontrollable bleeding. If the bleeding is uncontrollable, the patient may go into shock, which could result in organ disfunction such as kidney failure, and even cardiac arrest

Id. at 8-9 (citing *Fleisher Dec.* ¶¶ 15-22, Dkt. 17-3). In each of these scenarios, the stabilizing care EMTALA requires a physician to offer may include terminating a-still developing pregnancy covered under the Idaho

Supreme Court's more limited definition of "abortion." Thus, the exclusion of ectopic and other nonviable pregnancies from the Total Abortion Ban does not negate the continuing need to enjoin the ban to the extent it still clearly conflicts with EMTALA.

In short, the Court finds no reason to reconsider its decision granting the United States' motion for a preliminary injunction, and the injunction stands. To contest the preliminary injunction, the State and the Legislature may appeal and seek remedy with the Ninth Circuit. *Whittaker Corp. v. Execuair Corp.*, 953 F.2d 510, 515 (9th Cir. 1992) ("So I'm going to deny your motion and let's let the law lords of the Ninth Circuit reach a judgment.").

ORDER

IT IS ORDERED that:

1. The Idaho Legislature's Motion for Reconsideration of Order Granting Preliminary Injunction (Dkt. 97) is **DENIED**.
2. The State of Idaho's Motion to Reconsider Preliminary Injunction (Dkt. 101) is **DENIED.**

DATED: May 4, 2023

B. Lynn Winmill
U.S. District Court Judge

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UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF IDAHO, Defendant.	Case No. 1:22-cv-00329-BLW **NOTICE OF APPEAL**

Notice is hereby given that the State of Idaho, Appellant, hereby appeals to the United States Court of Appeals for the Ninth Circuit. The State of Idaho appeals the district court's May 4, 2023 Memorandum Decision and Order [135] denying the State of Idaho's motion to reconsider the district court's August 24,

2022 Memorandum Decision and Order [95] granting a preliminary injunction.

FORM 1 INFORMATION

- Date case was first filed in U.S. District Court: August 2, 2022
- Date of judgment or order being appealed: May 4, 2023 and August 24, 2022
- Docket entry number of judgment or order appealed from: 135 (Memorandum Decision and Order), 95 (Memorandum Decision and Order)
- Docketing fee of $505 paid to the U.S. District Court for the District of Idaho.
- Appellant: State of Idaho
    - This is not a cross-appeal
    - There is a pending appeal in this case. Its case number is 23-35153. The caption for this appeal is: UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STATE OF IDAHO, Defendant-Appellee, v. MIKE MOYLE, Speaker of the Idaho House of Representatives, et al., Movants-Appellants.
- A representation statement follows on the next page.

DATED: June 28, 2023.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: */s/ Lincoln Davis Wilson*
Lincoln Davis Wilson

Chief of Civil Litigation
and Constitutional Defense

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on June 28, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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/s/ Lincoln Davis Wilson
LINCOLN DAVIS WILSON

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

Form 1. Notice of Appeal from a Judgment or Order of a United States District Court

U.S. District Court case number:

1:22-CV-00329-BLW

Notice is hereby given that the appellant(s) listed below hereby appeal(s) to the United States Court of Appeals for the Ninth Circuit.

Date case was first filed in U.S. District Court: 08/02/2022

Date of judgment or order you are appealing: 05/04/2023

Docket entry number of judgment or order you are appealing: 135

Fee paid for appeal? (*appeal fees are paid at the U.S. District Court*)

- Yes No IFP was granted by U.S. District Court

List all Appellants (*List **each** party filing the appeal. Do not use "et al." or other abbreviations.*)

The Speaker of the Idaho House of Representatives, Mike Moyle; Idaho State Senate President Pro Tempore, Chuck Winder; and the Sixty-Seventh Idaho Legislature

Is this a cross-appeal? Yes • No

If yes, what is the first appeal case number?

Was there a previous appeal in this case?

● Yes No

If yes, what is the prior appeal case number? 23-35153

Your mailing address (if pro se):

City: State: Zip Code:

Prisoner Inmate or A Number (if applicable):

Signature /s/ Daniel W. Bower **Date** Jul 3, 2023

Complete and file with the attached representation statement in the U.S. District Court

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Form 6. Representation Statement

Instructions for this form: http://www.ca9.uscourts.gov/forms/form06instructions.pdf

Appellant(s) (*List **each** party filing the appeal, do not use "et al." or other abbreviations.*)

Name(s) of party/parties:

The Speaker of the Idaho House of Representatives, Mike Moyle; Idaho State Senate President Pro Tempore, Chuck Winder; and the Sixty-Seventh Idaho Legislature

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Is counsel registered for Electronic Filing in the 9th Circuit? ● Yes No

Appellee(s) *(List only the names of parties and counsel who will oppose you on appeal. List separately represented parties separately.)*

Name(s) of party/parties:

United States of America

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To list additional parties and/or counsel, use next page.

