UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-Civ-00196

PLAINTIFF STATES' REPLY BRIEF IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION

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PRELIMINARY STATEMENT

Plaintiffs seek a Preliminary Injunction to prevent the imminent harm that will occur in just two weeks, when the reductions in force (RIFs) issued as part of the March 27 Directive go into effect on June 2. Specifically, Plaintiff States seek a preliminary injunction narrowly tailored to four units within HHS as to which the evidence demonstrates that the March 27 Directive will cause irreparable injury to Plaintiffs unless enjoined: (1) the Centers for Disease Control and Prevention; (2) the Center for Tobacco Products within the Food & Drug Administration; (3) the Office of Head Start within the Administration for Children and Families and all employees of regional offices who work on Head Start matters; and (4) the Office of the Assistant Secretary for Planning and Evaluation, which is responsible for calculating the federal poverty guidelines.[1]

Although Defendants oppose Plaintiffs' motion for a preliminary injunction, they support their position with no evidence except a declaration relating only to recent developments at one sub-agency of CDC. They devote the bulk of their brief to attempts to avoid arguing the merits, but Defendants' scattershot attacks on this Court's jurisdiction and other threshold matters do not alter the fact that the key elements the Court needs to find are essentially undisputed.

First, Defendants do not dispute that within days of the March 27 Directive, ten thousand RIF notices described in the Directive were sent and staff were placed on administrative leave until the RIFs ultimately become effective on June 2.

Second, Defendants do not, on the main, dispute that many of HHS's key services have stopped, as detailed in Plaintiffs' extensive evidence. Defendants point to two news articles, *see*

[1] Plaintiff States reserve the right to move at a later date for preliminary injunctive relief as to the Directive's implementation as to other agencies or programs within HHS.

Opp'n 9, regarding the effect of the Directive at FDA's Center for Tobacco Products, but otherwise do not appear to dispute that the Directive has had the devastating effect on HHS's programs that the States' ample record demonstrates.

Third, the States have a detailed, specific record showing that they are harmed in a myriad of ways from the Directive, including the loss of HHS's critical public health services, resources, data, guidance, policies, and expertise.

Fourth, Defendants have failed to point to any reasoning supporting the March 27 Directive, which further confirms that the Directive was arbitrary and capricious.

Because of the brazen unlawfulness of Defendants' actions and imminent harm to Plaintiffs, the Court should order a preliminary injunction.

I. In the Ten Days Since Plaintiffs Filed Their Motion, Courts Have Issued Decisions Enjoining HHS's Hasty and Ill-Considered Decision-Making

Since Plaintiff States filed their motion, courts across the country have issued relevant decisions enjoining Defendants' unlawful actions.

In West Virginia, a coal mine worker who has been diagnosed with black lung disease sued Secretary Kennedy and HHS on behalf of a putative class of workers, asserting, *inter alia*, that HHS's RIFs at the National Institute for Occupational Safety and Health (NIOSH), particularly with respect to the Coal Workers Health Surveillance Program, violated the APA. On May 13, the court issued a preliminary injunction rescinding the RIFs in NIOSH's Respiratory Health Division to "facilitate the full restoration of" that division. *Wiley v. Kennedy*, No. 2:25-CV-00227, 2025 WL 1384768, at *13 (S.D. W. Va. May 13, 2025). The court noted that because the agency "does such specialized work," after the RIFs, "there is no one else, within HHS or any other agency, that does similar work" and "HHS cannot simply add [these] duties to epidemiologists with other

specialties." *Id.* at *10. As a result, the court concluded, "HHS and NIOSH are no longer fulfilling [their] obligations" under the Mine Act." *Id.*

Here in Rhode Island, States sued Secretary Kennedy and HHS to challenge the termination of $11 billion of public health grants appropriated by Congress. On May 16, the court issued a preliminary injunction prohibiting the grant terminations. Ex. 76, *Colorado v. Kennedy*, No. 1:25-CV-00121, slip op. (D.R.I. May 16, 2025) (McElroy, J.). While this case challenges the March 27 Directive rather than grant terminations, much of the court's reasoning applies equally to the March 27 Directive, including the Court's finding of irreparable harm to Plaintiff States in the form of "protecting public health, the elimination of healthcare services, and impact on public health infrastructure." *Id.* at *48.

In California, a group of unions, non-profit organizations, and local governments sued federal agencies, including HHS, asserting, *inter alia*, that the agencies' reductions in force (RIFs) and reorganization plans violate the APA. On May 9, the court issued a temporary restraining order pausing large-scale RIFs, including at HHS. *Am. Fed'n of Gov't Emps. v. Trump*, No. 25-CV-03698, 2025 WL 1358477, at *25 (N.D. Cal. May 9, 2025). The court based its decision, in part, on many of the same key facts at issue here. *See id.* at *2 (citing HHS cuts to NIOSH and Head Start).[2]

II. Meanwhile, Defendants Revoked some RIFs at NIOSH and Testified to Congress.

On May 13, 2025, the same day the court in West Virginia issued its preliminary injunction restoring NIOSH's Respiratory Health Division, *see supra* Section I, the head of NIOSH, Dr. John

[2] To date, no appeal has been docketed for the West Virginia or Rhode Island decisions. In California, a preliminary injunction hearing is set for May 22, *id.* at *25; the temporary restraining order is set to expire on May 23, *id*.; briefing on the government's motion to the Ninth Circuit to stay the TRO is in progress and, meanwhile, the government has filed an application to the Supreme Court for an immediate administrative stay, *Trump v. Am. Fed'n of Gov't Emps.*, No 24A1106 (May 16, 2025).

Howard, sent a NIOSH-wide email that contained most of the same content as his declaration that the government submitted in this case, ECF No. 52-1. The email explained that some NIOSH staff in specific programs who had previously received RIF notices had subsequently received additional notices explaining that their RIF had been rescinded. Ex. 68 (Suppl. John Doe 2 Decl.) ¶ 3.[3] According to Dr. Howard, these restorations affected "selected units" representing approximately thirty-eight percent of NIOSH's terminated staff.[4] *Id.* ¶ 4. These restorations did not include the Mining Safety Programs or Research Divisions in NIOSH's Spokane or Pittsburgh offices, or Spokane's Western States Division, among many others. *Id.* ¶¶ 5-9. Dr. Howard recognized that more NIOSH employees needed to be restored, noting in his email that "I am hopeful that we can continue to make the case reinstating everyone at NIOSH." *Id.* ¶ 3. Omitted from Defendants' brief and Dr. Howard's declaration is that some of the restorations at NIOSH were required by and happened on the same day as the West Virginia court's injunction. Further, according to an internal CDC email received by media outlets, the CDC plans a one-to-one "substitution" for all restored NIOSH employees—that is, terminate one additional employee for every employee restored—to "maintain the integrity and legality of the RIF." Ex. 77 (Government Executive, *CDC to cut one employee for each it is recalling from layoffs*).

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[3] Citations herein to Ex. 1 through Ex. 65 are exhibits to the May 9, 2025 Declaration of Andres Ivan Navedo, ECF No. 44. Additionally, Plaintiffs are submitting eight declarations executed since the original preliminary injunction motion to supplement the factual record with respect to the impacts of the March 27 Directive; six of these are from current or former HHS staff speaking to the impact of the March 27 Directive on their programs' functions. These, as well as a few additional exhibits, are numbered Exhibits 66 to 77 and are attached to the May 19, 2025 declaration of Molly Brachfeld.

[4] These programs were: the NIOSH Office of the Director; the Respiratory Health Division; the Division of Safety Research; the National Personal Protective Technology Laboratory; the Division of Compensation Analysis and Support; and part of the Division of Field Studies and Surveillance. These programs largely correspond to the five NIOSH programs identified by Plaintiff States in their Preliminary Injunction Motion, that each contained disclaimers on their website that they had stopped "due to the reduction in force across NIOSH." Ex. 35 (Leland Decl. - WA) ¶¶ 19, 25, 30, 33.

On May 14, while testifying before Congress, Secretary Kennedy addressed the RIFs and restructurings at issue in this lawsuit. Under questioning, Secretary Kennedy admitted that he decided to commence the "decisive action" of the HHS restructuring "quickly" instead of a "surgical[]" approach focused on individual employees, knowing he would make "mistakes," as a way to avoid "inertia." Brachfeld Decl. ¶ 5. Secretary Kennedy admitted to a number of "mistakes," including the termination of the World Trade Center Health Program, and testified that he was unaware that his RIFs had shut down the National Firefighter Registry for Cancer. *Id.* ¶ 6. When pressed about why these programs were cut in the first place, Secretary Kennedy responded: "[i]t was part of the overall budget cuts. Our agency was asked to make very, very serious budget cuts that were going to be painful." *Id.* And when pressed by Senator Murkowski as to why funding from HHS was not being received by grantees, he admitted it "could" be due to the RIFs. *Id.*

III. Defendants' Jurisdictional Arguments are Meritless.

A. The Unrebutted Record Shows that the March 27 Directive Has Caused and Will Continue to Cause Concrete, Particularized Harm to Plaintiff States.

Plaintiff States have made a "clear showing" that they are "likely to establish each element of standing." *Murthy v. Missouri*, 603 U.S. 43, 58 (2024) (internal quotes and citation omitted). They have suffered "concrete and particularized" injuries that are "actual [and] imminent"; "fairly traceable" to Defendants' challenged behavior; and "likely" to be redressed by a favorable decision. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992) (cleaned up).

Contrary to Defendants' arguments, the voluminous and unrebutted record demonstrates dozens of examples of concrete harms that the March Directive 27 has already caused and will continue to cause to the Plaintiff States absent preliminary injunctive relief. These harms are not, as Defendants suggest, based on a highly attenuated chain of possibilities; they are happening right now. *See Rhode Island v Trump*, No. 1:25-cv-128-JJM-LDA, 2025 WL 1303868, at *5 (D.R.I.

May 6, 2025); *Maryland v. U.S. Dep't of Agric.*, No. JKB-25-0748, 2025 WL 973159, at *12 (D. Md. Apr. 1, 2025). Those harms include:

- Plaintiff States have been harmed by the discontinuance of key public health services, including CDC laboratories and other resources, that ensure the health and safety of state residents.[5]
- Plaintiff States have been harmed by the loss of the gold standard scientific data collected, analyzed, and distributed[6] by HHS.[7]
- Plaintiff States have been harmed because HHS has ceased providing policies and guidance on which the States rely. After the RIFs, HHS does not have the capacity to design, distribute, and implement these policies and guidance.[8]

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[5] *See, e.g.*, Ex. 71 (Jane Doe 5 Decl.) ¶ 9 (noting that the now-shuttered STD Laboratory within CDC provided unique technical assistance and guidance to state and local public health labs); Ex. 23 (Gallagher Decl. - RI) ¶¶ 17–20 (explaining that, without the CDC's laboratories, Rhode Island must seek commercial testing for samples of drug-resistant gonorrhea and viral hepatitis); Ex. 21 (Underwood Decl. - MN) ¶ 16 (Plaintiff States are left without a surveillance system for hepatitis A after the elimination of CDC's Viral Hepatitis Lab); Ex. 74 (Sloss Decl. - CA) ¶¶ 20–22 (estimating that, without Office of Smoking and Health support, California's tobacco and nicotine quitline capacity will shrink by ten percent).

[6] Defendants characterize this harm as "informational injury" to Plaintiff States. Opp'n 13. To the extent that the characterization is accurate, Plaintiff States have met their burden under Article III to show (1) that they "lack access to information to which [they are] legally entitled"—the data formerly collected and reported to them by various agencies within HHS—and (2) "that the denial of that information creates a 'real' harm with an adverse effect." *Dreher v. Experian Info. Sols., Inc.*, 856 F.3d 337, 345 (4th Cir. 2017) (quoting *Spokeo, Inc. v. Robins*, 578 U.S. 330, 340 (2016)); *see also Amrhein v. eClinical Works, LLC*, 954 F.3d 328, 332–33 (1st Cir. 2020). Moreover, these "informational injuries" indeed would be redressable through the relief sought by Plaintiff States, *contra* Opp'n 15; if the Court vacates the March 27 Directive, and employees are reinstated, the activities currently on pause could reasonably be expected to resume.

[7] *See, e.g.*, Ex. 25 (Rosenberg Decl. - NY) ¶ 24, Ex. 69 (Jane Doe 3 Decl.) ¶¶ 11(a), 17 (noting that CDC has taken all Pregnancy Risk Assessment Monitoring System (PRAMS) data offline and no employees remain to maintain the system, analyze birth year 2024 data, or collect birth year 2025 data from the states); Ex. 57 (Chawla Decl. - NY) ¶¶ 11–15 (explaining that delays or inaccuracies in Federal Poverty Guidelines will result in erroneous benefit eligibility determinations, and necessitate additional system work by state agencies).

[8] *See, e.g.*, Ex. 59 (Hertel Decl. - MI) ¶ 33 (noting the National Center for Environmental Health has ceased sending regular notices about newly identified food and consumer products contaminated with lead).

- Plaintiff States have been harmed by the loss of access to agency experts who were RIFed. HHS experts provided crucial training and technical assistance to Plaintiff States before April 1.[9] They served as points of contact capable of providing specific guidance and instruction to the States, but Plaintiff States have been unable to reach their former points of contact to obtain answers without which state agencies may be unable to avail themselves of agency services, and inquiries to generic program email inboxes have gone unanswered.[10] The lack of clarity that would normally be provided by agency experts has forced the States to scramble to make future plans without input from their federal partners, putting substantial strain on state resources.[11]
- Plaintiff States have been harmed by delays and interruptions in funding because HHS is no longer collecting, reviewing, and processing grant applications and disbursing allocated funds to the States.[12]

Defendants' arguments in response are meritless. Defendants wrongly contend that Plaintiff States' harms are speculative because the Department's reorganization is ongoing. Opp'n

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[9] *See, e.g.*, Ex. 38 (Propheter Decl. - CA) ¶ 31, Ex. 39 (Marton Decl. - NY) ¶ 16 (noting Plaintiff States have lost training, technical assistance, monitoring site visits, and other support for Head Start programs previously performed by Office of Head Start staff); Ex. 25 (Rosenberg Decl. - NY) ¶ 23, Ex. 27 (Eilers Decl. - WA) ¶ 14 (explaining Plaintiff States have been left without guidance for how to proceed in Early Hearing Detection and Intervention Programs, which places increased strain on their ability to screen for hearing and provide services to infants).

[10] *See, e.g.*, Ex. 48 (Gagne-Holmes - ME) ¶ 20 (stating Childhood Lead Prevention Program staff did not respond to a recent inquiry from the Maine state health authority regarding potentially faulty blood collection tubes); Ex. 39 (Marton Decl. - NY) ¶¶ 16–17, Ex. 38 (Propheter Decl. - CA) ¶¶ 26, 31 (explaining that Head Start grantees cannot reach their former points of contact in the regional offices).

[11] *See, e.g.*, Ex. 34 (Miller Decl. - WA) ¶ 33, Ex. 35 (Leland Decl. - WA) ¶ 43, Ex. 52 (Cummings Decl. - CA) ¶¶ 10–14 (noting Washington State relied on NIOSH expert input in setting state workplace safety standards and preparing for emerging safety concerns, such as the upcoming wildfire season).

[12] *See, e.g.*, Ex. 31 (Simpson Decl. - WA) ¶ 18, Ex. 2 to Simpson Decl. (explaining Plaintiff States' Education and Research Centers will close next month because they cannot obtain NIOSH non-competitive grant renewals that they would have received in the normal course before the RIFs at NIOSH); Ex. 21 (Underwood Decl. - MN) ¶ 7 (noting the Office of Smoking and Health "returned" Minnesota's continuation application for the National and State Tobacco Control Program award for the stated reason that, because of "organizational changes at HHS/CDC," the grant manager could grant only a temporary no-cost extension).

27–28. "This argument invites the Court to speculate that perhaps HHS will someday reinstitute some version of the services" it used to offer. *Wiley*, 2025 WL 1384768, at *10. But Defendants have offered "no testimony or plan offered explaining how they will resume." *Id.*; *see also Abbott Labs v. Gardner*, 387 U.S. 136, 148 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977).

Defendants' contention that States' "informational deficiencies resulting from the [March 27 Directive] caused [no] real-life 'consequences'" is false. *See* Opp'n 13. The record establishes many current and imminent deprivations of information to which Plaintiff States are legally entitled. That the agencies can no longer collect, analyze, maintain, and deliver such information to the States constitutes a harm that is both concrete and particularized. *See Drs. for Am. v. Off. of Pers. Mgmt.*, No. 25-322 (JDB), 2025 WL 452707 (D.D.C. Feb. 11, 2025). For example, the discontinuance of the Pregnancy Risk Assessment and Monitoring System (PRAMS) program—which is required by 42 U.S.C. § 247b-12, 13—is concrete, particularized, and already causing current harm, *contra* Opp'n 14–15. Plaintiff States cannot access historical data from 1988–2023, have not received national weighted data for 2024, and cannot reasonably expect to receive 2025 data because it is not being collected. Ex. 69 (Jane Doe 3 Decl.) ¶ 17. Beyond forcing Plaintiff States to divert "resources" to fill data gaps, Opp'n 15, the lack of PRAMS data and programmatic support from CDC is interrupting Plaintiff States' public health activities in response to the crisis of maternal mortality and morbidity *right now*. *See* Ex. 26 (Brown Decl. - NJ) ¶ 8; Ex. 24 (Larkin Decl. - RI) ¶ 9.

Defendants also incorrectly argue that Plaintiff States assert harms in the form of lost state-program funding and "non-payment of grant funds." Opp'n 19. The funding loss to Plaintiff States is caused by the March 27 Directive not because the Directive directly cut funding to States, but

because the Directive resulted in funding processes collapsing due to lack of staff. This is not speculation; in less than two months since the termination notices were sent, the Department has failed to administer a growing number of its grants. *See, e.g.*, Pls.' Mem. 34 (at the Early Hearing Intervention and Direction team, all but one member was laid off and as a result the review of future grant applications was put on hold); *see also id.* at 42–43, 50.

Lastly, the harm to Plaintiff States caused by the cessation of vital, statutorily mandated services is not precluded by *United States v. Texas*, 599 U.S. 670 (2023), as defendants suggest, Opp'n 15–16. That case presented the question whether a state has standing to demand that the federal government make arrests and bring prosecutions under its immigration enforcement authority. *Texas*, 599 U.S. at 674. Here, rather than foregoing discretionary action, HHS has acted in such a way that stymies the will of Congress and harms Plaintiff States by causing the denial of statutorily mandated services on which the States rely, with "meaningful standards" to "assess[] the propriety of [the Department's action] in this area." *Id.* at 679. Moreover, the injuries to Plaintiff States go far beyond potential "downstream harms on the states' budgets and resources." Opp'n 16; *see infra* Section VI.[13]

B. Plaintiffs' Claims Need Not Be Channeled Through an Administrative Process.

Defendants maintain that Plaintiff States, who are not employees or labor unions and who are not raising claims sounding in employment law, must raise their claims in administrative fora designed for employees or labor unions. Opp'n 21–22. That argument, grounded on the Civil

[13] Defendants fare no better with *Gonzalez v. Cuccinelli*, 985 F.3d 357 (4th Cir. 2021), which they cite for the proposition that Plaintiff States do not have standing based on harms caused by disruptions to "discretion[ary]" services. Opp'n 17. *Gonzalez* did not address standing or injury-in-fact, and dealt only with when a Court may compel agency action that has been "unlawfully withheld or unreasonably delayed" under Section 706(1) of the APA. *Gonzalez*, 985 F.3d at 365–66 (citing *Norton v. S. Utah Wilderness All.*, 542 U.S. 55 (2024)). Plaintiff States are not seeking relief under that subsection of the APA. *See infra* Section IV.B.

Service Reform Act (CSRA) is wrong, and has been correctly rejected on similar facts. *See Rhode Island*, 2025 WL 1303868, at *7–8. More specifically, neither of the relevant factors articulated in *Thunder Basin Coal Co. v. Reich* applies here: there is no "fairly discernible" Congressional intent to channel States' claims, nor is there any indication that Congress intended to "preclude judicial review." 510 U.S. 200, 207 (1994). Defendants admit that CSRA has no applicable explicit provision, instead relying on an argument that the statute "*implicitly* precludes" such review. Opp'n 24 (emphasis added). And were the CSRA to apply here, Plaintiff States would be denied a forum, as the administrative bodies do not have jurisdiction over the States' claims. *See id.* 23; *Rhode Island*, 2025 WL 1303868, at *7.

Defendants cite many irrelevant cases brought by employees and unions that do not address the issues here. *See Roth v. United States*, 952 F.2d 611, 615 (1st Cir. 1991) (cited Opp'n 21) (addressing federal preemption of an employee's claims); *Am. Fed'n of Gov't Emps., AFL-CIO v. Trump*, 929 F.3d 748, 754 (D.C. Cir. 2019) (cited Opp'n 21) (describing "exclusive procedures" for "federal employees and their bargaining representatives"); *Nyunt v. Chairman, Broad. Bd. of Governors*, 589 F.3d 445, 448–49 (D.C. Cir. 2009) (cited Opp'n 23) ("*Federal employees* may not circumvent the CSRA . . . ") (emphasis added); *Mahoney v. Donovan*, 721 F.3d 633, 635–36 (D.C. Cir. 2013) (cited Opp'n 23) (addressing scope of "personnel action" under CSRA). Defendants further suggest that Plaintiff States are trying to "step into the shoes of" federal employees, Opp'n 22, but Plaintiffs are raising claims based on *their own* concrete harms. *See supra* Section III.A. Similarly, *Block v. Community Nutrition Institute*, cannot carry the weight Defendants place on it, *see* Opp'n 24–25, because in that case, the Supreme Court considered preclusion of "the *same* [legal] challenge," advanced by a different party. 467 U.S. 340, 347 (1984) (emphasis added); *see*

also United States v. Fausto, 484 U.S. 439, 448 (1988) (interpreting the CSRA and *Block* to limit *employees*' rights to district court judicial review).

C. Plaintiffs' Claims Need Not Be Adjudicated in the Court of Federal Claims

Defendants suggest that any "alleged breach of a specific funding agreement" falls within the ambit of the Tucker Act so that "any Plaintiff alleging harm based on the non-payment of grant funds" must "seek damages in the Court of Federal Claims." Opp'n 19–20. But that argument misreads the Tucker Act, and in any event, Plaintiffs make no such claim here. The Court should reject it, just as reviewing courts have routinely done. *Accord Rhode Island*, 2025 WL 1303868, at *6; *Maine v. U.S. Dep't of Agric.*, No. 1:25-CV-00131, 2025 WL 1088946, at *19 n.8 (D. Me. Apr. 11, 2025) (similar); *Massachusetts v. Kennedy*, 2025 WL 1371785, at *6–9 (D. Mass. May 12, 2025) (similar); Ex. 76, *Colorado v. Kennedy*, at *15-23 (similar).

Defendants' invocation of the Supreme Court's per curiam opinion in *Department of Education v. California*, 145 S. Ct. 966 (2025), is doubly flawed. First, Plaintiffs seek relief in the form of an order enjoining portions of the March 27 Directive which, as opposed to an order to require specific performance or compensation under any contract, falls outside the ambit of the Tucker Act. *See, e.g.*, *Pacito v. Trump*, No. 25-cv-255, 2025 WL 1077401, at *3 (W.D. Wash. Apr. 9, 2025). Second, the logic of the *Department of Education* stay decision does not extend to cases such as this in which "the terms and conditions of each individual grant that the States receive from the Agency Defendants are not at issue." *New York v. Trump*, No. 1:25-CV-39, 2025 WL 1098966, at *2 (D.R.I. Apr. 14, 2025). Rather, Plaintiff States' claims here fall squarely within the holding of *Bowen v. Massachusetts*, 487 U.S. 879 (1988), that "a district court's jurisdiction 'is not barred by the possibility' that an order setting aside an agency's action may result in the disbursement of funds." *Dep't of Educ.*, 145 S. Ct. at 968 (quoting *Bowen*, 487 U.S. at 910). These are "precisely the type of claims that belong in district court." Ex. 76, *Colorado v. Kennedy*, at *18.

IV. Plaintiffs Are Likely to Succeed on the Merits of their APA Claims.

A. The March 27 Directive Is a Discrete and Final Agency Action.

Defendants' argument that the March 27 Directive is not a "discrete agency action," and rather a broad programmatic attack that would "require the Court to supervise the Department's activities," is wrong as this case bears no resemblance to *Lujan v. National Wildlife Federation*. Opp'n 25–27. As the First Circuit explained, that case involved "a variety of programmatic deficiencies that [the plaintiff] claimed were unlawful for varied reasons," and "the broad programmatic attack . . . was an attempt to seek wholesale programmatic improvements." *New York v. Trump*, 133 F.4th 51, 67 (1st Cir. 2025) (quotations omitted)). Plaintiffs here do not challenge varied deficiencies; to the contrary, Plaintiffs challenge a single, discrete action—the March 27 Directive (and seek preliminary injunctive relief as to an even more limited subset of that Directive)—which is similar to actions recent courts have found to be discrete. *See Rhode Island*, 2025 WL 1303868, at *8; *Maryland*, 2025 WL 973159, at *14; *Nat'l Treasury Emps. Union v. Vought*, No. CV 25-0381, 2025 WL 942772, at *10 (D.D.C. Mar. 28, 2025); *c.f. New York v. Trump,* No. 25-CV-39-JJM-PAS, 2025 WL 715621, at *8 (D.R.I. Mar. 6, 2025). Nor does the broad scope of the March 27 Directive render Plaintiffs' lawsuit "programmatic, even if it is large." *Massachusetts*, 2025 WL 1371785 at *10.

Defendants fare no better with their unsupported assertion that the March 27 Directive is not "final" agency action. Opp'n 27–29. While Defendants attempt to characterize the March 27 Directive as a mere "press release," Opp'n 27, it is the effect of the Directive that matters. *See Wiley v. Kennedy*, 2025 WL 1384768, at *10 ("Shutting down programs without conducting rulemaking or otherwise engaging in a process that results in an official written statement announcing the shutdown is no less final."). Defendants do not offer any facts to contradict the voluminous record evidence offered by Plaintiffs that the Directive resulted in thousands of

employees with specialized knowledge and expertise being placed on administrative leave, and that on June 2, most of these workers will be officially separated from the government, permanently depriving the States of the benefits of their work. That is consistent with Secretary Kennedy's recent testimony, where he described the March 27 Directive as "*decisive* action *quickly* that could eliminate the metastasizing of [HHS], which was growing, and growing, growing as our health declined." Brachfeld Decl. ¶ 5 (emphasis added). No one could reasonably find that the March 27 Directive was "all bark and no bite," *Cal. Cmtys. Against Toxics v. EPA*, 934 F.3d 627, 637 (D.C. Cir. 2019) (cited Opp'n 27), because the Directive plainly had a massive and "direct effect on day-to-day business" of HHS, *see Franklin v. Massachusetts*, 505 U.S. 788, 797 (1992) (cited Opp'n 27).

Defendants next suggest (without evidence) that their actions are "ongoing and evolving." Opp'n 27; *see also id.* at 27–28 ("developing," "remain subject to changes," "still being planned"). But whether Defendants take hypothetical future actions to further dismantle HHS is irrelevant to whether the actions that they have already taken are final and thus subject to APA review. Plaintiffs can challenge final agency actions that have already happened—if that were not so, the government could always evade APA review by suggesting that it may take additional future action.

B. Defendants' Actions Are Not Committed to Agency Discretion.

The Defendants' attempt to recast the March 27 Directive as "programmatic decisions . . . committed to agency discretion," Opp'n 33–34, fails to overcome the APA's "basic presumption of judicial review." *Weyerhaeuser Co. v. U.S. Fish & Wildlife Serv.*, 586 U.S. 9, 22–23 (2018) (citation omitted). The exception for decisions committed to agency discretion must be read "quite narrowly" and is confined only to "those rare circumstances where the relevant statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion." *Id.* at 23. Requiring Defendants here to "articulate[] a satisfactory

explanation for [their] decision," *Dep't of Com. v. New York*, 588 U.S. 752, 773 (2019), is simply demanding compliance with a "fundamental requirement of administrative law" that "an agency set forth its reasons for decision." *Massachusetts v. Nat'l Insts. of Health*, No. 25-cv-10338, 2025 WL 702163, at *16 (D. Mass. Mar. 5, 2025). The Court certainly has a "meaningful standard against which to judge the" Agency's action: decades of applicable precedent for arbitrary and capricious review. *Cf. Weyerhaeuser*, 586 U.S. at 23; *see* Ex. 76, *Colorado v. Kennedy*, at *27. ("There are applicable constitutional, statutory, and regulatory standards that cabin HHS' discretion as an agency."). The cases cited by Defendants show that there is not, as Defendants suggest, *see* Opp'n 33-34, any rule that RIFs are unreviewable by Courts. *See McKenna v. Dep't of Interior*, 996 F.2d 1235 (Fed. Cir. 1993) (table) (cited Opp'n 33) (considering the strength of the agency's record evidence to determine the propriety of its decision); *Markland v. Off. of Pers. Mgmt.*, 140 F.3d 1031, 1033 (Fed. Cir. 1998) (cited Opp'n 34) (same).

Defendants' attempt to obtain a more deferential "mandamus-like" standard of review by mischaracterizing Plaintiffs' APA claims is also unavailing. *See* Opp'n 29–32. Defendants' argument rests on the incorrect assertion that Plaintiffs seek relief under 5 U.S.C. § 706(1), which permits courts to "compel agency action unlawfully withheld or unreasonably delayed." But Plaintiffs' APA claims are brought under 5 U.S.C. § 706(2), *see* Compl., ECF No. 1 ¶¶ 333, 341, 344–58, which authorizes courts to "hold unlawful and set aside agency action." The Complaint does not seek to compel an agency action withheld or delayed. Rather, it seeks vacatur of the March 27 Directive and an injunction preventing Defendants from implementing it. *Id.* at 96–97. The fact that agencies have stopped acting is a consequence of the March 27 Directive, but it is not the agency *inaction* that the Plaintiffs seek to remedy. *See NAACP v. Sec'y of Hous. and Urb.*

Dev., 817 F.2d 149, 160 (1st Cir. 1987) (the "purpose of § 706(2)(A) is to provide for judicial review of agency action and inaction that falls outside its statutory powers").

C. The Unrebutted Factual Record Demonstrates that the March 27 Directive Was Arbitrary and Capricious

The undisputed evidence in the record shows that the March 27 directive was arbitrary and capricious, in that it was not the result of the "logical and rational" decision-making process. *Allentown Mack Sales & Serv.*, *Inc. v. N.L.R.B.*, 522 U.S. 359, 374 (1998); *see also Rhode Island*, 2025 WL 1303868, at *10; *New York*, 2025 WL 715621, at *11–12; *cf. Nat'l Council of Nonprofits v. Off. of Mgmt. & Budget*, 763 F. Supp. 3d 36, 55-56 (D.D.C. 2025).

Defendants offer virtually no response to Plaintiffs' argument. Their brief does not describe any reasoning that Defendants purportedly undertook in issuing the March 27 Directive—let alone offer any evidence of such reasoning. Defendants claim that Plaintiffs "overlook the cost-saving value of actions like consolidating redundant departments," Opp'n 33, but Defendants do not specify what those cost savings are, have provided no evidence that they actually considered them, and have offered no indication that they considered countervailing financial costs and other harms.

Defendants have no rejoinder to Secretary Kennedy's own admissions that the Agency did not perform a careful review of employees' job responsibilities because doing so would "take[] too long and you lose political momentum," Navedo Decl., ECF No. 44 ¶ 4; that it was always the plan that "there [we]re going to be mistakes," *id.*; that it was "more important to do decisive action quickly" than to avoid those mistakes, Brachfeld Decl. ¶ 5; and that many of the consequences of the Directive were mistakes, including the termination of the World Trade Center Health Program, *id*. ¶ 6. Nor do Defendants counter Plaintiffs' evidence showing that Defendants failed to consider many "important aspect[s] of" the March 27 Directive before issuing it. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, (1983). There is nothing to show they

considered the chaos that would arise in the wake of the Directive or that they considered the reliance interests of anyone, including Plaintiff States, in violation of the APA. *Michigan v. E.P.A.*, 576 U.S. 743, 753 (2015); *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 591 U.S. 1, 30 (2020).

D. The March 27 Directive Violates the APA Because It Contravenes Numerous Statutes.

Defendants' broad claim that Plaintiffs have not identified any "statutory obligations" affected by the Directive is meritless. Opp'n 34–35. Plaintiffs have identified numerous ways in which Defendants have violated the APA by contravening statutory mandates and Defendants have not meaningfully responded to these arguments with anything more than conclusory assertions. By way of addressing a few:

NIOSH's Occupational Safety Research: Despite the Secretary's recent purported May 13, 2025, reinstatements of some employees, NIOSH's research laboratories and divisions remain largely shuttered and unable to fulfill its statutory responsibilities as an occupational health research institute. NIOSH was created by Congress as its own occupational research arm within HHS. *See* 29 U.S.C. § 671(b). None of the reinstatements covered NIOSH's occupational research programs, which are mandated by the Occupational Safety and Health Act. *See* 29 U.S.C. §§ 669(a), 671(c)(2) (directing NIOSH to conduct occupational safety and health research). This core area of NIOSH is not functioning. Ex. 68 (Suppl. John Doe 2 Decl.) ¶ 9.

Similarly, NIOSH's mine safety research divisions, which are run out of Spokane and Pittsburgh, have been eliminated. *Id.* ¶ 8; *see also Am. Fed'n of Gov't Emps.*, 2025 WL 1358477, at *25 (221 of 222 workers in NIOSH Pittsburgh's mining research division will be terminated). With their unique and immobile technology and employees' expertise, these are the only research laboratories able to fulfill NIOSH's statutory directive under the Mine Improvement and New

Emergency Response Act of 2006, which directed NIOSH to promote "research, development, and testing of new technologies and equipment designed to enhance mine safety and health." 29 U.S.C. § 671(h)(3); *see also* 30 U.S.C. §§ 937(b), 951(a)–(b) (requiring NIOSH to conduct research on mine worker health and mine safety). There has been no effort to transition these duties anywhere else, leaving Plaintiff States in the dark. Ex. 68 (Suppl. John Doe 2 Decl.) ¶ 9.

CDC's National Center on Birth Defects and Developmental Disabilities: In the Children's Health Act of 2000, Pub. L. No. 106-310, Congress mandated HHS to, among other tasks, "make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an intramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems." 42 U.S.C. § 247b-4a(d)(1). It established the program within CDC and made its programs mandatory. 42 U.S.C. § 247b-4(a)(1–2). But the Directive has eliminated the entire Early Hearing Detection and Intervention team at the CDC's National Center on Birth Defects and Developmental Disabilities; Plaintiff States' grantees are now being told future grant applications are "on hold," and the "the typical functions of project officers, health/data scientists and evaluation scientists are not occurring." Ex. 27 (Eilers Decl. - WA) ¶ 13.

FDA's Center for Tobacco Products: In passing the Family Smoking Prevention and Tobacco Control Act, 21 U.S.C. § 387a, *et seq*., Congress granted broad authority and direction to the FDA to regulate tobacco products, and specifically established within the FDA the Center for Tobacco Products (CTP), which was responsible for implementation of the Act. Pls.' Mem. 17-18; 21 U.S.C. § 387a(e) ("The Center shall be responsible for the implementation of this subchapter and related matters assigned by the Commissioner"). After the Directive was implemented, the Center for Tobacco Products had no employees in the office responsible for tracking tobacco user

fees (which entirely funded the Center for Tobacco Products), supporting contract acquisitions and monitoring payroll. Ex. 73 (John Doe 7 Decl.) ¶¶ 7, 23. Furthermore, the RIFs eliminated entire teams responsible for health communication and education projects, including "The Real Cost" campaign, a national tobacco prevention advertising campaign, leaving that work abandoned. *Id.* ¶ 24.

Lead Poisoning Programs: In passing the Lead Contamination Control Act of 1988, Congress directed HHS and CDC to work on the prevention of lead poisoning and asthma control through data collection, surveillance, publication, collaborative efforts, education, and technology assessment. 42 U.S.C. § 247b-3; *id.* § 247b-10. The CDC accomplished this through the National Center for Environmental Health (NCEH), but nearly everybody at NCEH doing this statutory work was laid off, meaning nobody is left to carry out these congressionally-mandated functions Ex. 46 (Doe 1 Decl.) ¶¶ 20–27; Pls.' Mem. 31, 49–51.

Reproductive and Maternal Health Programs: Congress ordered HHS to "continue a federal initiative to support State and tribal maternal mortality review committees," and "to improve data collection and reporting around maternal mortality," which the CDC accomplished through its PRAMS data collection efforts and support for state MMRCs. 42 U.S.C. § 247b-12(a)(1)–(a)(2). But Defendants gutted the entire PRAMS team, and have undermined support for Plaintiff States' MMRCs, destroying the programmatic framework Congress mandated. Pls.' Mem. 9–12, 40–42.

HIV and STD Prevention Program: Beginning in 1988, Congress directed HHS to undertake a range of programs targeted to the prevention of HIV/AIDS, including providing technical assistance, 42 U.S.C. § 300ee-4; administering grants to States, *id.* § 300ee-11, *et seq*.; and implementing public awareness campaigns, *id.* § 300ee-31, *et seq*. Until now, this work was

conducted only by CDC's National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention—work that has since halted as a result of the March 27 Directive. Pls.' Mem. 6–9, 31–32.

Federal Poverty Guidelines: For decades, Congress has specifically directed HHS to annually revise the Federal Poverty Guidelines. 42 U.S.C. § 9902(2). As of the date of this Reply, the sub-agency responsible, HHS's Office of Assistant Secretary for Planning and Evaluation (ASPE), has disclaimed the program, noting that "[d]ue to the current HHS restructuring," the "information" on its website (including the Federal Poverty Guidelines page) is "not being updated currently." Ex. 16 (May 5, 2025 ASPE Webpage).

Accordingly, aside from reportedly partial restoration of a few statutorily required NIOSH programs in the past week, the unrebutted record show these congressionally mandated programs will be destroyed as a result of Defendants' Directive.

Similarly, Defendants do not dispute that the Executive Branch is obligated to spend money appropriated by Congress. *See, e.g.*, *In re Aiken County*, 725 F.3d 255, 261 n.1 (D.C. Cir. 2013); *City & Cnty. of San Francisco v. Trump*, 897 F.3d 1225, 1235 (9th Cir. 2018); *New York*, 2025 WL 715621, at *1. And the unrebutted record shows that Congress has appropriated billions of dollars that Defendants will be unable to spend due to the March 27 Directive, including over $190 million to CDC's National Center for Environmental Health, over $50 million dedicated to addressing childhood lead poisoning, Pls.' Mem. 30–31, and nearly $1.2 billion to the CDC center that oversees the Office on Smoking and Health and the Division of Reproductive Health, but both of those offices were hit hard by the Directive, *id.* at 9–12, 17–18, 32–33. And although Defendants restored *some* NIOSH programs, others for which Congress had already allocated hundreds of millions of dollars, remain gutted. Defendants' actions are thus in violation of the APA because

they violate the appropriations statute. *See Rhode Island*, 2025 WL 1303868, at *13. They are, on multiple levels, contrary to law, and must be set aside.

V. Plaintiffs Are Likely to Succeed on the Merits of their Constitutional and *Ultra Vires* Claims

Defendants likewise offer no meaningful response to Plaintiff States' arguments that the March 27 Directive violates the Constitution's separation of powers principles and Appropriations Clause, and is *ultra vires*.

Defendants cite *Dalton v. Specter*, 511 U.S. 462 (1994), as support for their argument that Plaintiffs are "bootstrap[ping]" constitutional claims to "garden-variety" agency action, *see* Opp'n 37, but "*Dalton* suggests that some actions in excess of statutory authority may be constitutional violations, while others may not." *Sierra Club v. Trump*, 963 F.3d 874, 889 (9th Cir. 2020) (*vacated and remanded as moot sub nom. Biden v. Sierra Club*, 142 S. Ct. 46 (2021)). As one court reviewing mass RIFs recently explained, "[t]he facts of *Dalton* could not be more different from the scenario here," since *Dalton* "challenged Presidential action taken pursuant to statutory authority that Congress delegated to the President," whereas Plaintiff States's claims here are about Defendants "acting without *any* authority, constitutional or statutory." *Am. Fed'n of Gov't Emps.*, 2025 WL 1358477, at *18; *see also Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579 (1952).