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

Continued list of parties and counsel: *(attach additional pages as necessary)*

Appellants

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Address:

Telephone number(s):

Email(s):

Is counsel registered for Electronic Filing in the 9th Circuit? Yes No

Appellees

Name(s) of party/parties:

Name(s) of counsel (if any):

Address:

Telephone number(s):

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Name(s) of party/parties:

Name(s) of counsel (if any):

Address:

Telephone number(s):

Email(s):

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

Exhibit A to United States' Memorandum in Opposition to Motion to Stay

LEGISLATURE OF THE STATE OF IDAHO

Sixty-seventh Legislature

First Regular Session - 2023

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 374

BY STATE AFFAIRS COMMITTEE

AN ACT

RELATING TO ABORTION; AMENDING SECTION 18-604, IDAHO CODE, TO REVISE A DEFINITION AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 18-622, IDAHO CODE, TO REVISE THE SECTION CAPTION, TO REMOVE OBSOLETE LANGUAGE, TO PROVIDE THAT CERTAIN ABORTIONS AND ATTEMPTS ARE NOT CRIMINAL ABORTIONS, TO PROVIDE THAT CERTAIN PERSONS SHALL BE ENTITLED TO RECEIVE A CERTAIN REPORT UPON REQUEST AND TO MAKE A TECHNICAL CORRECTION; PROVIDING APPLICABILITY; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 18-604, Idaho Code, be, and the same is hereby amended to read as follows:

18-604. DEFINITIONS. As used in this ~~act~~ chapter:

(1) "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the

termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for the purposes of this chapter, abortion shall not mean ~~the~~:

(a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus;

(b) The removal of a dead unborn child;

(c) The removal of an ectopic or molar pregnancy; or

(d) The treatment of a woman who is no longer pregnant.

(2) "Department" means the Idaho department of health and welfare.

(3) "Down syndrome" means a chromosomal disorder associated either with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21. Down syndrome is sometimes referred to as "trisomy 21."

(4) "Emancipated" means any minor who has been married or is in active military service.

(5) "Fetus" and "unborn child." Each term means an individual organism of the species Homo sapiens from fertilization until live birth.

(6) "First trimester of pregnancy" means the first thirteen (13) weeks of a pregnancy.

(7) "Hospital" means an acute care general hospital in this state, licensed as provided in chapter 13, title 39, Idaho Code.

(8) "Informed consent" means a voluntary and knowing decision to undergo a specific procedure or treatment. To be voluntary, the decision must be made freely after sufficient time for contemplation

and without coercion by any person. To be knowing, the decision must be based on the physician's accurate and substantially complete explanation of:

(a) A description of any proposed treatment or procedure;

(b) Any reasonably foreseeable complications and risks to the patient from such procedure, including those related to reproductive health; and

(c) The manner in which such procedure and its foreseeable complications and risks compare with those of each readily available alternative to such procedure, including childbirth and adoption.

The physician must provide the information in terms that can be understood by the person making the decision, with consideration of age, level of maturity and intellectual capability.

(9) "Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(10) "Minor" means a woman under eighteen (18) years of age.

(11) "Pregnant" and "pregnancy." Each term shall mean the reproductive condition of having a developing fetus in the body and commences with fertilization.

(12) "Physician" means a person licensed to practice medicine and surgery or osteopathic

medicine and surgery in this state as provided in chapter 18, title 54, Idaho Code.

(13) "Second trimester of pregnancy" means that portion of a pregnancy following the thirteenth week and preceding the point in time when the fetus becomes viable, and there is hereby created a legal presumption that the second trimester does not end before the commencement of the twenty-fifth week of pregnancy, upon which presumption any licensed physician may proceed in lawfully aborting a patient pursuant to section 18-608, Idaho Code, in which case the same shall be conclusive and unrebuttable in all civil or criminal proceedings.

(14) "Third trimester of pregnancy" means that portion of a pregnancy from and after the point in time when the fetus becomes viable.

(15) Any reference to a viable fetus shall be construed to mean a fetus potentially able to live outside the mother's womb, albeit with artificial aid.