Defendants wrongly rely on *Lincoln v. Vigil*, 508 U.S. 182 (1993) to argue they have "unreviewable discretion to make choices on how the [challenged] appropriations are spent." Opp'n 36. Unlike in *Lincoln*, where "Congress never expressly appropriated funds for" the program whose cancellation was challenged, 508 U.S. at 186, here Congress *has* appropriated funds for the subagencies and centers that the March 27 Directive effectively ended. *See supra* Section IV.D; Pls.' Mem. 37–43 (listing statutory responsibilities and Congressional appropriations for the fulfillment of those responsibilities). Defendants not only fail to explain how they will

spend congressionally appropriated funds after having fired 10,000 people, but also claim that the March 27 Directive would save $1.8 billion. Ex. 1 at 2.

Defendants contend that they are permitted to broadly restructure and dismantle programs that Congress has required, and appropriated funds to support, because those appropriations "provide[] no limitations or instructions on how or when the funds should be spent." Opp'n 36. But the appropriations are explicitly tied to the statutory functions that Congress also directed Defendants to perform. Because the March 27 Directive renders ineffective the Congressional plan to delegate specific duties to HHS, where funds are appropriated for that purpose, it violates separation of powers principles, the Appropriations Clause, is *ultra vires* and unconstitutional. *See Lincoln*, 508 U.S. at 193 ("Of course, an agency is not free to simply disregard statutory responsibilities: Congress may always circumscribe agency discretion to allocate resources by putting restrictions in the operative statutes . . . ."); *see also Am. Fed'n of Gov't Emps. v. Trump* 2025 WL 1358477, at *17-18 ("[S]weeping reorganization of the federal bureaucracy requires the active participation of Congress.").

VI. The Unrebutted Factual Record Shows that Plaintiffs are Experiencing Irreparable Harm

A movant need not "demonstrate definitive harm" to support issuance of a preliminary injunction, *Animal Welfare Inst. v. Martin*, 588 F. Supp. 2d 70, 101 (D. Me. 2008); a showing that "irreparable injury is *likely*" will suffice, *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008) (emphasis in original). In any event, Plaintiffs have far exceeded this threshold, as they have submitted numerous declarations attesting with specificity that the March 27 Directive has already caused irreparable harm to Plaintiffs including the loss of public health services, resources, data, guidance, policies, and expertise and will continue to do so without court intervention, as detailed *supra* Section III.A.

Aside from conclusory assertions to the contrary, Defendants have not presented any facts to contradict this ample record that shows Plaintiff States have been and will continue to be harmed. Nor are Defendants' legal authorities to the contrary. For example, in *Roe v. Department of Defense*, cited Opp'n 38, the Court found that there *was* irreparable harm even with only an asserted reputational injury, noting that the Supreme Court had "rejected" a stricter standard and only "require[es] plaintiffs to 'demonstrate that irreparable injury is *likely* in the absence of an injunction.'" 947 F.3d 207, 228 (4th Cir. 2020), *as amended* (Jan. 14, 2020) (quoting *Winter*, 555 U.S. at 22).[14]

VII. The Balance of Equities and Public Interest Factors Heavily Favor Issuing Preliminary Relief.

Plaintiffs have a strong interest in critical public health and safety infrastructure, warranting an injunction. *See Woonasquatucket River Watershed Council v. U.S. Dep't of Agric.*, No. 25-cv-00097, 2025 WL 1116157, at *23 (D.R.I. Apr. 15, 2025); *Colorado v. U.S. Dep't of Health & Hum. Servs.*, No. 25-cv-00121, 2025 WL 1017775, at *5 (D.R.I. Apr. 5, 2025); *Maine Forest Prods. Council v. Cormier*, 586 F. Supp. 3d 22, 64 (D. Me. 2022), *aff'd*, 51 F.4th 1 (1st Cir. 2022). Defendants argue that "the American people have entrusted [the Executive Branch] with the power to direct the activities of executive departments," and that "any sort" of relief would be against the public's interest in seeing that power carried out effectively. Opp'n 39. But courts regularly find that the balance of harms favors issuing injunctive relief where there is a substantial likelihood that the agency acted unlawfully. *Rhode Island*, 2025 WL 1303868, at *17.

[14] Defendants' argument that Plaintiffs waited too long after the March 27 Directive to file their injunction, Opp'n 38, fails. First, there naturally was some time between when the Directive went into effect and when the States were able to assess the magnitude of its impacts. Second, the harms will become permanent on June 2 when the RIFs go into effect absent swift Court intervention.

Defendants cannot overcome these critical public interests by invoking the President and Secretary's interest in setting their own priorities for HHS, and their reliance on *Heckler v. Chaney*, 470 U.S. 821 (1985), is misplaced, as that case did not address the public interest or the balance of equities. Defendants also contend that requested relief is "impracticable in the extreme, if not impossible" because Defendants would have to "reverse steps already taken." Opp'n 40. This description is implausible: it is belied by the record which shows that Defendants have successfully recalled hundreds of employees from administrative leave in recent weeks, including after the West Virginia court order, *Wiley*, 2025 WL 1384768, at *13, Opp'n 9; it omits the fact that most employees subject to the RIFs will have those RIFs finalized on June 2, Opp'n 8–9, 39, *see* Howard Decl. ¶ 2, ECF No. 52-1; and it contradicts Defendants' own contention that the challenged Directive is "not final," Opp'n 10.

Defendants also cite the financial cost of an injunction—but to maintain the status quo at the Department the Government "merely" would have to spend money "Congress has appropriated." *Maine*, 2025 WL 1088946, at *29; *see also New York v. Trump*, No. 25-cv-39-JJMS-PAS, 2025 WL 357368, at *4 (D.R.I. Jan. 31, 2025); *Doe v. Trump*, No. 25-cv-10139-LTS, 2025 WL 485070, at *14 (D. Mass. Feb. 13, 2025); *Woonasquatucket River Watershed Council*, 2025 WL 1116157, at *23; *Nat'l Treasury Emps Union v. Trump*, No. 25-cv-0935, 2025 WL 1218044, at *20 (D.D.C. Apr. 28, 2025). The balance of equities and public interest therefore weigh heavily in favor of granting preliminary injunctive relief.

VIII. Defendants' Remaining Arguments Lack Merit

A. There Is No Basis to Narrow Plaintiffs' Requested Injunction.

Defendants state that Plaintiffs' requested injunction should be "significantly narrowed," but do not identify *how* the requested injunction should be narrowed or what part they deem too broad. *See* Opp'n 41–42. In any event, Plaintiffs are entitled to "complete relief" for their harms.

Califano v. Yamasaki, 442 U.S. 682, 702 (1979). The source of Plaintiffs' injuries is the March 27 Directive, and Defendants do not identify any administrable means by which they could reverse their actions only in part.[15]

B. The Court Should Not Require a Bond.

Defendants have not suggested what bond they would like the Court to order, nor have they identified a single expense they would incur from an injunction. *See* Opp'n 42. Instead, they argue that Plaintiffs "should have skin in the game," a suggestion that ignores the extensive evidence of harm in the record. *Id.* The Court should exercise its discretion to forego a bond here, like all three of the courts recently issuing injunctions against HHS, described *supra* in Section I, did. *Am. Fed'n of Gov't Emps.*, 2025 WL 1358477, at *24 (finding "significant public interest" and noting that "the government [will] incur costs if the RIFs are implemented hastily and unlawfully") (citation omitted); *Wiley*, 2025 WL 1384768, at *13 (noting "absence of any meaningful harm to the Defendants related to this injunction"); Ex. 76, *Colorado v. Kennedy*, at *58 (noting that "it would defy logic . . . to hold the States hostage for [HHS's] harm") (quotation omitted). To the extent a bond is required, Plaintiffs request that the bond be nominal. *See Nat'l Council of Nonprofits*, 2025 WL 597959, at *19; *Maine*, 2025 WL 1088946, at *29–30 (collecting cases showing practice in this Circuit of ordering nominal bonds).

C. The Court Should Not Issue a Stay.

Upon issuing an injunction, the Court should not preemptively stay its own order, as Defendants suggest without any reasoning or citation to authority, Opp'n 43. Given the specific,

[15] Defendants incorrectly contend that the Court should "remand" to the Department rather than vacate the March 27 Directive. Opp'n 34. The preliminary injunctive relief Plaintiffs seek is an interim measure until the parties litigate the merits to a final judgment. *See, e.g.*, 5 U.S.C. § 705. The Court can address the propriety of vacatur or remand at the merits stage; such potential final relief does not affect a court's ability to grant provisional relief.

concrete, documented harms to Plaintiff States arising from Defendants' actions, a stay would be inappropriate.

***

For the foregoing reasons, Plaintiffs respectfully request that their Motion be granted.

Dated: May 19, 2025

Respectfully submitted,

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196-MRD-PAS

DECLARATION OF MOLLY BRACHFELD

Pursuant to 28 U.S.C. § 1746, I, Molly Brachfeld, do hereby state:

1. I am an Assistant Attorney General in the Office of the Attorney General for the State of New York, and I appear on behalf of the State of New York in this action and am a member in good standing of the bar of the State of New York.

2. I am admitted to appear in this action in the United States District Court for the District of Rhode Island pursuant to this Court's Text Order from May 6, 2025.

3. I submit this Declaration and its attached Exhibits in further support of Plaintiff States' Motion for a Preliminary Injunction.

4. I make the following statements on the basis of my own knowledge or a review of files in my possession.

5. On May 14, Secretary Kennedy testified before Congress. Among other things, his testimony concerned the restructuring and reductions in force at the center of this lawsuit.

Senate HELP Committee, *Senate HELP Hearing: FY 2026 Department of Health and Human Services Budget*, YouTube (May 14, 2025), https://www.youtube.com/watch?v=do7L8jUvZoo.

Under questioning, Secretary Kennedy stated:

> I understand that if you look at this from a distance you'd say: "Why don't you just do this surgically and cut one person at a time?" This agency has grown so big so fast and everybody who comes in says "I'm going to cut it down." and nobody's been able to do it and there, there was an understanding that the longer that you wait the more the inertia kicks in.
>
> And we had to act quickly so that we could do something for the American people that is lasting. And we understood that there would be some mistakes made and that we would go back and reverse them when they were made. But it was more important to do decisive action quickly that could eliminate the metastasizing of this agency, which was growing, and growing, growing as our health declined.

Id. at 2:24:48.

6. Secretary Kennedy also testified that HHS made "a couple of mistakes," *id.* at 2:24:38. He stated that the cuts that terminated the World Trade Center Health Program "should not have been made," *id.* at 2:24:05, and testified that he "d[id]n't know" that the National Firefighter Registry for Cancer had been shut down, 2:26:15. When asked about why these programs were cut, Secretary Kennedy responded: "[i]t was part of the overall budget cuts. Our agency was asked to make very, very serious budget cuts that were going to be painful." *Id.* at 2:23:35. And when asked by Senator Murkowski why domestic violence funding from HHS was not being received by grantees, he responded:

> Sen. Murkowski: It may be that with the RIFs you don't have people that are processing these things.
>
> Secretary Kennedy: That could be.

Id. at 1:14:36.

7. For the ease of the Court and the parties, I have begun numbering the exhibits to my declaration at Exhibit 66 because the May 9, 2025 Declaration of Andres Ivan Navedo (Navedo Declaration) attached Plaintiffs' Exhibits 1-65. ECF No. 44.

8. Attached as Exhibit 66 is a true and accurate copy of the Declaration of Annick Benson-Scott, HIV/STD/TB Section Manager for the Center for Public Health Practice, Public Health Division of the Oregon Health Authority.

9. Attached as Exhibit 67 is a true and accurate copy of the Declaration of Dr. Maria Guadalupe Jaime-Mileham, Deputy Director of the California Department of Social Services, Child Care and Development Division.

10. Attached as Exhibit 68 is a true and accurate copy of the Supplemental Declaration of John Doe 2, an employee at the National Institute for Occupational Safety and Health (NIOSH). This is a supplemental declaration by the same pseudonymous declarant who submitted the Declaration of John Doe 2, Exhibit 47 to the Navedo Declaration, ECF No. 44-47.

11. Attached as Exhibit 69 is a true and accurate copy of the Declaration of Jane Doe 3, a former employee of the Division of Reproductive Health (DRH) in the Centers for Disease Control and Prevention (CDC).

12. Attached as Exhibit 70 is a true and accurate copy of the Declaration of Jane Doe 4, an employee of the Office of Smoking and Health (OSH) in CDC.

13. Attached as Exhibit 71 is a true and accurate copy of the Declaration of Jane Doe 5, an employee of the Division of STD Prevention in CDC.

14. Attached as Exhibit 72 is a true and accurate copy of the Declaration of Jane Doe 6, a former employee of the Division of Data and Technical Analysis within the Office of the Assistance Secretary for Planning and Evaluation (ASPE).

15. Attached as Exhibit 73 is a true and accurate copy of the Declaration of John Doe 7, an employee of the Center for Tobacco Products (CTP) within the Food & Drug Administration (FDA).

16. Attached as Exhibit 74 is a true and accurate copy of the Declaration of Gordon Sloss, Program Manager of the California Tobacco Prevention Program at the California Department of Public Health.

17. Attached as Exhibit 75 is a true and accurate copy of the Declaration of Eli Rosenberg attaching thereto Exhibits A-C. Mr. Rosenberg's declaration was attached as Exhibit 25 to the Navedo Declaration, ECF No. 44-25, but Exhibits A-C were omitted in error.

18. Attached as Exhibit 76 is a true and accurate copy of *Colorado v. Kennedy*, No. 1:25-CV-00121 (D.R.I. May 16, 2025), ECF No. 84.

19. Attached as Exhibit 77 is a true and accurate copy of a news article by Eric Katz, *CDC to cut one employee for each it is recalling from layoffs* (May 14, 2025), https://www.govexec.com/workforce/2025/05/CDC-cut-one-employee-each-it-recalling-layoffs/405336/.

20. Plaintiffs' Motion for a Preliminary Injunction erroneously stated that "[t]he March 27 Directive proposed to move the entire ASPE to the new 'Administration for a Healthy America,'" ECF No. 43 at 21, but, in fact, the March 27 Directive proposed to move the entire ASPE to the new "Office of Strategy," *see* Ex. 1 (March 27 Directive), ECF No. 44-1.

Dated: New York, New York
May 19, 2025

/s/ Molly Brachfeld
Molly Brachfeld
Assistant Attorney General
Office of the New York State Attorney General

Exhibit 66

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 25-cv-00196

DECLARATION OF ANNICK BENSON-SCOTT

I, Annick Benson-Scott, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the HIV/STD/TB Section Manager for the Center for Public Health Practice, Public Health Division of the Oregon Health Authority (OHA). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with staff and subject matter experts within OHA, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Reply in Support of Motion for a Preliminary Injunction.

Professional Background

3. I have been employed in public health program development, education, administration, and policy implementation in Oregon since 2000. I have been the OHA HIV/STD/TB Section Manager since 2016. My prior responsibilities include HIV/TB

Community Services Manager between 2005-2016 and Public Health Program Coordinator between 2000-2005.

4. The Center for Public Health Practice within the Oregon Health Authority Public Health Division includes several joint research projects that rely not just on federal funds but on program oversight by federal project officers, operational training, and collaboration between field sites in other states that the federal program officers fund and facilitate. The methodological and scientific integrity of these projects depends on continuity of the research. The research itself serves to inform public health initiatives in Oregon and nationally.

5. The OHA HIV/STD/TB Section is responsible for conducting two such projects. Both projects are managed by the Centers for Disease Control and Prevention (CDC), Division of HIV Prevention, Behavioral and Clinical Surveillance Branch of the National Center for HIV, Viral Hepatitis, STD and Tuberculosis Prevention within the Federal Department of Health and Human Services (HHS). These projects provide the State of Oregon with up-to-date information about health care need and utilization, access and quality of care, effectiveness of prevention messages, and specific communities of people at risk for HIV transmission or about people living with HIV. The information collected from these projects help Oregon providers plan and implement HIV prevention and care services to prevent HIV transmission and improve health outcomes.

6. The OHA HIV/STD/TB Section has been administering the Medical Monitoring Project (MMP) survey in Oregon since 2007. MMP data are the primary means of collecting needs assessment data related to people living with HIV in Oregon. Through MMP data, we better understand how people with HIV in Oregon are doing clinically, behaviorally, and socially. We can examine a wide variety of factors by geographic area and patient characteristics,

and adjust HIV care and prevention services, as needed, to ensure equitable access to health care and other supportive services for all Oregonians living with HIV.

7. On January 1, 2025, OHA responded to Notice of Funding Opportunity PS25-0008 requesting funds to continue the MMP project. On April 1, 2025, the OHA project contact received an email from the CDC project officer that their position and unit was eliminated. On April 14, 2025, OHA received an email from MMP@cdc.gov that all meetings were cancelled. To date, CDC has provided no information to OHA regarding the status of the grant application submitted. The current grant ends May 31, 2025.

8. OHA has three full time staff working as Data Collection Specialists in MMP. The next grant payment is due on June 1, 2025, and if CDC personnel are no longer in place to administer the grant, the loss of funding may require OHA to eliminate these public health positions.

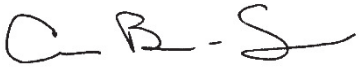
9. The OHA HIV/STD/TB Section has been administering the National HIV Behavioral Surveillance (NHBS) project survey in Oregon since 2016. NHBS data is the primary means of collecting needs assessment data related to people at risk for acquiring HIV. Through NHBS data, we better understand behavioral risk factors for HIV, HIV testing behaviors, receipt of prevention services, and use of prevention strategies for community members disproportionately affected by HIV. Medical and public health scientists use NHBS data to evaluate and develop behavioral health treatment and intervention that reduces spread of HIV and increases effectiveness of disease management.

10. On April 1, 2025, the OHA project contact received a text from the CDC project officer stating that the branch was eliminated and the entire NHBS staff were laid off. On May 9, 2025, the OHA project contact received a notice from CDC stating “all NHBS meetings—both

virtual and in-person—are cancelled". This includes in person Field Operations Training previously planned for May 2025.

11. OHA has a contract with Portland State University to administer NHBS. The current grant ends December 31, 2025. OHA and the contractor have no information pertaining to the continuation of this project. If CDC personnel are no longer in place to administer the grant, the loss of funding will require OHA to terminate this contract.

12. Each of the above-described projects affect Oregonians, as the loss of information pertaining to persons at risk for, or affected by HIV can have detrimental consequences, including a potential for outbreaks and increase in new infections and preventable deaths. In addition, the loss of these projects further reduces public health scientific expertise, hindering progress in understanding how to develop prevention programs that work and what services people need to thrive. Reestablishing these research programs after they have been dismantled would be costly, as the capacity that has been built will have been lost or greatly diminished



Annick Benson-Scott

Date: 5/15/2025

Exhibit 67

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF DR. MARIA GUADALUPE JAIME-MILEHAM

I, Dr. Maria Guadalupe Jaime-Mileham, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I am the Deputy Director of the California Department of Social Services, Child Care and Development Division. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

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

Professional Background

3. I have been the Deputy Director of the California Department of Social Services, Child Care and Development Division since January 2021. Prior to joining the California Department of Social Services, I served as the Senior Director for Early Childhood Education for the Fresno County Superintendent Schools since 2014. I was Deputy Director of the Central Valley Children's Services Network from 2009 to 2014, Adjunct Infant Toddler Instructor for the West Education Partners for Quality Infant and Toddler Caregiving from 2009 to 2014, and

Subsidized Manager for the Central Valley Children's Services Network from 2001 to 2009. I am a member of the Early Childhood Policy Council, the National Association for Young Children, and the County Offices of Education Program Administration of Child Development. I hold a Doctor of Education degree from California State University, Fresno and a Master of Education Degree from National University. One of my duties in my current role is to provide oversight of the California Head Start Collaboration Office. I also serve as a Child Care Development Fund Administrator.

4. The mission of the California Department of Social Services is to serve, protect, and support the people of California experiencing need in ways that empower wellbeing and disrupt systemic inequities.

5. The headquarters of the California Department of Social Services is located at 744 P Street, Sacramento CA, 95814, with several departmental offices throughout the state. The Department comprises close to 6,000 employees who are responsible for the oversight and administration of programs serving California's most vulnerable residents. Programs and services overseen and administered by the Department encompass cash assistance to eligible families; food benefits; child care and development programs, housing assistance and supportive services; child welfare services; support for individuals with disabilities; assistance for refugees, immigrants, and noncitizens; licensing and oversight of community care facilities for adults and seniors, group homes, and child care facilities; adult protective services; and assistance to disaster victims.

The Head Start Program

The federal Head Start program, founded in 1965, promotes school readiness for children from low-income families from birth to five years old. Head Start services support early learning and development, health, and family wellbeing.

6. Head Start is administered by the Office of Head Start (OHS) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS).

7. Head Start programs include Early Head Start programs for infants, toddlers, and expectant families and Head Start preschool programs for primarily 3- and 4-year-old children. In addition, Head Start includes American Indian and Alaska Native (AIAN) Head Start programs and Migrant and Seasonal Head Start (MSHS) programs serving farmworker families. Herein, these Head Start programs are referred to collectively as "Head Start" or "Head Start programs".

8. Head Start provides vital services to low-income children and families. In addition to providing high quality child care and early childhood education, Head Start connects children and families to wraparound social services and supports. Additionally, Head Start programs integrate state benefit programs to provide children with meals and snacks during the school day, diapers for young children, enrollment assistance for health insurance plans, and parental supports, including connections to career services and adult education.

9. Until April 1, 2025, Head Start was largely administered at the federal level by HHS employees working out of HHS Regional Offices located throughout the country.

10. In 2023-24, California's 100 direct Head Start regional recipients served over 80,345 children and families at 1,842 individual site locations, not including Family Child Care

Homes. Additionally, there are 13 direct AIAN recipients in California serving over 680 children and families at 25 site locations, and seven MSHS recipients serving over 6,330 children and families.

11. The California Department of Social Services currently administers the California Head Start Collaboration Office (CHSCO) grant which Congress established to "facilitate collaboration among Head Start agencies … and entities that carry out activities designed to benefit low-income children from birth to school entry, and their families." 42 U.S.C. § 9837b. The CHSCO provides a structure and a process for the OHS to work and partner with state agencies to leverage their common efforts in support of young children and their families to formulate, implement, and improve state and local policies and practices. In addition, the CHSCO is key in promoting parent choice to select the early care and education providers that best meet their family's needs for their children.

12. The California Department of Education is a regional Head Start recipient that administers and receives direct funding for Head Start programs.

13. I am providing this declaration to explain the impacts to California and the California Department of Social Services due to the changes to Head Start, including a reduction in HHS staffing, since April 1, 2025.

Reliance on HHS Head Start Staff Prior to April 1, 2025

14. Prior to April 1, 2025, the CHSCO and California Head Start recipients regularly relied on HHS Head Start staff for many aspects of the day-to-day operations and alignment of state and federal policies and initiatives.

15. HHS Head Start staff offered training, technical assistance, monitoring, site visits, and other support to California Head Start programs. Specifically, HHS Head Start staff would

routinely support the CHSCO in providing data and technical assistance to state agencies specific to the alignment of Head Start programs in California's mixed-delivery early care and education system, including comprehensive health and nutrition services and supportive services for children and families.

16. The HHS Head Start staff with whom the California Department of Social Services CHSCO communicated and relied on were primarily located in the HHS Region IX Office in San Francisco, California.

Changes in HHS Head Start Operations Since April 1, 2025

17. Since April 1, 2025, the California Department of Social Services CHSCO has seen significant changes to the operations of Head Start at the federal level.

18. Specifically, California's primary point of contact at HHS for providing technical assistance to the CHSCO is no longer available, and California Department of Social Services staff have not been able to locate other HHS staff with knowledge specific to the integration of Head Start programs in California's mixed-delivery early care and education system sufficient to perform these functions. The CHSCO and local Head Start programs rely on HHS staff who have knowledge of the federal and state laws specific to operating in California and the alignment of these programs with the Child Care and Development Block Grant and the California State Preschool Program.

19. Additionally, there have been significant delays in receiving important information from HHS Head Start staff since April 1, 2025. These delays have inhibited CHSCO in the provision of information and aligning services with state agencies, including the state's licensing system, schools, law enforcement, relevant community-based organizations, and substance abuse and mental health treatment agencies. Sharing information and facilitating

service alignment are critical components of strengthening family and community environments and reducing the impact of substance abuse, child abuse, domestic violence, and other high-risk behaviors that compromise healthy child development.

20. At the time of the closure of numerous HHS regional offices, the CHSCO was providing support to the California Department of Social Services' Community Care Licensing Division and the OHS to ensure Head Start-funded programs could maintain compliance with federal background check requirements. This work included identifying areas where the current state system needed updates to come into compliance with federal Head Start requirements. However, due to the regional office closures and the unavailability of HHS staff to provide needed policy interpretations and technical assistance , this work has halted. At this time, Head Start programs in California will be required to conduct background checks on all staff for a second time, rather than utilizing the "rap back" system to receive continuous updates on criminal history. These duplicative efforts will require Head Start programs to redirect funding from providing direct services to instead focus on background check compliance.

21. Moreover, the absence of support from the federal Head Start Office has required the CHSCO to redirect its work from supporting local programs to instead use resources to provide the best information available regarding the potential impacts of short- and long-term interruptions in Head Start services to programs administered by state partners, such as the California Department of Education's California State Preschool Program, and other California Department of Social Services programs, including but not limited to the Child and Adult Care Food Program and the Child Care and Development Block Grant.

22. On April 3, 2025, the California Department of Social Services received an email from Laurie Todd-Smith, Ph.D., Deputy Assistant Secretary for Early Childhood Development at

the HHS, Administration for Children and Families (ACF), confirming the closure of five HHS Regional Offices effective April 1, 2025 and requesting that communications to HHS about Head Start be directed to the following email address: ohsrecipientsupport@acf.hhs.gov.

23. On May 1, 2025, the OHS held a brief public webinar to provide information on the new organizational structure of the OHS. During the webinar, a map was displayed which showed how states were reorganized into existing Regional Offices. Per the reorganization, California was placed under Region XIII, which now includes Alaska, Idaho, Oregon, Washington, Hawaii, Colorado, Montana, Utah, Wyoming, Kansas, Nevada, Nebraska, American Samoa, Guam, Northen Mariana islands, and Palau. OHS did not allow any questions to be asked during the webinar and the CHSCO has not been assigned an HHS Head Start staff contact. As such, for more than a month, the CHSCO's only known contact information is the nation-wide general support email address referenced in Paragraph 22.

Effect on State's Head Start Program

24. The California Department of Social Services and local Head Start programs have been significantly and detrimentally affected by the changes to the HHS Head Start Program described above, which in turn creates a higher risk of harm to children and families throughout California.

25. HHS Head Start staff are no longer available to offer training, technical assistance, monitoring, site visits, and other support to Head Start programs. Approximately 80% of Head Start recipients in California layer and blend funding streams to support broader access to early care and education programs. This combined funding is used to expand to full-day, full-year programs as well as to provide comprehensive services. Head Start recipients in California rely on support and technical assistance from HHS Head Start staff to ensure that federal

requirements are met in blended funded programs No such support or technical assistance, whatsoever, has been provided since April 1, 2025.

26. Head Start programs are struggling to understand how to maintain compliance with the recent federal Executive Order prohibiting a range of activities related to Diversity, Equity, and Inclusion (DEI), and specifically how this order impacts Head Start performance standards. For example, Head Start programs are federally required to publicly post an annual program report on services provided the previous year, which includes DEI activities. Without training and technical assistance support from the OHS explaining how to navigate possibly contradictory federal directives, programs fear they will receive a letter of non-compliance for violating the Executive Order, potentially putting their federal grant at risk.

27. There have also been delays in funding and slower response times to inquiries. This includes processing of grant applications; processing requests for changes to program operations; issuance of official guidance to maintain compliance with Head Start program performance standards and the recent federal Executive Orders; drawing down and receiving funds in the Payment Management System; and receipt of Notices of Award, causing some programs to issue layoff pink slips to staff and risk closure.

28. The California Department of Social Services has received numerous reports from recipients of Notices of Awards being received late, causing programs to issue layoff notices to staff and prepare for potential closure of programs, including notifying parents of the potential closure.

29. There is an imminent risk that funding to Head Start programs in California will be delayed because the HHS Head Start staffing cuts have impacted HHS's ability to make payments to Head Start programs. These staffing cuts have also affected the ability of the

CHSCO to operate efficiently. This will in turn harm California through short and long-term interruptions in Head Start services that will cause increased applications for unemployment benefits and CalWORKs, California's Temporary Assistance for Needy Families program, by three core populations: 1) Head Start employees; 2) Head Start parents and guardians unable to work due to loss of child care; and 3) employees of vendors that rely on Head Start.

30. There will also be additional impacts to the California Department of Social Services and the California Department of Education early care and education services as families transition out of Head Start programs and look for other care options, straining limited state child care and preschool resources and risking unsafe child care options for children.

31. In sum, the changes described above risk significant harm to young children and their families in California and will disrupt the provision of high-quality services in safe and healthy settings that support a child's growth from birth to age five through services that support early learning and development, health and wellness, family well-being, and family engagement.

Lupe Jaime-Mileham Digitally signed by Lupe Jaime-Mileham
Date: 2025.05.16 12:16:22 -07'00'

DR. MARIA GUADALUPE JAIME-MILEHAM

Date:

Exhibit 68

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

SUPPLEMENTAL DECLARATION OF JOHN DOE 2

I, John Doe 2, an employee at the National Institute for Occupational Safety and Health (NIOSH, the Institute), declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am over the age of 18 and have personal knowledge of all the facts stated herein through personal experience, through conversations with my colleagues, and through review of the records to which I have access.

2. I submit this Supplemental Declaration in support of the States' Motion for a Preliminary Injunction, and as a continuation of the Declaration I have already submitted in this case. I am doing so anonymously, and withholding certain identifying details, because I am still employed by the Federal Government and fear retaliation for my participation in this lawsuit.

3. On May 13, 2025, Dr. John Howard sent a NIOSH-wide email explaining that some of the NIOSH staff in specific programs who had previously received Reduction in Force (RIF) notices had received additional notices explaining that their RIF had been rescinded. These restorations affected some select staff in in the NIOSH Office of the Director; the Respiratory

Health Division; the Division of Safety Research; the Division of Compensation and Analysis Support; the National Personal Protective Technology Laboratory; and part of the Division of Field Studies and Surveillance. None of the positions restored are in the Western United States. A true and correct snapshot of that email appears below:

From: Howard, John (CDC/NIOSH/OD)
Sent: Tuesday, May 13, 2025 10:59:31 AM
To: CDC All - NIOSH Personnel
Subject: Reduction-in-Force Update

Colleagues:

Today many NIOSH staff who had previously received Reduction in Force (RIF) notices on April 1st and May 2nd received letters from HHS indicating that their RIF notice was being rescinded and they were being reinstated into their positions. We are pleased to see these NIOSH staff members brought back to continue the important work of the Institute. Those who have been called back include staff from selected units in the NIOSH Office of the Director; the Respiratory Health Division; the Division of Safety Research; the Division of Compensation and Analysis Support; the National Personal Protective Technology Laboratory; and part of the Division of Field Studies and Surveillance.

While we celebrate with those who received a recission letter from HHS, I am mindful that others did not. I am hopeful that we can continue to make the case for reinstating everyone at NIOSH. We realize that there are still many who are facing a separation from NIOSH and their federal service. This continues to be a difficult time to navigate, and we are dedicated to supporting all NIOSH staff during an uncertain future. I want to encourage all staff who continue to be affected by the RIF to join the CDC sessions on how to register for the Reemployment Priority List (RPL) and Priority Reemployment List (PRL). Below is the information about the next session that will be held tomorrow, at 1 pm ET.

Every one of you has made a significant and positive impact in the lives of workers across the Nation. Today we saw a recognition of the importance of much of our work and we continue to hope that we will see further actions that will allow us to continue to conduct the best science and service for all workers.

JH

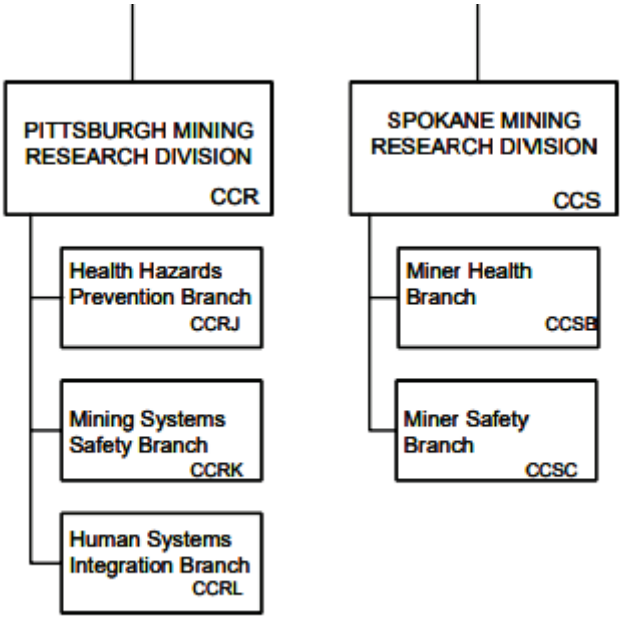
4. It is my understanding that this restoration affected approximately 38% of NIOSH's terminated staff, a number seemingly confirmed by Secretary Kennedy in his May 14, 2025 testimony before the U.S. Senate, where he testified to restoring "328 workers, mostly in the Cleveland and Morgantown office and for the World Trade Center site."[1]

5. NIOSH does not have any facility in Cleveland, Ohio, though it does have one in Cincinnati, Ohio. There is no mining safety research conducted by NIOSH in either Cincinnati or Morgantown, despite the Secretary's insistence that the "epicenter" of NIOSH's "critically important" work on mine safety was "Cleveland and Morgantown."[2] My understanding (and

[1] Senate HELP Committee, *Senate HELP Hearing: FY 2026 Department of Health and Human Services Budget*, YouTube (May 14, 2025), https://www.youtube.com/watch?v=do7L8jUvZoo (at 57:00).

[2] Senate HELP Committee, *supra* note 1, at 57:30.

according to Director Howard) is that the employees restored in Morgantown were those working on the Coal Workers' Health Surveillance Program (CWHSP) within the Respiratory Health Division, which does not do mine safety research (the Respiratory Health Division has only a "Field Studies Branch" and a "Surveillance Branch," and the CWHSP is within the latter). NIOSH's mine safety research programs are run out of the mining research divisions in Spokane and Pittsburgh, a fact that can be confirmed via NIOSH's official organizational chart.[3]



6. Despite the Secretary's recent actions, my RIF has not been rescinded. I know of nobody else in NIOSH's Spokane Mining Research Division that had their RIF rescinded. I, along with the rest of the trained NIOSH mine researchers in Spokane I mentioned in my previous Declaration, are still slated to be officially separated from government employment either June 2, 2025, or July 2, 2025.

[3] NIOSH Organizational Chart, CDC (last visited May 16, 2025), https://www.cdc.gov/about/media/pdfs/niosh-org-chart.pdf

7. I also have not received any indication that the NIOSH employees working on mine safety research in Pittsburgh have had their RIFs rescinded.

8. It is also my understanding that no employee in NIOSH's Western States Division (WSD), also housed in Spokane, received RIF rescissions. This understanding is additionally supported by the comments of Senator Lisa Murkowski of Alaska (one of the states served by the Western States Division) during the May 14, 2025 hearing, where she confirmed with Secretary Kennedy that employees in the NIOSH Center for Maritime Safety and Health (operated by the WSD) did not have their RIFs rescinded.[4]

9. It remains my understanding that following the RIFs, NIOSH will still face widescale closure, with over half of its workforce officially eliminated. The mining research done in Spokane, for instance, will still lose all of the employees providing its direction and expertise, and will effectively cease to exist. There still has been no transition plan given to us to transfer our duties anywhere else in the government. I continue to believe these reductions in force will cripple NIOSH's broader research capabilities.

10. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

JOHN DOE 2

JOHN DOE 2, NIOSH EMPLOYEE
Spokane, Washington

Date: May 19, 2025

[4] Senate HELP Committee, *supra* note 1, at 1:11:45.

Exhibit 69

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JANE DOE 3

I, Jane Doe 3, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Division of Reproductive Health (DRH), part of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within the Centers for Disease Control and Prevention (CDC). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in public health for over 35 years, of which 20 of those years were in DRH.

5. I am providing this declaration to explain the impacts of the reductions in force (RIFs) of April 1, 2025, on the operations of DRH. The April 1 RIFs have brought much of DRH's work to a halt. These impacts will be felt by the states as well as by their residents, as DRH will no longer be able to perform vital surveillance activities on maternal and infant health outcomes, in vitro fertilization (IVF), abortion, and contraception safety, nor will DRH be able to continue its field work to provide direct assistance to states through assignment of senior maternal and child health epidemiologists and capacity building to address the needs of reproductive-aged, pregnant, and postpartum women and their infants for an emergency response, such as a pandemic or natural disaster.

DRH's Mission and Work Prior to April 1, 2025

6. DRH has been dedicated to improving women's health, maternal health, and infant health for nearly 60 years, aiming to enhance the lives of women, infants, and families through science, data, and partnerships. DRH aims to combat preventable maternal mortality and morbidity and ensure optimal birth outcomes across the nation. Programs within DRH provide crucial data and data analysis as well as resources to empower state and local jurisdictions to monitor health behaviors and outcomes, guide program and policy evaluation and development, and implement tailored solutions. These data-driven approaches strengthen community initiatives, promote healthy families, and improve the well-being of women and infants.

7. DRH's priority areas are to:

a. Improve infant health outcomes and care;

b. Improve maternal health outcomes and care; and

c. Eliminate preventable maternal mortality.

8. DRH is made up of several subdivisions, including the Office of Director and three branches: Maternal and Infant Health Branch, Women's Health and Fertility Branch, and Field Support Branch.

9. The Office of Director is responsible for science, policy, partnerships, and communication activities for the division and includes a Division Director, Associate Director for Science, and an Associate Director for Policy, Partnerships, and Communication. The Associate Director for Science supervises DRH's Senior Health Economist, Health Services Lead, and Informatics Lead. The Associate Director for Policy, Partnerships, and Communication supervises the Communication Lead and the Policy Lead.

10. The Maternal and Infant Health Branch (MIHB) leads efforts to reduce health problems and death among mothers, newborns, and infants through robust data and surveillance and implementation of quality improvement interventions. The Maternal and Infant Health Branch includes three teams: Maternal Mortality Prevention Team, Perinatal and Infant Health Team, and Maternal Health and Chronic Disease Team. The Maternal and Infant Health Branch's activities are authorized by Congress in the Safe Motherhood Act, 42 U.S.C. § 247b-12, Preventing Maternal Deaths Act (Pub. L. 115-344), and Scarlett's Sunshine on Sudden Unexpected Death Act (Pub. L. 116-273). Since 2016, CDC has worked with state and territorial health departments to enhance measurement and provide better data on maternal mortality in the United States via the Enhancing Reviews and Surveillance to Eliminate

Maternal Mortality (ERASE MM) initiative. ERASE MM directly funds maternal mortality review committees (MMRCs) in 46 states and 6 U.S. territories to obtain detailed data on maternal mortality cases through standardized, high quality and faster data collection. Because of the ERASE MM program, the number of operational MMRCs nearly doubled between 2015 and 2020. Findings from MMRCs indicate that 80% of pregnancy-related deaths are preventable; therefore, MMRCs also develop actionable clinical and non-clinical recommendations for the prevention of maternal mortality. The Pregnancy Mortality Surveillance System (PMSS) is a national system that has provided comparable data across the United States for over 30 years on pregnancy-related deaths. In alignment with ERASE MM and PMSS work, CDC also funds 36 state Perinatal Quality Collaboratives (PQCs) and the National Network of PQC; these clinical partnerships with PQCs implement quality improvement efforts to address the prevention recommendations from MMRCs to improve obstetric and neonatal care and outcomes in a state or region based on local priorities and data. The Branch also supports the Sudden Unexpected Infant Death (SUID) Case Registry in 32 jurisdictions, which compiles data to provide a better understanding of circumstances and risk factors among SUID and to develop strategies to reduce future deaths, and also funds enhanced SUID prevention activities in 10 selected communities.