SECTION 2. That Section 18-622, Idaho Code, be, and the same is hereby amended to read as follows:

18-622. ~~CRIMINAL ABORTION~~ DEFENSE OF LIFE ACT. ~~(1) Notwithstanding any other provision of law, this section shall become effective thirty (30) days following the occurrence of either of the following circumstances:~~

~~(a) The issuance of the judgment in any decision of the United States supreme court that restores to the states their authority to prohibit abortion; or~~

~~(b) Adoption of an amendment to the United States constitution that restores to the states their authority to prohibit abortion.~~

~~(2) Every~~ (1) Except as provided in subsection (2) of this section, every person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion. Criminal abortion shall be a felony punishable by a sentence of imprisonment of no less than two (2) years and no more than five (5) years in prison. The professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense.

~~(3) It shall be an affirmative defense to prosecution under subsection (2) of this section and to any disciplinary action by an applicable licensing authority, which must be proven by a preponderance of the evidence, that:~~

(2) The following shall not be considered criminal abortions for purposes of subsection (1) of this section:

(a)~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ and:

~~(ii)~~ (i) The physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman. No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself; and

~~(iii)~~ (ii) The physician performed or attempted to perform the abortion in the manner that, in

his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith medical judgment, termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman. No such greater risk shall be deemed to exist because the physician believes that the woman may or will take action to harm herself; or

(b)~~(i)~~ The abortion was performed or attempted by a physician as defined in this chapter~~;~~ during the first trimester of pregnancy and:

~~(ii)~~ (i) If the woman is not a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman has reported ~~the act of rape or incest~~ to a law enforcement agency that she is the victim of an act of rape or incest and provided a copy of such report to the physician who is to perform the abortion~~;~~. The copy of the report shall remain a confidential part of the woman's medical record subject to applicable privacy laws; or

~~(iii)~~ (ii) If the woman is a minor or subject to a guardianship, then, prior to the performance of the abortion, the woman or her parent or guardian has reported ~~the act of rape or incest~~ to a law enforcement agency or child protective services that she is the victim of an act of rape or incest and a copy of such report has been provided to the physician who is to perform the abortion~~; and~~. The copy of the report shall remain a confidential part of the woman's

medical record subject to applicable privacy laws.

~~(iv) The physician who performed the abortion complied with the requirements of paragraph (a)(iii) of this subsection regarding the method of abortion.~~

(3) If a report concerning an act of rape or incest is made to a law enforcement agency or child protective services pursuant to subsection (2)(b) of this section, then the person who made the report shall, upon request, be entitled to receive a copy of such report within seventy-two (72) hours of the report being made, provided that the report may be redacted as necessary to avoid interference with an investigation.

(4) Medical treatment provided to a pregnant woman by a health care professional as defined in this chapter that results in the accidental death of, or unintentional injury to, the unborn child shall not be a violation of this section.

(5) Nothing in this section shall be construed to subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty.

SECTION 3. Section 2 of this act shall apply retroactively to any pending claim or defense, whether or not asserted, as of July 1, 2023.

SECTION 4. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after July 1, 2023.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, *Plaintiff-Appellee*, v. STATE OF IDAHO, *Defendant*, v. MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE, *Proposed Intervenor-Defendants, Movants-Appellants*.	Nos. 23-35440 23-35450 D.C. No. 1:22-cv-00329-BLW ORDER

Filed September 28, 2023

Before: Bridget S. Bade, Kenneth K. Lee, and Lawrence VanDyke, Circuit Judges.

Order by Judge VanDyke

SUMMARY*

Stay / Abortion / Preemption

The panel granted the Idaho Legislature's motion to stay, pending appeal, the district court's order preliminarily enjoining Idaho Code section 18-622, which makes it a crime for a healthcare provider to perform an abortion unless, among a few other exceptions, "the physician determine[s], in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman."

The federal government argued that section 622 was preempted by the Emergency Medical Treatment and Labor Act (EMTALA), which was enacted to ensure that the poor and uninsured receive emergency medical care at hospitals receiving Medicare reimbursement, and requires emergency room doctors to stabilize patients' emergency medical conditions before transferring them. The district court granted the federal government's motion for a preliminary injunction.

The panel considered the factors set forth in *Nken v. Holder*, 556 U.S. 418, 434 (2009), in considering the Idaho Legislature's request for a stay of the district

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

court's injunction, and held that each of the factors favored issuing a stay.

First, the Legislature made a strong showing that it would succeed on the merits because EMTALA does not preempt section 622. The panel rejected the federal government's assertion that it is impossible to comply with both EMTALA and section 622. And even if the federal government were right that EMTALA requires abortions in limited circumstances, EMTALA would not require those abortions that are punishable by section 622 because termination of a pregnancy is not punishable under section 622 when a doctor determines that an abortion is necessary to save the life of the mother. Nor do section 622's limitations on abortion services pose an obstacle to the purpose of EMTALA because they do not interfere with the provision of emergency medical services to indigent patients.