11. The Women's Health and Fertility Branch (WHFB) conducts surveillance and research and implements programs aimed at improving reproductive health, fertility, and pregnancy outcomes. The Women's Health and Fertility Branch includes three teams: Pregnancy Risk Assessment Monitoring System (PRAMS) Team, Fertility Epidemiology Studies Team, and Assisted Reproductive Technology Surveillance and Research Team. The Branch's activities are congressionally authorized by the Safe Motherhood Act, 42 U.S.C. §

247b-12, the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act (PREEMIE Act), Pub. L. 109-450, and the Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. 102-493. Key activities in the Women's Health and Fertility Branch include:

a. **PRAMS:** PRAMS was established in 1987 by Section 317K of the Public Health Service Act, also known as the Preventing Maternal Deaths Act of 2018 (P.L. 115-344), to reduce maternal and infant mortality and morbidity by monitoring maternal experiences behaviors and experiences before, during, and shortly after pregnancy. The PRAMS team works directly with 50 jurisdictions (46 states and 4 cities/U.S. territories) to provide scientific and technical support for continuous, year-round data collection (e.g., survey development, data collection system infrastructure, standardized methodology, and data processing and weighting) and publishes annual data and reports for public use. The data represents approximately three million live births annually in the United States. PRAMS is the only standardized state-specific data source for maternal and infant health and is crucial for informing programs and public health policies at the state and national levels aimed at improving maternal and infant health. PRAMS data are used by states for needs assessment and as performance and outcome measures for the Health Resources and Services Administration (HRSA) Title V Maternal and Child Health Block Grants and by academic and other researchers to investigate emerging maternal and infant health issues.

b. **Surveillance of contraception safety and contraception guidelines:** The Branch supports healthy pregnancy planning and the prevention of teen and unintended pregnancy by providing essential, up-to-date, and evidence-based clinical contraception guidelines for health care providers on safe and effective use of contraceptive methods (*U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use*). Based on continuous evidence identification and rigorous methodology, these are the only federal guidelines on the safety of contraceptive use for women with certain medical conditions and characteristics and help providers and patients make safe choices for pregnancy planning and pre-pregnancy health optimization, which is especially crucial for women with underlying medical conditions that may exacerbate risks associated with either contraception or pregnancy.

c. **Abortion data collection**: The Branch annually publishes the only federal national report on abortion data, which has been produced by DRH since 1969, and provides technical support to jurisdictions for abortion reporting (e.g., sample of standardized case reporting form, data collection system infrastructure, data processing).

d. **IVF surveillance:** The Branch works to enhance women's chances of successful IVF pregnancies through the National ART Surveillance System (NASS). Since 1995, NASS has tracked IVF activities annually for every clinic in the United States under a congressional mandate, offers critical IVF data to clinics, and supports families seeking assistance with infertility. The Branch provides

scientific and technical support (e.g., survey development, data collection system infrastructure, standardized methodology, data processing) to over 500 IVF clinics across the United States and its territories to annually collect and publish data for public use on patient and clinical characteristics and pregnancy and infant outcomes. Data from clinics represents approximately 95,000 live births annually in the United States. NASS is the only standardized state-specific and clinic-specific data source for IVF and is crucial for informing clinicians, patients, and public health policies aimed at increasing access to IVF and improving maternal and infant health.

12. The Field Support Branch assists domestic and international health agencies in epidemiologic monitoring and program evaluation, surveillance, emergency preparedness, and translation of findings by providing technical assistance, subject matter expertise, capacity building, partnership, and workforce development in reproductive, maternal, infant, and perinatal health programs. The Field Support Branch includes three teams: Maternal and Child Health Epidemiology Team, Emergency Preparedness and Response Team, and Global Reproductive Health Evidence for Action Team. The Field Support Branch's activities are authorized by Congress in the Public Health Service Act (PHSA), the Pandemic and All-Hazards Preparedness Act, Pub. L. 109-417, and the Safe Motherhood Act, 42 U.S.C. § 247b-12. Key activities in the Field Support Branch include:

a. **Maternal and child health epidemiology support to states:** The Branch has provided direct assistance to states since 1986 through the assignment of CDC maternal and child health epidemiologists as field assignees. These epidemiologists serve in states across the country by analyzing public health

data, advising leadership on applying evidence to programs, providing subject matter expertise, overseeing scientific projects, training other epidemiologists, improving quality and use of data systems, and evaluating public health programs. Field assignees are requested by states, who fund 80% of the salary and benefits for their field assignee, with the other 20% funded by CDC.

b. **Emergency preparedness and response:** The Branch builds capacity at national, state, and local levels for infectious disease outbreaks, natural disasters and other public health emergencies through training, leadership development, and practice exercises to optimize maternal and infant health. Staff identify, measure, and address the special needs of reproductive-aged women, pregnant women, and postpartum women and infants during emergency responses of emerging and re-emerging infections (e.g., COVID-19, Oropouche virus, measles) as well as environmental concerns (e.g., extreme heat, natural disasters, radiation exposure).

c. **Global maternal health:** The Branch improves global maternal and infant health by strengthening the evidence base and public health capacity. Staff established guidelines and pilot initiatives on maternal death surveillance and response and assessed the impact of interventions to increase access to emergency obstetric care.

The April 1, 2025 RIFs and Effects on DRH

13. On April 1, 2025, approximately 80 of 130 total DRH employees received RIF notices, including almost 60 scientists and medical officers. RIFed employees were placed on administrative leave immediately until their expected termination at the end of day on

June 2, 2025. None of the RIFed DRH employees have been permitted to continue work of the division during this time.

14. The RIFs effectively shut down all but one branch of DRH. All civil service employees of the Office of the Director and two of the three branches (Field Support Branch and Women's Health and Fertility Branch) were placed on administrative leave. Only the employees of the Maternal and Infant Health Branch remain employed by CDC.

15. Prior to the April 1 RIFs, most of the probationary employees and contractors in DRH's Office of the Director, Women's Health and Fertility Branch, and Field Support Branch were terminated on or before April 1, 2025.

The April 1 RIFs Have Devastated DRH's Work

16. With the exception of the work of the Maternal and Infant Health Branch, the RIFs have effectively halted all of DRH's work because there is no one left in the Division to carry it out. This includes many of DRH's statutorily mandated functions.

17. The April 1 RIFs have had an especially damaging effect on DRH surveillance systems. By eliminating the Women's Health and Fertility Branch, long-standing surveillance activities ceased that are vital for the health, safety, and well-being of families, mothers, and infants. PRAMS data for 2025 births is not being collected, data for 2024 births will be released to states in a raw and unusable format, and historical data from 1988-2023 are no longer available from CDC for policymakers and researchers to use. Notably, states and jurisdictions own their PRAMS data and contractually obligated functions with states are not occurring. The investment put into establishing this system and collecting this data to improve maternal and infant health outcomes is now wasted. In addition, there will no longer be continuous and systematic monitoring of scientific evidence on contraceptive safety or updated clinical

contraception guidance for health care providers, jeopardizing the health and safety of 47 million women in the United States who use contraception. The annual abortion data collection report by CDC has also ceased, eliminating the only federal source of data on the topic that has been published for over 50 years. Furthermore, data collection on IVF procedures has ceased, meaning critical surveillance data that informs procedural, safety, and ethical guidance for families seeking assistance with infertility is gone.

18. The April 1 RIFs have also eviscerated DRH's field work. Because the entirety of the Field Support Branch was terminated, epidemiologists assigned to work in the field as CDC employees in 11 state health departments have been removed from their posts. States immediately and without warning lost maternal and child health epidemiology leadership and progress on ongoing, often state-mandated, projects was halted. Data produced only by programs within DRH (e.g., PRAMS, abortion data collection) is used by states to prioritize and implement maternal and child health improvement efforts in their jurisdictions. Without these data and staff to lead needs assessments and data analysis with state-level data, states will not know what health conditions or outcomes to prioritize nor will they be able to track progress on their efforts. Additionally, immediate impacts to state and local jurisdictions include the loss of emergency preparedness and response capacity-building programs that DRH had funded since 2018; the removal of critical tools and resources for maternal and infant health emergency preparedness hosted on the CDC website; and the loss of CDC obstetrical and neonatal expertise available to public health and clinical staff during public health emergencies. Together, these losses will result in jurisdictions being less ready to support pregnant and postpartum women and infants during public health emergencies, including the current measles outbreak in the United States.

19. DRH's work is not and cannot be duplicated elsewhere in CDC or the broader Department of Health and Human Services (HHS). While HRSA's Maternal and Child Health Bureau (MCHB) administers a range of impactful programs, CDC's focus on surveillance and prevention in order to advance the scientific evidence base of public health risks, interventions, and outcomes related to maternal and infant health, and on providing clinical prevention and treatment guidance is distinct. For example, PRAMS maternal and infant health surveillance work is different from, but complements, HRSA MCHB program administration functions. PRAMS provides high quality data that are needed for states to conduct maternal and child program needs assessment and justification for their HRSA Title V block grants, with many of the PRAMS health indicators used by HRSA MCHB as their maternal and child health performance and outcomes measures. Through PRAMS, HRSA MCHB is able to evaluate the impact of their program funding on improving maternal and infant health. Furthermore, CDC's DRH is the only federal program to directly support states with assigned field epidemiologists, with states typically using funds from the HRSA Title V block grant to fund placement of the field assignees. While MCHB recognizes the importance of emergency preparedness on optimal maternal and infant health by requiring Title V block grant recipients to report out annually on jurisdictional MCH planning and preparedness, CDC conducts the research to determine the impact of public health emergencies on maternal and infant health, develops scientific tools and resources and clinical prevention and treatment guidance, and provides clinical consultations to health providers. Other groups within HHS and CDC specialize in emergency preparedness and response for different hazards (e.g., infectious diseases, natural disasters) and other populations (e.g., children, people with disabilities), but DRH is the only division in the federal government with all-hazards emergency preparedness and response expertise focusing on maternal and

infant health. Additionally, other DRH programs that were abolished by April 1 RIFs are not performed by any other federal agency, including within CDC: contraception guidelines on safety of contraceptive use, abortion data collection, and IVF surveillance.

20. Moreover, without staff in its Office of Director and two of its three branches, DRH does not stand ready to respond to the public health challenges that will emerge in the coming months and years for women, infants, and families. For example, staff in the impacted areas of the Division have been called upon to provide crucial subject-matter expertise and leadership in public health responses, including those involving infectious agents that necessitate special considerations for reproductive-aged, pregnant, or postpartum women, and infants (e.g., measles, influenza, Zika virus). DRH's field assignees frequently serve as on the ground experts to relay information to CDC on emerging issues related to maternal and infant health in their states and jurisdictions, such as observed increases in deleterious health exposures or outcomes, often before these exposures or outcomes are observed in other states or in national data. With many public health emergencies increasing in frequency (e.g., infectious pandemics, extreme heat events) and severity (e.g., wildfires, tropical storms), the elimination of DRH and its scientific, clinical, and capacity-building work will have a harmful impact on the ability of CDC, states, and jurisdictions to prepare for and respond to the needs of pregnant and postpartum women and infants during emergencies. Women and infants will be less safe and emergency/disaster-related morbidity and mortality may rise.

Conclusion

21. The April 1 RIFs have incapacitated DRH. Without DRH's expertise, no other agency within CDC, HHS, or the federal government will carry out DRH's functions aimed at promoting reproductive, maternal, and infant health.

___"/s/ Jane Doe 3"_____
Jane Doe 3

Date: 2025.05.17

Exhibit 70

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JANE DOE 4

I, Jane Doe 4, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Office on Smoking and Health (OSH), part of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within the Centers for Disease Control and Prevention (CDC). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in OSH for over 10 years.

5. I am providing this declaration to explain the impacts of the reductions in force (RIFs) of April 1, 2025, on the operations of OSH. The April 1 RIFs have brought OSH's work to a halt. These impacts will be felt by the states as well as by their residents, as OSH will no longer be able to support state and territorial health departments for tobacco prevention and control activities, monitor tobacco use trends among youth and adults to guide state efforts, run the Tips from Former Smokers national media campaign, or support state quitlines, among other activities aimed at addressing tobacco prevention and cessation in all populations.

OSH's Mission and Work Prior to April 1, 2025

6. OSH was the lead federal agency for comprehensive tobacco prevention and control and played a critical role in preventing youth tobacco use, which includes smoking, vaping, and usage of other nicotine products, and helping adults to quit smoking. Cigarette smoking is the leading preventable cause of premature death in the United States. More than 28 million U.S. adults smoke cigarettes. OSH worked to prevent and reduce cigarette smoking and other tobacco product use by collecting, studying, and sharing information on cigarette smoking and its effects on health, as mandated by Congress. 15 U.S.C. § 1341 ("Smoking, research, education and information").

7. OSH provided millions of dollars in funding to the National and State Tobacco Control Program to all 50 states, District of Columbia, Puerto Rico, and Guam, 8 U.S. territories and freely associated states, and 26 tribes or tribal organizations. States and territorial health departments used OSH funds to prevent kids from using tobacco products, reduce secondhand smoke exposure, help people quit smoking, monitor tobacco use in their state, and address disparities in tobacco use.

8. OSH committed to educating the public about the harms of tobacco use, including media campaigns such as the Tips from Former Smokers (Tips Campaign). The Tips Campaign ads, which were placed on television, radio, and billboards, encouraged people who smoke to quit by featuring real people with serious health conditions caused by smoking and secondhand smoke exposure. The 2012–2018 Tips Campaign had a significant positive impact on Americans' health. CDC estimated that over 16.4 million people who smoke attempted to quit and approximately one million successfully quit because of the Tips Campaign. People who smoke and who saw Tips Campaign videos reported greater intentions to quit smoking, and former smokers with higher exposure to the ads were associated with lower odds of relapse. The Tips Campaign was credited with helping to prevent early deaths and save precious government resources.

9. OSH maintained the national network of tobacco cessation quitlines to encourage people to quit tobacco use by supporting quitline services in fifty states, two U.S. territories, and the District of Columbia. OSH funded state quitlines to deliver resources such as counseling and medications. The Tips Campaign resulted in a sustained and dramatic increase of calls to quitlines.

10. Further, CDC/OSH and the Division for Cancer Prevention and Control co-funded national networks reaching populations disproportionately affected by cancer. The cooperative agreement sought to increase equitable delivery of tobacco prevention and cancer-related strategies and related interventions.

11. OSH played an important role in surveillance and surveys, including the state-based Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and National Youth Tobacco Survey (NYTS). OSH's national surveillance

system provided reliable, consistent, and cost-effective data collection that many states used to evaluate their work and monitor progress in tobacco prevention and cessation. NYTS collected data on tobacco use among high school and middle school students, including which products they were using, how often they used them, and how youth accessed them. Further, OSH made public-use NYTS datasets available to researchers on the CDC website, which were heavily used by external researchers. OSH also monitored tobacco use trends and health impacts in part to inform FDA regulations and enforcement.

12. The first Surgeon General's Report on Smoking and Health was released in 1964, and was a landmark first step to diminish the impact of tobacco use on the health of the American people. Over the course of more than 40 years, OSH was responsible for 35 Surgeon General's reports on the health consequences of smoking and secondhand smoke exposure and strategies to address tobacco use. OSH funded and led the development of these Surgeon General's reports on tobacco, including by managing contracts with external scientific editors for each report; contributing to writing, editing, and review; managing the clearance process; developing plain-language translational materials to communicate the reports' findings to the public; and supporting the Office of the Surgeon General to release the reports. Developing each Surgeon General's report is an enormous and complicated undertaking that takes several years. For instance, the most recent report released in November 2024 addressed disparities in eliminating tobacco-related disease and death. Work began on the report in 2017.

13. Surgeon General's reports serve as a foundation for public health education and provide a scientific basis for public health policies aimed at reducing tobacco use. The 2016 Surgeon General's report on e-cigarette use among youth and youth adults was the first report issued by a federal agency to comprehensively review the public health issue of e-cigarettes and

their impact on youth. The reports have been crucial in identifying diseases and conditions causally related to smoking and secondhand smoke exposure, including lung cancer and heart disease, and alerting the public on the serious health consequences of smoking. The reports inform public health policy by providing reliable and evidence-based recommendations for effective cessation treatments and strategies that can be adopted to minimize the harm from tobacco products on an individual and health care systems level. Critical findings emerging from Surgeon General's reports are even used by the tobacco industry in court-ordered disclosures to the public (sometimes called "corrective statements") and will be included in new required cigarette pack labels.

14. During 2019-2020, OSH's subject matter experts supported the response to the e-cigarette, or vaping, product use associated lung injury (EVALI) outbreak and contributed to the identification of its source.

15. OSH scientists published high-quality reports on tobacco use trends that states utilized to prioritize interventions, monitor progress, and reduce disparities. OSH also issued two editions of CDC's *Best Practices for Comprehensive Tobacco Control Programs*, which advise states on how to develop, implement, and fund an evidence-based tobacco control program. OSH likewise dedicated its publications and resources to the "Publication Catalog and Ordering System" where state agencies and other users could access campaign materials and Surgeon General's reports.

16. OSH also maintained the Media Campaign Resource Center, a collection of free and low-cost tobacco education campaign materials available to the tobacco control community, including state health departments. This data portal allowed for states to efficiently use many existing campaign materials, rather than develop individual campaigns.

17. OSH managed a tobacco use data portal which provided access to the latest tobacco prevention and control data, graphs, and maps, as well as the State Tobacco Activities Tracking and Evaluation (STATE) System, which presented data on traditional Medicaid coverage of tobacco cessation treatments in fifty U.S. States and the District of Columbia. This dataset was used by Plaintiff States to assess tobacco cessation policies and served as a national clearinghouse of information for the public.

18. OSH also managed annual submissions of cigarette and smokeless tobacco ingredient reports from manufacturers, packagers, and importers.

19. OSH is largely administered at the federal level by HHS/CDC employees working out of the CDC headquarters.

The April 1, 2025 RIFs and Effects on OSH

20. On April 1, 2025, the remaining 80% of the roughly 120 full-time employees—myself included—were dismissed along with many contract workers who lost their jobs in February. Twenty percent of the staff, including many contract workers and probationary employees, were laid off or forced to retire prior to April 1.

21. The RIFs effectively shut down OSH. All employees who had not already filed for retirement or early retirement received a RIF notice.

22. OSH employees have not received any communication from HHS about the specific reason for OSH's elimination nor any intention to reinstate OSH employees.

The April 1 RIFs Have Devastated OSH's Work

23. The RIFs have effectively halted all of OSH's work because there is no one left in the Office to carry it out and because OSH-funded contracts have been terminated. This includes

many of the OSH's statutorily mandated functions and activities that Congress appropriated funds to OSH to carry out.

24. The RIFs have had an especially damaging effect on OSH's National and State Tobacco Control Program. Because the entire OSH was eliminated, there is no one left within OSH to provide funding or national technical assistance on the best available science. OSH will not be able to advise states on how to develop, implement, and fund an evidence-based tobacco control program.

25. The RIFs have also halted OSH's work to update its guide, *Best Practices for Comprehensive Tobacco Control Programs*. Because the entire OSH was terminated, there is no one left to finalize and publish the latest version of Best Practices, intended for release in 2025. Even if OSH is reinstated, publication will be substantially delayed due to the April 1 RIFs.

26. OSH's work is not and cannot be duplicated elsewhere in CDC or the broader Department of Health and Human Services (HHS).

27. OSH will not be able to provide funding to the states or the Tips Campaign, as OSH had a budget of about $240 million. OSH and its contractors will no longer manage the Tips Campaign and evaluation.

28. Moreover, OSH will no longer be able to work with states and communities on effective tobacco control prevention and control efforts. States that relied on OSH for the majority of their tobacco funding may lose their programs.

29. Because the entire OSH was eliminated, OSH will not be able to finalize or make public the findings of a Surgeon General Report that was nearing completion. OSH will not have an infrastructure to support the complexity of the process with the Surgeon General's Reports.

The work of numerous external scientists to prepare report chapters, including original data analyses and literature reviews, will be lost.

Conclusion

30. The April 1, 2025 RIFs have incapacitated OSH. Thus, OSH's work in tobacco use prevention is not being completed. Without OSH's expertise, no other agency within CDC or HHS will carry out OSH's functions providing guidance and support in tobacco use prevention. CDC will also be less prepared to respond to outbreaks similar to EVALI in the future.

/s/ Jane Doe 4

Jane Doe 4

Date: May 19, 2025

Exhibit 71

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JANE DOE 5

I, Jane Doe 5, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Sexually Transmitted Disease (STD) Laboratory Reference & Research Branch, Division of STD Prevention (**DSTDP**), part of the National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention (**NCHHSTP**) within the Centers for Disease Control and Prevention (**CDC**). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in public health at CDC for over 10 years.

5. I am providing this declaration to explain the impacts of shutting down the STD Laboratory Reference & Research Branch due to reduction in force (RIF) on April 1, 2025. The April 1 RIFs have brought the STD Laboratory Reference & Research Branch's work to a complete halt abruptly. These impacts will be felt very soon by the states as well as by their residents, as the STD Laboratory Reference & Research Branch will no longer be on the frontline together with state and local public health laboratories to safeguard the American public from the emerging STDs. The number of reported STD cases every year are dangerously high and are still on the rise. In 2023, over 2.4 million cases of syphilis, gonorrhea, and chlamydia were diagnosed and reported, underscoring a critical public health crisis demanding immediate attention. Most concerningly, among these cases are 3,882 instances of congenital syphilis—a preventable condition—tragically resulting in 279 stillbirths and neonatal/infant deaths. The continued rise in these infections highlights the urgent need for enhanced prevention, diagnosis, and treatment efforts to protect public health and save lives.

STD Laboratory Reference & Research Branch's Mission and Work Prior to April 1, 2025

6. NCHHSTP is a National Center within a federal agency that works to prevent and control HIV, viral hepatitis, sexually transmitted infections, and tuberculosis in the U.S. NCHHSTP's work includes public health surveillance and disease prevention research, funding grassroots disease prevention programs, developing and promoting strategies to reduce harm, and implementing resources for providers and affected or at-risk communities. It was created to further the objective set forth in the Public Health Service Act (PHSA).

7. NCHHSTP oversees the Division of STD Prevention (DSTDP), whose mission is to maximize the impact of STI prevention through science, programs, and policy.

9. The STD Laboratory Reference & Research Branch's functions are mandated by 42 U.S.C. § 247c ("provide technical assistance in the training and public health programs for the prevention and control of sexually transmitted diseases"). It served as the only STD national reference lab and provided unique and essential technical assistance and guidance to state and local public health labs to accurately detect and track drug-resistant gonorrhea, syphilis, and other emerging STDs. The STD Laboratory Reference & Research Branch also provides laboratory support by delivering high quality reference materials and quality assessment programs to ensure accurate testing and capacity building of state laboratories.

10. Further, the STD Laboratory Reference & Research Branch monitored and responded to STD outbreaks in the U.S. together with public health laboratories, such as a lymphogranuloma venereum outbreak in Chicago and Michigan in 2015-2016, identification of cases of a novel multi-drug non-susceptible *Neisseria gonorrhoeae* strain in Massachusetts in 2022, as well as increasing prevalence of ocular syphilis in multiple states, and atypical presentation of syphilis (painful lesions) in Orange County, NY.

11. The STD Laboratory Reference & Research Branch was one of the very few labs which administered and supported proficiency testing and quality assessment programs for public health labs in the U.S. for gonorrhea antibiotic susceptibility testing (in collaboration with a state public health laboratory) and gonorrhea genome sequencing to ensure tests being performed in U.S. public health labs are accurate and reliable.

12. The STD Laboratory Reference & Research Branch was home to thousands of unique clinical specimens for STD surveillance and development of improved and novel diagnostic testing methods.

13. In addition, the STD Laboratory Reference & Research Branch maintained an extensive repository of reference materials including over 100,000 unique bacterial isolates (cultures of bacterial cells), and a well characterized syphilis serum bank that are critical for American state and local public health labs, commercial entities, and universities to develop and validate the most up-to-date diagnostics and treatment strategies.

14. The STD Laboratory Reference & Research Branch also generated the most comprehensive national genomic surveillance data for STDs and published peer-reviewed annual reports of strains and antibiotic resistance determinants prevalent in the U.S. The branch also provided these sequences for reference purposes, for tracking infections, developing tests for antimicrobial resistance markers, as well as for improving diagnostic tests.

15. Moreover, the STD Laboratory Reference & Research Branch developed software tools for analyzing genomic data for all STDs and implemented them at state public health labs to improve diagnostic & surveillance capacity. The STD lab developed the first molecular method to distinguish syphilis strains. Commonly used and novel point-of-care serological diagnostic tests for syphilis were originally developed in the STD lab, and the technologies were successfully transferred to companies for commercialization.

16. The STD Laboratory Reference & Research Branch in collaboration with its partners and world renowned STD experts developed the most vital CDC laboratory recommendations for the diagnosis of syphilis, chlamydia, and gonorrhea. These laboratory recommendations provided the

most comprehensive and thorough guide for the nation's STD testing and are referenced worldwide by laboratory directors, public health professionals, and clinicians.

17. The STD Laboratory Reference & Research Branch also provided expert consultation for the collaborative development of the CDC STI Treatment Guidelines (2021) with current evidence-based prevention, diagnostic and treatment recommendations for physicians and other health care providers in the U.S.

18. The STD Laboratory Reference & Research Branch is administered at the federal level under DSTDP, which is overseen by NCHHSTP/CDC/HHS.

The April 1, 2025, RIFs and Effects on NCHHSTP

19. On April 1, 2025, all 33 employees of the STD Laboratory Reference & Research Branch—myself included—received RIF notices. All staff were placed on administrative leave and no longer had building access beginning on the same day RIF notices were received. Specifically, 23 working scientists (15 of which are PhDs), 7 training scientist, and 3 support staff were RIF'ed.

20. The abrupt closure of the STD Laboratory Reference & Research Branch provided no time to inform collaborators with whom the Branch partnered on many ongoing important clinical projects and transfer samples/reagents back to them.

21. Millions of dollars' worth of highly specialized equipment, over 30,000 unique patient samples, and over 100,000 isolates were left unattended in the lab without proper shutdown and storage. Each day, stored samples and specimens are at risk of being un-usable, thus jeopardizing decades of ground breaking research and investment in staff and resources.

22. Until today, equipment and specimens are still unattended in the lab space.

23. Until today, inquiries and requests for help from state and local public health laboratories are still coming in and go unanswered because the STD Laboratory Reference and Research Branch scientists and subject matter experts were all placed on admin leave.

24. In early April, I emailed the Office of Human Resources (OHR) to inform them of the errors on my RIF notice and inquired about the RIF retention register and benefits for RIF'ed employees. As of today, I have not received any reply from OHR/HHS.

The April 1 RIFs Have Devastated the NCHHSTP's Work

25. The RIFs have completely halted all of the STD Laboratory Reference & Research Branch's work because there is no one left in the lab to carry out the important functions which are clearly mandated by the statutory authority found in 42 U.S.C. § 247c established in 1998.

26. The RIFs have had an especially damaging effect on technical assistance and guidance provided by the STD Laboratory Reference & Research Branch to state and local public health labs for STD diagnostic testing, surveillance testing, and guidance for treatment and preventive strategies. Because the entire STD Laboratory Reference & Research Branch was eliminated, there is no scientists left with the unique expertise and technical skills, no lab testing is available to confirm concerning test results for difficult cases from state laboratories, no reference materials and quality assessment programs left for quality assurance and new test development, and there is no other group in HHS who can replace these functions.

27. The RIFs have also eviscerated the STD Laboratory Reference & Research Branch's work in monitoring and responding to STD outbreaks in the U.S. Because the entire Branch was terminated, there are no scientists left to monitor and respond to ever-evolving bacterial STDs and increasing rates of antibiotic resistance, and there are no scientists to provide instant on-call troubleshootings for laboratory testing during outbreaks. The most recent STI outbreak was reported

in Alaska by ‘Psychology Today’ magazine on 4/15/2025. What is happening in Alaska could be a warning sign for what might happen in other U.S. jurisdictions anytime.

28. As a result, this could present a higher risk of antibiotic-resistant gonorrhea spreading undetected within the U.S. and a harder fight against surging syphilis cases in women and children in the U.S.

29. Moreover, the STD Laboratory Reference & Research Branch will no longer be able to complete the ongoing update to CDC’s recommendations for the laboratory testing for chlamydia and gonorrhea, two most common STDs in the nation, which is used nationally as guidance by state and local public health diagnostic labs.

30. The STD Laboratory Reference & Research Branch will no longer be able to administer STD quality assessment programs to ensure tests that are performed in public health labs are accurate and reliable. Requests for reference materials and quality assessment panels are continuing to come in as of this week and remain unanswered.

31. The STD Laboratory Reference & Research Branch’s unique repository of reference materials, including over 100,000 unique bacterial isolates, the most comprehensive genomic surveillance data, and a well characterized syphilis serum specimens from multiple disease stages, face the possibility of being permanently destroyed or discarded- defeating the purpose of supporting public health laboratories in the US.

32. CDC estimated over 13 million sexually acquired infections of chlamydia, gonorrhea, trichomoniasis, syphilis, genital herpes, human papillomavirus, hepatitis B, or HIV in the U.S. in 2018, and CDC estimated the lifetime medical cost of STIs acquired through sexual contact in 2018 to be $15.9 billion. The STD prevention work carried out by the STD Laboratory Reference & Research Branch is critical to reducing this lifetime medical cost.

33. The RIF intended to make administrative cuts, but not working scientists and the policy was to make sure none of working scientists were lost and that research continues, as Mr. Kennedy stated. The fact that 30 out of 33 RIF'ed from the STD Laboratory Reference and Research Branch are working scientists who are highly educated with various years of experience. And approximately 59% of CDC personnel affected by the RIF were scientists, medical professionals, veterinary professionals, engineers, and other STEM leaders.

34. The STD Laboratory Reference and Research Branch's work is not duplicated elsewhere in the CDC, or the broader Department of Health and Human Services (HHS). The STD Laboratory Reference & Research Branch is the only national STD reference lab in the U.S. and is one of three labs in the world that tracks drug-resistant STDs.

35. There are over 20 media reports highlighting the importance of our STD lab functions and experts noted that "without the laboratory, we are essentially flying blind on STD outbreaks" and "[a]brupt and staggering CDC cuts will cost lives." The consequence of dismantling the STD lab is severe and irreversible in this time of record-high STDs.

36. A letter from Scott Becker, Chief executive officer of The Association of Public Health Laboratories (APHL), which represents state and local public health laboratories across the country, addressed to HHS Secretary stated that the STD lab and the Hepatitis lab (both of which were RIF'ed) conduct national testing services "that do not exist anywhere else within the HHS agencies" and "the services they do are no longer available to our nation." The letter asked Mr. Kennedy to restore these national labs.

Conclusion

37. The April 1, 2025 RIFs have completely and abruptly incapacitated the STD Laboratory Reference & Research Branch and its 30 STD working scientific experts, valuable

technological tools, unique reference materials and quality programs which were established over the decades, "to provide technical assistance in the training and public health programs for the prevention and control of sexually transmitted diseases" as mandated by 42 U.S.C. § 247c.

38. Without the STD Laboratory Reference & Research Branch's expertise, no other operational division within CDC or HHS can carry out the lab function of providing critical guidance and support to state jurisdictions, clinicians, and state public health labs in STD prevention.

39. The shutdown of CDC's national STD Laboratory Reference & Research Branch is a serious setback for STD control at a time facing a complex STD epidemic with over 2.4 million reported cases in 2023. The lab and state public health labs are indispensable partners to combat the STDs. This is about protecting communities: ensuring that dangerous infections like drug-resistant gonorrhea or congenital syphilis are swiftly identified and contained. Their work and mission are vital to protecting communities, advancing public health, and saving lives.

40. If the purpose of the reorganization of HHS is to return to its core mission of preparing for and responding to epidemics and outbreaks, then laying off highly experienced and specialized CDC STD lab scientists and closing the key lab does not align with this goal.

Jane Doe 5

_____

Jane Doe 5

Date: May 16, 2025

Exhibit 72

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JANE DOE 6

I, Jane Doe, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. Until January 2025, I was employed by the Division of Data and Technical Analysis (DTA), part of the Office of Human Services Policy within the Office of the Assistant Secretary for Planning and Evaluation (ASPE). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I have worked in public health/human services for twenty-five years, including over a decade of full-time employment at ASPE.

4. I am providing this declaration to explain the operations of ASPE with respect to the calculation of the Federal Poverty Guidelines ("Guidelines") and the impact of the recent impacts of the reductions in force (RIFs) of April 1, 2025.

5. ASPE is responsible for calculating the Federal Poverty Guidelines each year, consistent with the statutory mandate that HHS perform this calculation. I have personal knowledge that ASPE has performed the Guidelines calculation each year in the same manner for at least a dozen years, and I understand from my colleagues that the calculation has been performed in this manner for at least forty years.

6. To calculate the Guidelines, staff from DTA, who are trained economists or social science analysts, perform calculations using data from the Census Bureau and the Bureau of Labor Statistics.

7. Accurate calculation of the Guidelines is so critical that there are redundancies built into the system. Each year, DTA staff perform four independent calculations of the Guidelines; all four calculations must match exactly before the Guidelines can be finalized. Further, the Guidelines must go through three additional levels of review and approval once finalized by DTA staff.

8. DTA staff perform additional work and calculations related to the Guidelines. Some examples of that additional work include an Application Programming Interface (API) and charts showing various percentages of the Guidelines. The API permits computer systems, such as those used by health insurers and hospitals, to retrieve the Guidelines levels without the risk of human error. The API and additional calculations are critical to reducing errors in the use of the Guidelines that may be introduced by human error, incorrect calculations by users, or other errors. Any errors in the calculation of Guidelines or percentages of the Guidelines can result in

people applying to a specific benefit being rendered ineligible, despite them being eligible had the Guideline percentage been calculated correctly.

9. It is my understanding based on regular conversations with my former colleagues that on April 1, 2025, all DTA staff whose job responsibilities included calculating the Guidelines received a RIF (except one staff member who had already opted for early retirement) and were placed on administrative leave until their expected termination on June 2, such that there is no longer any staff person working at ASPE who has experience in calculating the Guidelines.

10. Without any staff who are trained on the Guidelines employed at ASPE, there is a substantial risk that there will be errors or delay in the calculation of the next Guidelines. That would have far-reaching negative consequences, as the Guidelines are relied upon a daily basis by many state and federal programs affecting millions of people.

/s/ Jane Doe
Jane Doe

Date: May 18, 2025

Exhibit 73

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JOHN DOE 7

I, John Doe 7, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Center for Tobacco Products (CTP), within the U.S. Food & Drug Administration (FDA). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or previous position at CTP, I would be willing to provide it *ex parte* and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in public health for over 14 years.

5. I am providing this declaration to explain the impacts of the reductions in force (RIFs) of April 1, 2025 on the operations of CTP. The April 1 RIFs have brought much of CTP's work to a halt. These impacts will be felt by the states as well as by their residents, as CTP will no longer be able to support public education campaigns, award contracts with states to conduct retailer inspections, and collect and manage user fees.

CTP's Mission and Work Prior to April 1, 2025

6. CTP oversees the implementation of the Family Smoking Prevention and Tobacco Control Act by, among other things, setting performance standards for tobacco products, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.

7. Pursuant to the Food, Drug, and Cosmetic Act, 21 U.S.C. § 387s, CTP is funded entirely by tobacco user fees collected from domestic manufacturers and importers of cigarettes, snuff, chewing tobacco, roll-your-own tobacco, cigar, and pipe tobacco. These appropriated user fees are available only for the purpose of paying costs related to tobacco regulation activities and are the only funds authorized to be made available for this same purpose. 21 U.S.C. § 387s(c)(2)(A)-(B).

8. Among other duties, CTP conducts compliance checks on vendors and retailers to ensure that tobacco products are not sold to those under the age of twenty-one, reviews premarket applications for new tobacco products before they can be marketed in the United States, enforces advertising and promotion restrictions, and educates the public about the risks of tobacco use including the dangers of cigarettes, e-cigarettes and other tobacco products.

9. Further, CTP collaborates with the Centers for Disease Control and Prevention (CDC) in administering the National Youth Tobacco Survey (NYTS), a national data collection program that informs states' tobacco prevention policies and regulatory efforts.

10. CTP is administered by the FDA within the U.S. Department of Health and Human Services (HHS).

11. CTP is led by a director and oversees five offices: the Office of Management, Office of Regulations, Office of Science, Office of Health Communication and Education, and the Office of Compliance and Enforcement.

12. The Office of Regulations promulgates regulatory policies on tobacco. The Office of Regulations also handles public comment by using public dockets announced in the Federal Register to gather information from the public and stakeholders on draft guidance, proposed regulatory actions, rules, and other topics related to the regulation of tobacco products.

13. The Office of Management oversees CTP's budget and fiscal management, contracting, travel, and hiring. It also contains CTP's call center, mail center, and IT services. Significantly, it assesses and collects user fees which fund all the work of CTP, including activities related to public education (including public education campaigns and communicating CTP activities), regulatory science (including research, product review, and developing the science to support regulations and guidance), compliance and enforcement (including tobacco retailer inspections, manufacturer and import inspections and enforcement, and advertising and labeling surveillance), and administrative programs. The Office of Management has 6 groups: Division of Financial Management; Acquisitions and Assistance; Management Logistics Group; Management and Analysis Group; Human Capital Team; and IT Services.

14. Within the Office of Management, the Division of Financial Management formulates CTP's budget and oversees execution of the budget. It certifies funds, monitors payroll, and ensures CTP is following federal appropriations laws and responds to congressional inquiries related thereto. The Acquisitions and Assistance Group creates and submits contract and grant packages for award and submits funding for those awards. The Management Logistics Group oversees travel, timekeeping, has oversight of invoice receiving/payment, contains the document control center handling the mail, and manages the call center. The Human Capital Group oversees human resources, which submits packages to hire and track staff, manages staff benefits, and oversees training required by HHS regulations. The Management and Analysis Group oversees ethics filings among other activities. The IT Services Group manages CTP's centralized IT systems, ensures CTP compliance with federal and HHS regulations related to IT systems, and also manages highly specialized systems including the tobacco inspection management system and the tobacco user fee system.

15. The Office of Science employs scientists to review premarket tobacco product applications (PMTAs), which can be submitted by any person for any new tobacco product seeking an FDA marketing order. Further, the Office of Science is directly involved with administering the NYTS in collaboration with CDC.

16. The Office of Health Communication and Education's work involves communication about CTP's activities, public education campaigns such as "The Real Cost" campaign, and the distribution of important messages and information on the regulation of tobacco products as well as the health risks associated with tobacco use. The Office of Health Communication and Education has three divisions: the Division of Public Health Education, the

Division of Research and Evaluation, and the Division of Regulatory Communication. They also have a "front office" for administrative personnel and FOIA responsibilities.

17. The Office of Compliance and Enforcement monitors retailer, manufacturer, importer, and distributor compliance with federal tobacco laws and regulations and takes regulatory or enforcement actions when violations occur. Such regulatory or enforcement actions include issuing warning letters and civil money penalties, placing tobacco products on an import alert, and assisting the Office of Inspections and Investigation in performing seizures of unauthorized products at the border.

The April 1, 2025, RIFs and Effects on CTP

18. On April 1, 2025, at least 100 employees—myself included—received RIF notices and are awaiting final separation from federal employment. Employees who had not already filed for retirement or early retirement and who received a RIF notice included employees from CTP's five offices.

19. CTP's Office of Management and Office of Regulations have been eliminated because all of their employees either separated from service before April 1, or received RIF notices on April 1. CTP's Office of Compliance and Enforcement lost about 25 to 40 employees. Employees within the Office of Compliance and Enforcement's Division of Business Operations, which handles civil monetary penalties and administers contracts critical to CTP's enforcement efforts were RIFed but their RIF notices were rescinded on May 9, 2025. The Office of Health Communication and Education also lost employees.

20. I have not received any communications from HHS about the specific reason why the Office of Regulation was eliminated, nor any indication that the Department intends to

reinstate the RIFed employees. The same is true of all other CTP employees that I have communicated with about the RIF.