Second, Idaho will be irreparably injured absent a stay because the preliminary injunction directly harms Idaho's sovereignty.

Finally, the balance of the equities and the public interest support a stay to ensure Idaho's right to enforce its legitimately enacted laws during the pendency of the State's appeal.

ORDER

In *Dobbs v. Jackson Women's Health Organization*, the Supreme Court "heed[ed] the Constitution and return[ed] the issue of abortion to the people's elected representatives." 142 S. Ct. 2228, 2243 (2022). After *Dobbs*, a number of states, including Idaho, have exercised that prerogative to

enact abortion restrictions. In response, the federal government has sued Idaho claiming that a federal law unrelated to abortion preempts the will of the people of that state, through their elected representatives, to "protect[] fetal life," as *Dobbs* described it. *Id.* at 2261. Because there is no preemption, the Idaho Legislature is entitled to a stay of the district court's order improperly enjoining its duly enacted statute.

BACKGROUND

In 2020, Idaho passed section 622, which prohibits most abortions in the state. *See* S.B. 1385, 65th Leg., 2d Reg. Sess. (Idaho 2020). The law contained a trigger, meaning that it was only to take effect thirty days after judgment was entered "in any decision of the United States supreme court that restores to the states their authority to prohibit abortion." 2020 Idaho Sess. Laws 827. The law makes it a crime for a healthcare provider to perform an abortion unless, among a few other exceptions, "[t]he physician determine[s], in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman." Idaho Code § 18-622(2)(a)(i). Idaho law defines abortion as "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child," except in a few listed circumstances. Idaho Code § 18-604.

Dobbs triggered section 622, after which the federal government challenged Idaho's law, arguing

that it is preempted by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (EMTALA). EMTALA was enacted to prevent hospitals that receive Medicare reimbursement from refusing to provide emergency care to the indigent because of their inability to pay. *Id.* As relevant to this case, it requires emergency room doctors to stabilize patients' emergency medical conditions before transferring them. The federal government moved for a preliminary injunction to stop Idaho's law from taking full effect on the trigger date following *Dobbs*. The district court granted the preliminary injunction in August 2022 and denied reconsideration in May 2023. Both the State of Idaho and the Idaho Legislature, which was allowed to intervene for purposes of the preliminary injunction, have appealed the district court's decision. The Legislature has also moved for a stay of the injunction pending appeal. Because Idaho's law is not preempted by EMTALA and the equitable factors favor a stay, we grant the Legislature's motion to stay this case pending appeal.

DISCUSSION

We consider four factors when considering a request for a stay of a district court's injunction: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Nken v. Holder*, 556 U.S. 418, 434 (2009) (quoting *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987)).

Each of the four *Nken* factors favors issuing a stay here. The Legislature has made a strong showing that EMTALA does not preempt section 622. EMTALA does not require abortions, and even if it did in some circumstances, that requirement would not directly conflict with section 622. The federal government will not be injured by the stay of an order preliminarily enjoining enforcement of a state law that does not conflict with its own. Idaho, on the other hand, will be irreparably injured absent a stay because the preliminary injunction directly harms its sovereignty. And the balance of the equities and the public interest also favor judicial action ensuring Idaho's right to enforce its legitimately enacted laws during the pendency of the State's appeal.

I. The Legislature Has Made a Strong Showing That It Is Likely to Succeed on the Merits.

Under *Nken*, a stay applicant must make a "strong showing" that it is likely to succeed on the merits. 556 U.S. at 434. This threshold is met because EMTALA does not preempt section 622.

"When Congress has considered the issue of preemption and has included in the enacted legislation a provision explicitly addressing that issue … there is no need to infer congressional intent to preempt state laws from the substantive provisions of the legislation." *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 517 (1992) (alterations, internal quotation marks, and citations omitted). EMTALA contains an express provision stating that "[t]he provisions of this section *do not* preempt any State or local law requirement, except to the extent that the requirement *directly* conflicts with a requirement of

this section." 42 U.S.C. § 1395dd(f) (emphases added); *see also Baker v. Adventist Health, Inc.*, 260 F.3d 987, 993 (9th Cir. 2001) ("The statute expressly contains a non-preemption provision for state remedies." (citing § 1395dd(f))). Because this court looks to "[c]ongressional intent [as] the sole guide in determining whether federal law preempts a state statute," we must look "only to this language and construe [EMTALA's] preemptive effect as narrowly as possible." *Draper v. Chiapuzio*, 9 F.3d 1391, 1393 (9th Cir. 1993) (citations omitted).

As this court has recognized, when determining the preemptive effect of EMTALA "[t]he key phrase is 'directly conflicts.'" *Id.* Direct conflicts occur in only two instances. First, when compliance with both is a "physical impossibility." *Id.* (quoting *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142–43 (1963)); *see also McClellan v. I-Flow Corp.*, 776 F.3d 1035, 1039 (9th Cir. 2015). And second, when the state law is "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Chiapuzio*, 9 F.3d at 1393 (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)). In this case, neither type of conflict exists.

A. It Is Not Impossible to Comply with Both EMTALA and Section 622.

EMTALA was enacted to ensure that the poor and uninsured receive emergency medical care at hospitals receiving Medicare reimbursement. *See Arrington v. Wong*, 237 F.3d 1066, 1069 (9th Cir. 2001). It provides certain procedures that hospitals must follow but does not set standards of care or specifically mandate that certain procedures, such as

abortion, be offered. But even assuming that EMTALA did require abortions in certain, limited circumstances, it would not require abortions that are punishable by section 622. So it still would not be impossible to comply with both EMTALA and section 622.

In interpreting a statute, we must "start with the statutory text." *Tanzin v. Tanvir*, 141 S. Ct. 486, 489 (2020). The text of EMTALA shows that it does not require hospitals to perform abortions. Instead, EMTALA requires a hospital to determine whether an emergency medical condition is reasonably expected to place "the health of the individual (or, with respect to a pregnant woman, the health of the woman *or her unborn child*) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A) (omissions removed) (emphasis added). So an emergency medical condition includes one that "plac[es] the health of the … unborn child[] in serious jeopardy." *Id.* Where such a condition exists, the hospital must stabilize the condition before transferring the individual to another medical facility unless certain conditions are met. *Id.* § 1395dd(b)(1). "[T]o 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." *Id.* § 1395dd(e)(3)(A).

EMTALA therefore has dual stabilization requirements: hospitals must ensure that "no material deterioration of the condition" of a woman *or* her unborn child is likely to occur. The assumption

that EMTALA implies some hierarchy when stabilization of the woman might require "a material deterioration of the condition" of the child requires us to read *in* an *implicit* duty to perform abortions from the explicit duty to stabilize, which is far beyond that required for a *direct* conflict.

The federal government nonetheless argues that because hospitals are required to stabilize patients' medical conditions, they must perform abortions because abortion could be a "form of stabilizing treatment." But EMTALA does not require the State to allow every form of treatment that *could conceivably* stabilize a medical condition solely because, as the government argues, a "relevant professional determines such care is necessary." In fact, EMTALA does not impose *any* standards of care on the practice of medicine. Nor could it within the broader statutory scheme. *See Baker*, 260 F.3d at 993. It certainly doesn't require that a hospital provide whatever treatment an individual medical professional may desire. For example, a medical professional may believe an organ transplant is necessary to stabilize a patient's emergency medical condition, but EMTALA would not then preempt a state's requirements governing organ transplants.

Because Congress's "clear and manifest" purpose confirms that EMTALA does not impose specific methods of "stabilizing treatment," we must assume "that the historic police powers of the States [are] not to be superseded by" EMTALA. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). The purpose of EMTALA is "to prevent hospitals [from] dumping indigent patients by either refusing to

provide emergency medical treatment or transferring patients before their conditions were stabilized." *Arrington*, 237 F.3d at 1069 (alternations, internal quotation marks, and citation omitted). The purpose of EMTALA is not to impose specific standards of care—such as requiring the provision of abortion—but simply to "ensure that hospitals do not refuse essential emergency care because of a patient's inability to pay." *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995). To read EMTALA to require a specific method of treatment, such as abortion, pushes the statute far beyond its original purpose, and therefore is not a ground to disrupt Idaho's historic police powers.

Even if the federal government were correct that EMTALA requires abortions as "stabilizing treatment" in limited circumstances, EMTALA still would not conflict with Idaho's law. Section 622 includes an exception allowing abortion when a "physician determine[s], in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion [is] necessary to prevent the death of the pregnant woman." Idaho Code § 18-622.