The April 1 RIFs Have Devastated CTP's Work

21. The RIFs have effectively halted much of CTP's work because most employees in the Office of Management or the Office of Regulations were immediately placed on administrative leave pending final separation and are unavailable to carry out the work. Of crucial importance to CTP's operation, without employees in the Office of Management to assess and collect the tobacco user fees, CTP runs the risk of losing its sole funding source.

22. The RIFs have impacted CTP's Office of Management's ability to track user fees, support contract acquisitions, and monitor payroll. For instance, the Office of Management will no longer be able to create contract actions for states and territories on retailer inspections as required by statute. Because the entire Office of Management is terminated, there is no one left to certify funds, manage the tobacco inspection management system and e-submission system, or ensure that CTP follows federal appropriations laws. Further, staff are not available to create a fiscal year 2026 execution budget, recruit new staff, monitor timekeeping, ensure timely receiving/payment of invoices, and conduct oversight of CTP's document control center and call center.

23. Although at least some of the employees RIFed from the Office of Compliance and Enforcement have been reinstated, the RIFs within that Office nonetheless interrupted CTP's work. Contractor support is required for many enforcement activities including issuing warning letters and civil money penalties, conducting retailer and manufacturing inspections, and surveillance of tobacco advertising. These activities will be disrupted if support staff in the Office of Management are unavailable to ensure these contract actions are created and funded.

24. The employees managing crucial projects in the Office of Health Communication and Education have also been RIFed, leaving their work abandoned. This includes many of CTP's statutorily mandated functions. The RIFs have devastated the ability of CTP's Office of Health Communication and Education's Division of Public Health Education to run "The Real Cost" campaign, a national tobacco prevention advertising campaign that provided accurate and current information about the harmful effects of tobacco use. All of the employees working on the Campaign were RIFed on April 1, and without the necessary staffing and their expertise, "The Real Cost" campaign will not be able to continue its mission to reduce the lifetime risks of tobacco-related disease and death, and reduce smoking-related costs, which have saved more than $53 billion dollars as a result of "The Real Cost" Campaign. Further, employees of the Office of Health Communication and Education will be limited in their ability to develop educational materials for industry and retailers about the laws pertaining to the sale of tobacco to anyone under age twenty-one. This work is not and cannot be duplicated elsewhere within FDA or the broader Department of Health and Human Services (HHS).

Conclusion

25. The April 1, 2025 RIFs have incapacitated several offices of CTP and some of its most crucial functions. Thus, CTP's work in tobacco use prevention is not being diligently completed. Without CTP's expertise, including that of experts such as toxicologists and epidemiologists, no other agency within FDA or HHS will carry out CTP's functions to provide guidance and support in tobacco-related death and disease prevention.

John Doe 7

Date: 5/19/2025

Exhibit 74

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-196

DECLARATION OF GORDON SLOSS

I, Gordon Sloss, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Program Manager of the California Tobacco Prevention Program (CTPP) at the California Department of Public Health (CDPH). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. Since April 2022, I have served at CDPH as a Program Manager. In this role, I oversee and support California's Tobacco Prevention Program. Prior to this role, I served as the CTPP Assistant Program Manager and the Assistant Division Chief for Chronic Disease and Injury Control. I have worked at CDPH since September 2015.

3. Prior to my time at CDPH, I worked at the Department of Health Care Services (DHCS) in the Office of the Medical Director overseeing the administration of federal grant programs, including the Delivery System Reform Incentive Pool, a quality improvement initiative for public hospitals funded by the Centers for Medicare and Medicaid Services (CMS), and the Medi-Cal Incentives to Quit Smoking demonstration project funded by the Centers for

Medicare and Medicaid Innovation through the Medicaid Incentives for the Prevention of Chronic Diseases program.

4. I received an undergraduate degree from the University of California Santa Barbara in 1989 and a Master of Public Administration degree from Golden Gate University in 2009.

5. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Background on CDPH and California Tobacco Prevention Program

6. CDPH's mission is to protect public health and shape positive health outcomes for individuals, families and communities in California. CTPP began in 1989 and aims to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products.

7. CDPH furthers its mission through a cooperative agreement with the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health (OSH) as part of the National and State Tobacco Control Program (NTCP).

8. CDC is the only federal agency that provides funding to help support all 50 states, the District of Columbia, 8 United States territories, and 28 tribes/tribal organizations for tobacco control and prevention efforts. OSH has provided critical infrastructure, technical assistance, and media placement to support tobacco cessation through the Tips From Former Smokers© (TIPS) campaign, as well as other tobacco control issues, in the face of a highly organized, sophisticated, and well-resourced industry that costs California and the United States billions of dollars in healthcare costs each year because of its deadly and addictive products.

9. Beginning in 2020, through its CDC-OSH cooperative agreement, CDPH received an annual budget of $3,552,129 each budget year ending April 28, 2025.

10. California has leveraged CDC-OSH funding to advance tobacco control program strategies. California utilizes this funding to augment state infrastructure through 13.5 Full Time Equivalent employees dedicated to reducing the death and disease attributable to tobacco use.

11. Funding for the current budget year beginning April 29, 2025, was not awarded by CDC. Instead, a no-cost extension through October 29, 2025, was released. CDC has provided no communication regarding current or future funding for NCTP.

12. In addition to its cooperative agreement with CDC-OSH, CDPH has relied on the Food and Drug Administration's (FDA) Center for Tobacco Products (CTP) to advance successful smoking and vaping prevention media campaigns.

13. CTP educates the public about the risks of tobacco use including the dangers of e-cigarettes and other tobacco products. CTP has been administered by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), within CDC.

14. It is my understanding and belief that as a result of the massive reduction in force (RIF) across the United States Department of Health and Human Services, OSH was effectively eliminated, and CTP lost key staff as well.

15. I am providing this declaration to explain the impacts on California and CDPH of the RIF in OSH and CTP, since April 1, 2025.

16. Prior to April 1, 2025, CDPH regularly relied on CDC staff for many aspects of the day-to-day operation of the NTCP. However, since April 1, 2025, CDPH has seen significant cutbacks to the operations of the CDC.

17. Specifically, our state's primary point of contact at OSH, Ms. Mackenzie Collins, Federal Program Officer, is no longer available to be contacted regarding the NTCP. CDPH has not been able to receive answers or guidance regarding technical assistance for the implementation of our cooperative agreement.

18. Without CDC's staff, resources, and expertise, CDPH's capacity to achieve its tobacco prevention and control goals will be severely reduced. CDPH and CTPP's access to comprehensive tobacco prevention and control program best practices from the federal government will end.

19. CDPH will have reduced capacity to develop and maintain the partnerships necessary to effectively support treatment of tobacco and nicotine use and dependence, and provide guidance to parents, schools, and community organizations, including tribal communities, to reduce youth uptake of tobacco products. Additionally, CDPH will have reduced capacity to provide technical assistance, including developing educational materials, and trainings for local health jurisdictions implementing tobacco cessation programs. CDPH will have reduced capacity to promote changes in health care facilities to encourage and support treatment for tobacco use and dependence. California's tobacco cessation services will be significantly reduced. The RIF will also diminish the state's evaluation and surveillance efforts and the tobacco and nicotine prevention and cessation media campaigns.

Tobacco Cessation Programming in California

20. California relies on OSH to support California's tobacco and nicotine quit line, Kick It California (KIC), which provides free cessation services for people addicted to tobacco and nicotine products.

21. I estimate that, with the virtual elimination of OSH and the essential technical assistance and funding it provides, KIC's capacity for client intake will be reduced by ten percent.

22. Moreover, the following life-saving services provided by KIC will be severely reduced or eliminated entirely: provision of nicotine replacement therapy (NRT), adequate staffing for the KIC quit line, and partnerships with healthcare systems to refer patients to KIC for evidence-based treatment.

23. In addition, California will cancel or curtail planned technological upgrades to KIC to increase useability and accessibility, including adapting online services to support additional languages, and implementing digital-based technologies such as text and/or web services.

24. The RIF will also result in the reduction or termination of culturally competent trainings for healthcare providers to better serve and provide cessation information and referral options to tribal clinics, school clinics, county oral health programs, and organizations focused on underserved communities.

25. Without OSH, the national Asian Smokers' Quitline (ASQ), operated by KIC, will cease its operations. ASQ provides counseling and tobacco medications to tobacco users who are trying to quit. Services are offered in four languages (Cantonese, Mandarin, Korean and Vietnamese).

26. Furthermore, the RIF will harm CDPH's ability to collect, monitor, analyze, and disseminate data on use of quitline services. As a result, CDPH will not have access to adequate information to tailor programming and outreach by population characteristics. California's ability

to submit intake and services data to the National Quitline Data Warehouse will be greatly reduced.

27. CDPH is unable to maintain the same level of tobacco cessation programming without OSH's support.

Evaluation and Surveillance of Tobacco Cessation Efforts Through Data

28. The loss of OSH will hinder the development of data collection instruments to be used by local partners and the dissemination of local and statewide surveillance and evaluation of findings through peer-reviewed publications, reports, and fact sheets. Without OSH, California will lose the ability to evaluate the impact of California's state flavors law (California State Senate Bill 793, 2020), including developing reports and disseminating data.

29. Prior to the RIF, CDC-OSH developed national surveillance surveys, such as the National Youth Tobacco Survey (NYTS), but access to this national comparison data will likely end. CDPH has frequently relied on the NYTS to inform its work. National comparison data, like the NYTS results, are necessary to provide a perspective on California's performance in tobacco use prevention, as well as identifying new trends in tobacco use and behaviors, and informing policy decisions. California has also used national data as the basis for performance benchmarks to evaluate the impact of the state's policies and intervention work.

30. CDC-OSH provided weekly highlights of tobacco control work throughout the country, known as the Weekly Dose. This has been an effective method of communicating and disseminating new publications and webinars, as well as a place for peer discussion and data sharing between and among states. The discontinuation of the OSH Weekly Dose has hampered the sharing of information dissemination of innovation, which has hampered California's ability to learn and stay up to date about lessons and data from outside California.

31. As part of OSH, Philip Rosenbaum, ORISE Fellow, provided guidance on evaluation deliverables, and information sharing for surveillance tools, such as the OSH Disparity Dashboard, and the Behavioral Risk Factor and Surveillance System (BRFSS).

32. Without OSH, CDPH's capacity to sustain its data collection and evaluation efforts will be reduced. The RIF will also eliminate CDPH's ability to compare its health surveillance data to any national data, as CDPH will be unable to replicate OSH's national surveillance surveys.

National Coordination of Media, Communications, and Anti-tobacco Campaigns

33. The RIF in OSH and CTP would dramatically impair effective media campaigns targeting tobacco and nicotine prevention.

34. The loss of OSH will lead to the elimination of over half of the state's cessation service promotions to adult Californians addicted to tobacco and nicotine products. For the last 14 years, Californian adults who are addicted to tobacco and nicotine products were able to receive the promotion of free services year-round to help them quit smoking with the CDC TIPS campaign running for six to eight months of the year, and the CDPH cessation campaign running in the off months. This has created sustained effective messaging promoting free cessation services. These cessation campaigns are critical counter-marketing to the tobacco industry, which spends over $1 million per day on marketing in California to attract young people to start using tobacco, and to keep them addicted to their deadly products. The RIF will substantially alter the quantity and quality of messaging Californians receive about the dangers of tobacco and nicotine use.

34. The RIF in CTP may also significantly impact the youth tobacco and nicotine prevention media campaigns in California. California youth benefitted immensely from CTP's

steady media support that has aired for 10 years to help prevent youth initiation to tobacco. For the past ten years, CTP's youth tobacco prevention campaign, "The Real Cost," has aired on television, streaming platforms, and on social media in California. Research shows that "The Real Cost" prevented up to 587,000 youth ages eleven to nineteen nationally to not take up tobacco products. Half of these youth would have become adult smokers without the CTP's media campaign. The campaign saved $180 for every dollar spent on the effort in its first two years, totaling more than $53 billion in reduced smoking-related costs like early loss of life, costly medical care, lost wages, lower productivity and increased disability.

35. Additionally, the RIF will cause California to lose access to other states' evidenced-based tobacco prevention and control messaging. The CDC's Media Campaign Resource Center (MCRC) held a collection of researched and evidence-based tobacco control ads made available to other states at low or no cost. Research and production are both time consuming and costly, so this was a turn-key way for states to invest most of their media funds in media placement. Although California has borrowed ads from MCRC that were difficult or costly to make, CTPP was also the largest ongoing contributor of ads to MCRC, and shared ads addressing emerging products and issues. MCRC contracted experts in talent rights, video editing, and other advertising expertise to make high quality media assets easier to access and place for states with limited budgets and resources.

36. California will not be able to replace the massive void left by CDC-OSH and CTP and the national campaign partnerships established through OSH's and CTP's work.

37. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED on May 15, 2025 in Sacramento, California.

Gordon Sloss
Program Manager
California Tobacco Prevention Program
California Department of Public Health

Exhibit 75

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. _____

DECLARATION OF ELI ROSENBERG

I, Eli S. Rosenberg, PhD, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Office of Science at the New York State Department of Health (NYSDOH). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with NYSDOH staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the Plaintiffs' Motion for a Preliminary Injunction.

Professional Background

3. I am the Director of the Office of Science at NYSDOH and I serve as a lead and advisor to the NYSDOH Commissioner for public health data, research, epidemiology, and surveillance activities at NYSDOH. In this capacity, I have also served as a liaison to Health and Human Services (HHS) agencies, principally the US Centers for Disease Control and Prevention (CDC), regarding matters related to our public health data and systems. I joined NYSDOH in

2021, as the Deputy Director of Science for the Office of Public Health (OPH), and as director of the Office of Science, which was part of OPH at that time. From 2017 to 2021, I was an Associate Professor in the Department of Epidemiology and Biostatistics at the University at Albany School of Public Health, part of the State University of New York, in Albany, New York. From the beginning of the COVID-19 pandemic in March 2020, I was on assignment to NYSDOH, helping to support research and public health surveillance activities, and served as an advisor to the governor's office regarding epidemiology and disease modeling for the pandemic. From 2013 to 2017, I was an Assistant Professor in the Department of Epidemiology at the Emory University Rollins School of Public Health in Atlanta, Georgia. As a professor in both universities, I taught graduate courses and conducted National Institutes of Health (NIH) and CDC-funded research studies focused on infectious disease epidemiology and data analytic methods. During this time, I also held guest appointments as a Senior Epidemiologist at CDC within two of its centers: the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention and the National Center for Emerging and Zoonotic Infectious Disease. I have authored or co-authored over 200 publications in the peer-reviewed literature on the topics of epidemiology and public health surveillance, particularly for infectious diseases such as HIV, sexually transmitted infections, polio, and COVID-19. I received my PhD in Epidemiology from Emory University Rollins School of Public Health and my BS in Biometry and Statistics from Cornell University's College of Agriculture and Life Sciences. Across these experiences I have built significant familiarity with the federal and state public health programs that are the subject of this case.

4. New York State Department of Health's mission is to protect and promote health and well-being for all, building on a foundation of health equity. The Office of Science, which

reports to the Commissioner's office of NYSDOH, provides epidemiologic, analytic and data capabilities to support data-driven decision making at NYSDOH and its programs. Office of Science focus areas are on leading data, research and informatics activities to support cross-cutting priority health topics, emerging threats, and population health. Relevant examples of this work include the production of surveillance data dashboards and reports, information technology development and support for the systems that collect and transmit data to HHS agencies, and the conduct of epidemiological programs such as the Pregnancy Risk Assessment Monitoring System and opioid and overdose surveillance. I, and the Office of Science, collaborate and coordinate with the other sections of NYSDOH whose work is described in this document. This includes the AIDS Institute, within the Office of Health Equity and Human Rights, and the Center for Environmental Health and the Center for Community Health, within the Office of Public Health.

5. I am providing this declaration to explain the impacts on New York State of the cuts to HHS, including cuts to CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Reliance on HHS Data and Technical Expertise

6. Prior to April 1, 2025, NYSDOH relied on data from, technical support from, and relationships with HHS agencies in order to conduct its federally- and state-supported work that serves New York's population, across numerous programs and topic areas. In some cases, data from HHS programs supplemented state-generated data in order to form a more complete picture of a condition that we are tracking and responding to. In other cases, our NYSDOH data are transmitted to HHS, along with those from other jurisdictions, and are not available for our use

until a finalized dataset is returned to us by the HHS program. Technical assistance provided by many HHS programs enables NYSDOH programs -- in forms such as documentation, guidance for surveys and data systems, and conference calls -- to operate more efficiently and in a coordinated fashion that enables comparability of data between New York and other jurisdictions. In some instances, project operations support provided by HHS agency programs is essential to the conduct of our NYSDOH programs, such that they cannot function absent the HHS program team. The relationships with HHS agencies for these data and technical support are established both formally via cooperative agreements and grant contracts, and less formally via working groups, initiatives, and individual relationships established by areas within HHS agencies with our NYSDOH programs.

7. New York State has relied on CDC for its assistance in ensuring that children are screened for hearing loss and receive appropriate interventions for hearing loss. The New York State Early Hearing Detection and Intervention program (NY EHDI) supports the US Surgeon General's Healthy People 2030 goals of increasing the proportion of newborns who are screened for hearing loss by no later than age one month, have audiologic evaluation by age three months, and are enrolled in appropriate intervention services no later than age six months. The CDC EHDI program provided substantial support to NY EHDI as part of a cooperative agreement, which included collaboration on enhancing and expanding outcomes surveillance activities, including the collection, management, analysis, and dissemination of EHDI data, collaboration to develop and implement strategies and evaluation plans and use evaluation findings, provision of technical assistance to define and operationalize performance measures and implement recipients' performance measurement plans, and collaboration on and co-authoring scientific

reports, manuscripts and other derivative works arising from data collected and analyzed for the N Y EHDI Program.

8. Further, New York State Public Health Law Section 2500-g requires all Article 28 health care facilities to report results to the New York Early Hearing Detection and Intervention Information System (NY EHDI-IS) when the provider performs newborn hearing screening and out-patient follow-up hearing screening or diagnostic audiological evaluation on infants less than six months of age. The CDC cooperative agreement is leveraged to support EHDI-IS.

9. New York State relied on CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a survey of state residents who have recently given birth to ask about behavior and experiences before, during, and immediately after pregnancy. These experiences may influence health outcomes such as infant development, illnesses, and maternal and infant mortality. Established in 1987, PRAMS is active in 50 U.S. jurisdictions and represents over 80% of all live births in the United States. The PRAMS survey is extremely valuable in that it provides information about pregnancy and the first few months after birth that are not available from other data sources. These data are used to identify groups of parents and infants at a high risk for health problems, measure progress towards goals for improving the health of families and infants, plan, evaluate and assess perinatal health programs, evaluate policy, report essential federal performance measures related to maternal and child health, and to meet state statutory reporting requirements.

10. The CDC Notice of Award to NYSDOH requires data be collected via the PRAMS Integrated Data Collection System (PIDS), which is an entirely CDC hosted and supported electronic system. Sites such as NYSDOH are not able to extract raw data collected

from PIDS. Rather, the CDC team must extract and send the weighted data (weights are statistical adjustments that help to ensure that sampled data represent the underlying population) to NYSDOH. CDC statisticians maintain the expertise to properly and consistently weight the data, and this function is not performed by NYSDOH. Thus, sites are dependent upon the CDC PRAMS Data Team to extract, clean, process, weight, and provide states the weighted data sets. Additionally, CDC PRAMS creates and maintains the national dataset for researchers to request and use data from all states that meet the required response rate.

11. PRAMS data are for essential monitoring and reporting for a number of activities and grants at NYSDOH. This includes the State Maternal Health Innovation (SMHI) grant that was awarded to the Division of Family Health by the Human Resources and Services Administration (HRSA) to improve maternal health outcomes and address health disparities in response to the ongoing maternal mortality crisis in New York State. As a core data innovation component, the SMHI program includes a project which involves the linkage of PRAMS data to other sources of maternal health information, such as hospital discharge data and vital records. The Maternal and Child Health Services Title V Block Grant (Title V) is funded through HRSA and provides $38 million annually to support essential maternal and child health programs and services across New York State. PRAMS is a core data source necessary for the successful completion of ongoing Title V reporting, monitoring, and evaluation activities. Title V includes several national outcome/national performance measures derived exclusively from PRAMS data, and reporting on at least one of these measures is a direct requirement of the Federal funder. The New York State Department of Health has also contracted with the New York State Office of Cannabis Management (OCM) since 2021 to collect information about cannabis consumption and provider screening about cannabis consumption during the perinatal period via the PRAMS

survey. These data are used to monitor key public safety outcomes among pregnant and breastfeeding women post-legalization of adult use cannabis in New York State in 2021. OCM uses these data in their statutorily- required reporting.