The district court concluded that there is a gap between what a doctor might believe necessary to save the life of a pregnant woman and what might be reasonably expected to place the health of her or her unborn child in serious jeopardy, seriously impair their bodily functions, or cause serious dysfunction of any bodily organ or part. Specifically, the district court invoked the supposed ambiguity in Idaho's law to construe it as creating a conflict with EMTALA. But almost all the examples in the district court's

parade-of-horribles are no longer true, given the Idaho Legislature's recent amendment to the statute and clarification from the Supreme Court of Idaho.

First, relying on declarations from certain doctors, the district court repeatedly noted that the Idaho law's ambiguity would interfere with doctors' medical judgment. For example, it held that "against the backdrop of these uncertain, medically complex situations, [the statutory exception] is an empty promise—it does not provide any clarity." It added that it "offers little solace to physicians attempting to navigate their way around both EMTALA and Idaho's criminal abortion laws" and that "Idaho law criminalizes as an 'abortion' what physicians in emergency medicine have long understood" as required to save lives.

But after the district court issued its injunction, the Supreme Court of Idaho authoritatively interpreted this state law provision as providing a broad, subjective standard requiring the doctor, in his or her good faith medical judgment, to believe it necessary to terminate the pregnancy. *Planned Parenthood Great Nw. v. Idaho*, 522 P.3d 1132, 1203 (Idaho 2023). Put another way, the Supreme Court of Idaho clarified that the text of the exception means what it says: if a doctor subjectively believes, in his or her good faith medical judgment, that an abortion is necessary to prevent the death of the pregnant woman, then the exception applies. *Id.* Thus, the district court's reliance on declarations from certain doctors claiming that the law would undermine their medical judgment is no longer valid.

Second, the district court also relied on some of the federal government's experts who argued that Idaho doctors could not terminate a pregnancy while complying with section 622 because they could not be *certain* that an abortion is necessary. But the Supreme Court of Idaho has made clear that "certainty" is not the standard under Idaho law. That Court also held that the standard has no imminency requirement. *Id.* at 1203–04. It explicitly held that the "necessary to save the life of the mother" standard does not require certainty, a substantial risk of death, or any other particular probability level. *Id.* Nor is a "medical consensus on what is necessary to prevent the death of the woman … required …." *Id.* at 1204 (internal quotation marks omitted). As the Supreme Court of Idaho put it, "[t]he plain language of the [exception] leaves wide room for the physician's 'good faith medical judgment' on whether the abortion was 'necessary to prevent the death of the pregnant woman' based on those facts known to the physician at that time." *Id.* at 1203.

Third, the district court heavily relied on ectopic pregnancies—mentioning them eleven times in the opinion—as a justification for finding section 622 in direct conflict with EMTALA. But Idaho recently amended its law to clarify that "the removal of an ectopic or molar pregnancy" is not an abortion. *See* 2023 Idaho Sess. Laws 906 (excluding from the statute's definition of "abortion"). So that issue is now moot.

Fourth, the district court emphasized that the life of the mother exception in the statute was technically an affirmative defense, noting that an "affirmative defense is an excuse, not an exception" and that this

"difference is not academic." But Idaho amended the law to make it a statutory exception, not an affirmative defense. 2023 Idaho Sess. Laws 908. So this objection, too, has been superseded by events.

Given the statutory amendments and the Supreme Court of Idaho's recent decision, any ambiguity identified by the federal government and the district court no longer exists: if a doctor believes, in his or her good faith medical judgment, that an abortion is necessary to save the life of the mother, then the exception applies. Neither the probability nor the imminency of death matters to the exception's application. *Id.* at 1203. For all the hypotheticals presented by the district court, the conduct required by EMTALA has been shown to satisfy section 622's "life of the mother" standard, so the two laws would not conflict even if EMTALA actually required abortions.

In sum, when a doctor determines an abortion is necessary to save the life of the mother, termination of a pregnancy is not punishable by section 622. Idaho Code § 18-622. Therefore, even if the federal government were right that EMTALA requires abortions in certain limited circumstances, EMTALA would not require abortions *that are punishable by section 622*. The federal government is thus wrong when it asserts that it is impossible to comply with both EMTALA and section 622.

B. Section 622 Does Not Pose an Obstacle to the Purpose of EMTALA.

Obstacle preemption occurs when, "under the circumstances of a particular case, the challenged state law stands as an obstacle to the accomplishment

and execution of the full purposes and objectives of Congress." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 373 (2000) (alterations and internal quotation marks omitted) (quoting *Hines*, 312 U.S. at 67). "What is a sufficient obstacle is a matter of judgment, to be informed by examining the federal statute *as a whole* and identifying its purpose and intended effects …." *Id.* (emphasis added).

As relevant here, "Congress enacted EMTALA to respond to the specific problem of hospital emergency rooms refusing to treat patients who were uninsured or who could otherwise not pay for treatment." *Baker*, 260 F.3d at 993. EMTALA was "not intended to create a national standard of care for hospitals or to provide a federal cause of action akin to a state law claim for medical malpractice." *Id.*; *see also Eberhardt*, 62 F.3d at 1258 ("The statutory language of the EMTALA clearly declines to impose on hospitals a national standard of care in screening patients."). This conclusion is "[c]onsistent with the statutory language" of EMTALA, *id.*, under which the duty to stabilize is "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)(A). Under the language of EMTALA, Congress left it to state healthcare standards to determine which course of treatment "may be necessary" to prevent "material deterioration …." *See id.*

It is not the purpose of EMTALA to force hospitals to treat medical conditions using certain procedures. Instead, EMTALA seeks to prevent hospitals from

neglecting poor or uninsured patients with the goal of protecting "the health of the woman" and "her unborn child." 42 U.S.C. § 1395dd(e)(1)(A). Section 622's limitations on abortion services do not pose an obstacle to EMTALA's purpose because they do not interfere with the provision of emergency medical services to indigent patients.

II. The Legislature Has Shown Irreparable Harm Absent a Stay.

"[A]ny time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (alterations in original) (quoting *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977)). The district court's injunction prevents Idaho from enforcing section 622 as enacted by representatives of its people, so the State easily meets its burden of showing irreparable harm. The federal government's two arguments to the contrary do not convince us otherwise.

First, the government argues that the Legislature cannot establish irreparable harm by pointing to harm to the State of Idaho itself. But it makes no difference to our harm analysis that the State seeks the stay through its Legislature, rather than through its Attorney General; the government's argument to the contrary relies upon a distinction without a difference. The State itself, not merely its officials, "suffers a form of irreparable injury" when it cannot effectuate its statutes. *Id.* And the State "is free to 'empower multiple officials to defend its sovereign interests in federal court.'" *Berger v. N.C. State Conf.*

of the NAACP, 142 S. Ct. 2191, 2202 (2022) (alteration omitted) (quoting *Cameron v. EMW Women's Surgical Ctr., P.S.C.*, 142 S. Ct. 1002, 1011 (2022)). Here, Idaho law empowers the Legislature as a state entity to represent those interests. *See* Idaho Code § 67-465. The Legislature may thus invoke the State of Idaho's irreparable harm.

Second, the federal government claims that the Legislature's delay in requesting the stay is "substantial and inexplainable," and therefore prevents a showing of irreparable harm. The record is somewhat mixed on this issue, but usually "delay is but a single factor to consider in evaluating irreparable injury." *Arc of Cal. v. Douglas*, 757 F.3d 975, 990 (9th Cir. 2014). While "failure to seek judicial protection can imply the lack of need for speedy action," here there is no evidence that the Legislature was "sleeping on its rights." *Id.* at 990–91 (internal quotation marks and citation omitted).

It appears that the extended period of time after the district court's original injunction here is instead explained primarily by the long time that court took in ruling on Idaho's reconsideration motions, together with other circumstances outside the Legislature's control. On September 7, 2022, only two weeks after the district court granted the federal government's injunction, the Legislature moved for reconsideration. And in November 2022, it sent a letter to the court requesting a ruling on the motion to reconsider. In January 2023, three months after the federal government responded to the reconsideration motion and two months after the Legislature requested an expedited ruling, the Supreme Court of Idaho issued a decision authoritatively interpreting section 622.

Idaho requested leave to file supplemental briefing in federal court addressing the Supreme Court of Idaho's decision. The district court took another three months after the supplemental briefing was complete to decide the motion for reconsideration; the Legislature was not at fault for these delays. And the Legislature moved for a stay in the district court on the same day it timely noticed its appeal of the district court's denial of its motion for reconsideration. We cannot say that the Legislature was clearly dilatory in defending the State's rights. The record suggests that the Legislature tried to protect those rights before the district court before seeking a stay from this court.

III. The Balance of the Equities Favors a Stay.

The third and fourth *Nken* factors—"whether issuance of the stay will substantially injure the other parties interested in the proceeding" and "where the public interest lies"—also favor a stay. 556 U.S. at 435.

Idaho enacted section 622 to effectuate that state's strong interest in protecting unborn life. That public interest is undermined each day section 622 remains inappropriately enjoined. Beyond that specific interest, improperly preventing Idaho from enforcing its duly enacted laws and general police power also undermines the State's public interest in self-governance free from unwarranted federal interference. *See BST Holdings, L.L.C. v. OSHA*, 17 F.4th 604, 618 (5th Cir. 2021) ("The public interest is also served by maintaining our constitutional structure[.]"); *Sierra Club v. Trump*, 929 F.3d 670, 677 (9th Cir. 2019) (public interest is served by

"respecting the Constitution's assignment of … power").

The federal government points to no injury to itself caused by Idaho's law. Instead, relying on its merits argument that Idaho's law is preempted, it cites to cases holding that "preventing a violation of the Supremacy Clause serves the public interest." But because Idaho's law is not preempted, those arguments do not help the federal government.

Beyond that inapposite concern, the federal government argues that a continued stay will result in public health benefits for pregnant women needing emergency care, and also benefit hospitals in neighboring states who would otherwise be forced to treat women denied such care in Idaho. But Idaho's law expressly contemplates necessary medical care for pregnant women in distress. *See* Idaho Code § 18-622(4). So the federal government's argument that pregnant women will be denied necessary emergency care overlooks Idaho law. And as explained above, even assuming abortions were required to "stabilize" emergency conditions presented by some pregnant women, and that EMTALA required such treatment, Idaho's law would not prevent abortions in those circumstances.

Ultimately, given our conclusion that EMTALA does not preempt Idaho's law, the federal government has no discernable interest in regulating the internal medical affairs of the State, and the public interest is best served by preserving the force and effect of a duly enacted Idaho law during the pendency of this appeal. Therefore, the balance of the equities and the public interest support a stay in this case.

CONCLUSION

For the above reasons, the traditional stay factors favor granting the Legislature's motion. The Legislature's motion for a stay pending appeal is therefore **GRANTED**.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STATE OF IDAHO, Defendant, v. MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE, Proposed Intervenor-Defendants, Movants-Appellants.	Nos. 23-35440, 23-35450 D.C. No. 1:22-cv-00329-BLW District of Idaho, Boise **ORDER**

MURGUIA, Chief Judge:

Upon the vote of a majority of nonrecused active judges, it is ordered that this matter be reheard en banc pursuant to Federal Rule of Appellate Procedure 35(a) and Circuit Rule 35-3. The order published at 2023 WL 6308107 (9th Cir. Sep. 28, 2023) is vacated.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. STATE OF IDAHO, Defendant, v. MIKE MOYLE, Speaker of the Idaho House of Representatives; CHUCK WINDER, President Pro Tempore of the Idaho Senate; THE SIXTY-SEVENTH IDAHO LEGISLATURE, Proposed Intervenor-Defendants, Movants-Appellants.	Nos. 23-35440, 23-35450 D.C. No. 1:22-cv-00329-BLW District of Idaho, Boise **ORDER**

Before: MURGUIA, Chief Judge, and GOULD, CALLAHAN, M. SMITH, OWENS, MILLER, BRESS, FORREST, VANDYKE, KOH and MENDOZA, Circuit Judges.

The Idaho Legislature's motion to stay the district court's injunction pending appeal (Dkt. 31) is denied. *See Nken v. Holder*, 556 U.S. 418, 434 (2009). The district court's injunction therefore remains in effect.

Further, we deny the Idaho Legislature's Emergency Motion Under Circuit Rule 27-3 (Dkt. 71) as moot.

The en banc court will proceed to consider the merits of this preliminary injunction appeal. Absent further order of the Court, no additional briefing is required.

En banc oral argument will take place during the week of January 22, 2024, in Pasadena, California. The date and time will be determined by separate order. For further information or special requests regarding scheduling, please contact Deputy Clerk Paul Keller at paul_keller@ca9.uscourts.gov or (206) 224-2236.

Within seven days from the date of this order, the parties shall forward to the Clerk of Court eighteen additional paper copies of the original briefs and ten additional paper copies of the excerpts of record. The paper copies must be accompanied by certification (attached to the end of each copy of the brief) that the brief is identical to the version submitted electronically. The Form 18 certificate is available on the Court's website at http://www.ca9.uscourts.gov/forms/.

Judges Callahan, Miller, Bress, and VanDyke respectfully dissent from the order denying Idaho's motion to stay the district court's injunction pending appeal and would have granted the stay for substantially the reasons set forth in the original three-judge motions panel order. *See United States v. Idaho*, 83 F.4th 1130 (9th Cir. 2023).

42 U.S.C. 1395dd

Examination and treatment of emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

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[1] So in original. Probably should be followed by a comma.

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer--

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call

physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who--

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of

the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means--

(A) 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 organ or part; or

(B) with respect to a pregnant woman who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), 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, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), 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 described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.