12. New York State has relied on CDC for their assistance in tobacco prevention and control. The NYS Tobacco Control Program has both an internal Tobacco Surveillance, Evaluation and Research Team and a legislatively-mandated independent evaluation, conducted by a NYSDOH-funded contractor. Both the internal and the independent teams rely on standards set by CDC's Office of Smoking and Health (OSH) to conduct effective evaluation and surveillance activities that monitor the effectiveness of the state's investment in tobacco prevention and control and contribute to the scientific evidence base in tobacco prevention and control. The National Youth Tobacco Survey (YTS), supported by OSH, informs question development for the New York Youth Tobacco Survey, and serves as a basis for comparison to understand NY trends in context. The National YTS findings help inform the broader conversation about NY's tobacco-related outcomes among decision makers, the media and public health practitioners; and helps to fill in the gaps in data for items that NY does not have in the NY YTS. OSH also supports the National Quitline Data Warehouse (NQDW). The independent evaluator has been able to conduct robust studies of the NY Quitline's reach and effectiveness because of the access we have to other state and national data via the NQDW. CDC's OSH disseminates several fact sheets and publications which serve as foundational evidence-based guides for tobacco control programs' interventions and evaluations. These publications set the stage for talking about emerging products, shifting trends and key priorities. The STATE system, also supported by OSH, helps NY to facilitate data analysis and evaluation and supports reporting from the Independent Evaluator to the NYS Department of Health.

13. New York State has relied on CDC for its assistance in preventing sexually transmitted infections (STI), viral hepatitis, and HIV/AIDS, across a number of activities outlined in the following sections. New York State has specifically relied on the STD Laboratory Reference Branch to develop novel sexually transmitted infection diagnostic tools to address the rising cases of reportable sexually transmitted infections. Further, New York State relied on the over 40 years of data and expertise from the STD Lab that supported national surveillance of antimicrobial resistant trends in *Neisseria gonorrhoeae* (N. gonorrhoeae; gonorrhea) and served as a repository of 50,000 *Neisseria gonorrhoeae* isolates. Gonorrhea is resistant to nearly all antibiotics making it an urgent public health threat; we are on the last line of effective antibiotics to treat the second most reported sexually transmitted infection in the country and in New York State. The State relied heavily on the STD Lab in 2023 when a multi-drug non-susceptible gonorrhea strain was reported in a resident in Massachusetts. Once alerted, the CDC STD Lab issued guidance on how to contact them for consultation and specimen processing. Subsequently, New York State issued a health advisory directing clinicians to notify CDC's STD Lab immediately for consultation if there was a suspected gonorrhea cephalosporin treatment failure or any N. gonorrhoeae specimen with decreased cephalosporin susceptibility. Lastly, New York State relied on the CDC STD Lab to provide the factual data for the evidence based-Sexually Transmitted Infection Treatment Guidelines promulgated by the CDC and underpinned New York State's own, state-focused, evidence-based STI and Sexual Health Treatment, Prevention, and Care Clinical Guidelines.

14. New York State has relied on the CDC Hepatitis Laboratory to support the investigation of hepatitis C virus (HCV) outbreaks. CDC scientists developed and maintained the Global Hepatitis Outbreak and Surveillance Technology (GHOST) system, which utilizes

advanced sequencing methodologies and analysis methods to characterize viral genotypes and transmission links among HCV cases, allowing for the identification of a common infection source. Identification of the source of infection is crucial for the interruption and prevention of outbreaks. In 2024, New York State used GHOST to establish genetic linkages between 20 new HCV cases from multiple healthcare facilities, likely caused by exposure to a single HCV-infected healthcare provider at a surgery center. The GHOST program and technical expertise of CDC scientists to help interpret the results were critical to that outbreak investigation and the success of measures taken in response to the findings.

15. The CDC provides coordinated national guidance for all aspects of HIV Surveillance and prevention. The agency develops and maintains standardized data collection tools and systems for collecting and storing data, including demographic, behavioral, diagnostic, and other HIV-related test information. In collaboration with funded programs, the CDC also provides training and technical support, produces technical guidance documents and benchmarks to measure progress towards timely, high quality, and nationally comparative data. These efforts help establish standards for data collection and ensure the security and confidentiality of HIV Surveillance information. The CDC provides expertise in specialty settings especially related to laboratory reporting and case ascertainment from other federal agencies, i.e., the Veterans Administration. Through training and technical guidance on quality assurance for laboratory reporting, the agency sets the standard on HIV-testing, reporting, and results interpretation, especially related to challenges cases. Without the CDC's expert input, New York State's progress toward ending the HIV epidemic would be significantly hindered.

16. A specific program of note is the CDC's HIV Medical Monitoring Project (MMP), which is a program that generates nationally representative estimates related to

behaviors, clinical outcomes, quality of care for people living with HIV and is conducted in 23 project areas around the United States, including in New York State. When I was a Senior Epidemiologist at CDC, I was embedded in the Behavioral and Clinical Surveillance Branch, within the National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention's Division of HIV/AIDS Prevention, that conducted MMP and am intimately familiar with its operations. Similar to PRAMS described above, the CDC team supporting MMP provides essential technical, operational, and statistical functions for the project, such that the program cannot fully function in funded project areas absent the CDC team. In New York State, the Medical Monitoring Project has been ongoing since 2005 and is one of few sources of representative data on people living with HIV. The State relies heavily on the Medical Monitoring Project to monitor trends, identify unmet healthcare needs, and assess access to ancillary care, and supportive services. The Medical Monitoring Project is also critical in locating individuals with HIV who are sampled but appear to be out of care, facilitating their re-linkage to HIV medical providers, and enumerating barriers to care. The Medical Monitoring Project is also the only data source within the State that measures HIV-related stigma among people living with the virus. New York State relies on MMP to track this Ending the Epidemic metric.

17. New York State has relied on CDC National Center for Environmental Health for its technical assistance with childhood lead poisoning prevention. Childhood lead poisoning remains a significant public health problem in New York State. Due to substantial state investment in secondary and primary prevention programs, cases have steadily declined since 1998, but New York State still has the greatest number of childhood lead poisoning cases in the nation. From 2016-2019, 16.5 per 1000 children under age 6 tested statewide had blood lead levels at or above 5 micrograms per deciliter. Thousands more are at risk due to other risk factors

in the State (e.g., poverty, old and deteriorating housing stock). New York State relies on CDC's nationwide surveillance through their Childhood Blood Lead Surveillance System to identify new sources of lead and inform targeted interventions at the State level. When there are programmatic emergent issues, CDC serves as a liaison with other states to develop nationwide guidance and strategies. In 2021, New York State medical providers experienced a shortage of a chelation medication; in response, CDC coordinated with other states to develop solutions and alternative approaches to medical treatment. Additionally, CDC's national response is critical to product safety awareness, particularly regarding new sources of lead-bearing products in the marketplace. New York State has relied for decades on CDC and other federal partners for their technical expertise to inform regulations and policy in the primary and secondary lead poisoning prevention efforts in children.

18. For decades, CDC's National Institute for Occupational Safety and Health (NIOSH) has served as a cornerstone for worker health and safety. New York State has been part of NIOSH's Adult Blood Lead Epidemiology and Surveillance (ABLES) program since 1994. We later expanded our relationship with NIOSH in the early 2000s with a cooperative agreement to conduct additional surveillance of a variety of other occupational health conditions including work-related respiratory conditions and workplace fatalities investigations. The ABLES program monitors work-related exposure in adults in the U.S. The data has been vital in monitoring workplace lead exposure trends and is used to guide interventions and prevent work-related lead exposures.

19. New York State has relied on CDC for their assistance addressing excessive alcohol use and its harms, including providing technical assistance and guidance for NY's Alcohol Surveillance and Epidemiology Program. The CDC Alcohol Program provided guidance

and technical assistance to states to build capacity to conduct alcohol surveillance and epidemiology, disseminate consistent messaging about the harms of alcohol use and promote information about evidence-based solutions. Specifically, they provided assistance in the form reviewing all NY-generated alcohol reports for accuracy/alignment with the evidence base, sharable graphics for messaging, and they developed, hosted and maintained key data systems like the Alcohol-Related Disease Impact (ARDI) application, which is the primary source for states about alcohol-attributable disease and death.

20. New York State also relies on SAMHSA, which funds the National Survey for Drug Use and Health, an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals, aged 12 years and older. This survey provides estimates on the use of tobacco products, alcohol, illicit drugs, and mental health in the United States (US). These data provide state and national estimates to track trends in the use of substances, assess the consequences of substance use and abuse, and identify those groups at high risk for Opioid Use Disorder. In New York State, the survey provides key indicators that allow New York State Department of Health to compare the national prevalence to New York State prevalence on specific substance use; allowing to observe trends in substance use and mental health, among other topics. Since 2018, when available data, from the survey has been included in the NYS Opioid Annual Report, a report that is legislatively mandated. These data are also included in the New York State Opioid Data Dashboard and the New York State key tracking indicators, which are both used for monitoring the opioid crisis in New York. NSDUH indicators are further prioritized and incorporated in the New York State Health Improvement Plan, known as the Prevention Agenda, to assist in monitoring progress of opioid and substance use interventions and programs throughout New York State.

21. New York State has relied on CDC for their assistance supporting our program related to STD/HIV Disease Intervention Training Centers (DITC). Health Research Incorporated as the grantee has been supporting these state-provided services for more than 15 years. The intent of this program was to improve the quality of disease intervention services provided by states in HHS Region II by providing training and technical assistance to regional jurisdictions. Disease Intervention Specialists function as the "on the ground" investigators of sexually transmitted infections in states and cities across the country. They provide an essential intervention limiting disease spread in New York State and throughout HHS Region II.

Changes in HHS Data and Technical Assistance Since April 1, 2025

22. Since April 1, 2025, changes at HHS have and will continue to impact our data and technical assistance received from HHS agencies, which in turn impedes numerous functions at NYSDOH. The discontinuation of HHS data and surveillance programs, because the personnel are no longer employed, will mean some national data will be unavailable to supplement our NYSDOH data, limiting our ability to track and respond to conditions. For other surveillance programs, we are unable to retrieve our own data submitted to HHS. The loss of whole teams at HHS agencies removed essential guidance and coordination needed to conduct our work and, in some cases, NYSDOH project operations have ceased because the HHS team conducted key steps in our program's operations. For some activities we have received notice that active awards are being discontinued, or recently submitted funding applications cannot be reviewed, because the HHS teams overseeing these awards and application review processes have been terminated.

23. Since April 1, 2025, New York State has experienced harm relating to CDC's role in helping to ensure that children are screened for hearing loss and receive appropriate interventions for hearing loss. We learned that, on April 1, the entire CDC branch for the Early

Hearing Detection and Intervention (EHDI) program was eliminated. Since that date, all technical assistance and the supports described above have been completely terminated, and New York State EHDI staff have been left without guidance or direction on how to proceed with activities described in the cooperative agreement, in which the CDC team substantially participated. The elimination of the CDC also has created uncertainty regarding our competitive Grant Application for July 1, 2025 - June 30, 2030 funding, which was recently submitted. Specifically, an April 24, 2025 e-mail sent to Health Research, Inc. from CDC indicated that there was no staff to review the recently submitted competitive application (CDC-DD-25-0157) for the above funding cycle, due to the federal RIF impact on the program. This puts a significant portion of the EHDI program's overall funding at risk, with no current alternative state funding available to absorb costs and staffing. A copy of this email is annexed hereto as **Exhibit A**.

24. Since April 1, 2025, New York State has experienced harm relating to CDC data that describe the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). Starting January 31, 2025, the PIDS electronic data system has effectively been shut down. As PIDS is essential for data collection and operations, this pause abruptly ended the 2024 birth year data collection and resulted in over 20% reduction in the New York State 2024 sample. This reduction has serious implications for analysis, statistical power, and data publication and research products. On April 30, the Department received additional communication informing us that CDC could "no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity". A copy of this email is annexed hereto as **Exhibit B**. This has serious implications for the future of data collection and places the timeline to receive prior year datasets for data collected by NYSDOH and transmitted to CDC. As described in section 9

above, the CDC PRAMS team is responsible for providing scientific and technical assistance including producing the weighted dataset. Without staff, or this technical assistance, it is unclear if, how, and when states will gain access to data that was already collected, such as the weighted 2024 dataset. Furthermore, continued outage of PIDS has a direct impact on operations. A normal schedule for beginning data collection of January 2025 births is April 2025. Any delay in 2025 data collection could result in a reduction of 2025 birth year sample. As sampled cases are no longer valid when the infant turns 9 months old, any delay to the start of data collection will limit the amount of time for collection, result in additional work to collect multiple sample batches at one time and put more strain on staff and increasing operations costs. The longer the delay, the greater and more costly the impact. This will additionally affect the ability to meet the requirements of the SMHI project, future Title V reporting, and the OCM contract, which are described in Section 9 above. Continued outage of the data collection platform and loss of CDC technical assistance to clean, process, and weight the data will have further impact on NY's continued ability to effectively identify high risk populations, measure progress towards goals for improving the health of families and infants, plan, evaluate and assess perinatal health programs, evaluate policy, report essential federal performance measures related to maternal and child health, and to meet certain state reporting requirements. The loss of PRAMS data would jeopardize the New York State Title V program's ability to meet reporting requirements and would also severely compromise the Department's ability to track progress on key maternal and child health goals and objectives outlined in the Title V State Action Plan, the New York State Title V Dashboard, the New York State Maternal and Child Health Dashboard, and the New York State Prevention Agenda. PRAMS data are crucial to understanding key factors that contribute to maternal and infant morbidity and mortality and our ability to monitor, intervene, and ultimately

protect mothers and infants and without PRAMS data in the future, efforts to reduce infant and maternal morbidity and mortality will be affected.

25. Since April 1, 2025, New York State has experienced harm relating to CDC's role in tobacco prevention and control. Staff at CDC established and maintain specifications for data systems needed to track measures of tobacco use for all 50 states, including New York. Furthermore, they maintain the case definitions of measures essential to monitoring progress in tobacco control, cigarette smoking, use of other tobacco products, vaping and quit attempts. Public health surveillance and epidemiology rely on stable data systems and standard case definitions. By firing the experts responsible for these central data systems and technical measure specifications, HHS did irreparable harm to all 50 states and US territories involved in tobacco control, including losing access to the technical advisors at CDC who provide guidance and feedback regarding state program evaluation and performance measurement plans. Without key staff at CDC's OSH, updates to the National Youth Tobacco Survey, the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for New York State's tobacco quit line are unlikely to occur, significantly hampering NY's efforts to effectively evaluate their tobacco prevention and control programming.

26. Since April 1, 2025, New York State has experienced harm relating to CDC's role in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis. The elimination of the STD Laboratory Reference and Research Branch will imminently result in harm to New York State as there is no reference laboratory to provide a national picture of antibiotic-resistant gonorrhea to inform New York State's clinical response, serve as a consultant on suspected treatment failures and/or reduced susceptibility cases, or to provide technical assistance in such cases involving pregnant persons.

27. The closure of the CDC Hepatitis Laboratory has harmed New York State because we no longer have access to the GHOST analysis computer program nor the CDC scientists who provided technical assistance to interpret GHOST results. Without GHOST, outbreaks of hepatitis C virus will take longer to investigate, linkages between cases and clusters may remain undetected, and prevention interventions will be delayed, resulting in continued transmission of HCV and potentially increased morbidity and mortality from this lethal infection.

28. The CDC has provided essential national guidance, data systems, and technical support for HIV surveillance and prevention, ensuring consistent standards, data quality, and confidentiality across states. Its expertise, especially in laboratory reporting and interagency case ascertainment, is critical to New York's HIV response. Elimination of the Division of HIV Prevention's Behavioral and Clinical Surveillance Branch that housed the Medical Monitoring Project and the Quantitative Sciences Branch that produced HIV incidence and HIV status awareness estimates weakened CDC's involvement and has directly impaired the state's ability to effectively monitor, prevent, and respond to HIV.

29. We understand that the Behavioral and Clinical Surveillance Branch was terminated, including the team conducting the HIV Medical Monitoring Project (MMP). The current data collection cycle of the Medical Monitoring Project ends May 15, 2025. Due to these circumstances, the following harms have been realized:

30. The State has not received weighted data from the CDC for the two most recent years of data collection (i.e., the 2023-2024 and 2024-2025 data collection cycles). Without the weights, the samples are not truly representative of individuals living with HIV in New York State.Training and technical support for data collection activities (interviewers, data collectors) have gone unmet.

31. Technical assistance needs related to data quality and participant recruitment have gone unmet.

32. Training and technical support for data management and data analytics have ceased.

33. Reconciling differences and gaps in recruitment data between funded jurisdiction ceased; this cross jurisdictional activity was facilitated by the CDC.

34. The ability to detect changing and emerging trends among people living with HIV will be compromised, hindering timely and effect public health responses.

35. CDC's obligation to New York State as part of the current CDC HIV prevention and surveillance cooperative agreement notes substantial involvement to provide technical assistance to support HIV surveillance and prevention. (The first year one of the five year cycle is slated to end May 31st 2025 and pending a Notice of Award for year two, starting June 2025). This technical assistance is critical to calculate HIV incidence in New York State and percent of people with HIV aware of their status. These are two critical metrics included in New York State's efforts to end the HIV epidemic. On April 29, 2025, New York State was notified that "the publication of CDC's *HIV Surveillance Supplemental Report*: Estimated HIV Incidence and Prevalence in the United States, 2019–2023 has been delayed and that the *HIV Surveillance Supplemental Report*: Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Territories and Freely Associated States, 2023 (this year's Monitoring Report) does not include data on PrEP coverage. In 2024, CDC paused PrEP coverage reporting for one year to update overall PrEP coverage estimates using newly available data sets and determine the best way to present PrEP coverage. However, CDC is unable to resume PrEP coverage reporting at this time, due to a reduction in force affecting the

Division of HIV Prevention (DHP). As part of this staffing reduction, the DHP branches that produced HIV incidence estimates and provided the statistical expertise needed to assess PrEP coverage were eliminated. CDC is currently evaluating plans and capacity to resume this work.

36. Since April 1, 2025, New York State has experienced harm relating to CDC's role in monitoring for and responding to lead poisoning, especially in children. Since April 2025, CDC has been unavailable and has not participated in our long-standing monthly technical assistance calls to review grant deliverables and discuss childhood lead poisoning prevention matters. At this time, CDC is not providing further technical assistance to New York State. New York State is currently pursuing an investigation into a recent discovery of lead contamination in baby food and CDC is unavailable to consult on the federal recall of this food or to provide information from other states as to their experience and response. New York State does not have a technical lead on the national level to consult during emerging issues that continue to rise and require prompt response to mitigate lead poisoning in children and the lifelong impact that such poisoning presents.

37. The recent federal restructuring has led to the dismantling of the CDC's National Institute for Occupational Safety and Health (NIOSH). It has been reported that nearly 900 staff positions and a wide range of critical programs have been eliminated. All but a few employees, primarily a few commissioned officers, will remain after June 2, 2025. The worker health data submitted and collected on a national level is at risk of being deleted and gone forever. Without NIOSH staff support, data, or funding to support our follow up with lead poisoned adults will be much more limited and our ability to continue the pregnant women collaborative program with the NYS Childhood Lead Prevention Program and county health departments, where we work to

ensure timely identification of lead poisoned pregnant women and follow-up of their at-risk newborn babies, will be extremely limited and most likely stopped altogether.

38. Since April 1, 2025, New York State has experienced harm relating to SAMHSA data about drug use. According to media reports and a public post from the National Survey for Drug Use and Health Director on LinkedIn from early April, the entire team overseeing National Survey for Drug User Health at the Office of Population Surveys at SAMHSA was laid off. As noted in Section 16 above, this survey provides estimates on the use of tobacco products, alcohol, illicit drugs, and mental health in the United States (US). The national and state estimates are used in key data products (also described in Section 16) that help New York State monitor trends and the loss of this data source would make it challenging for New York State to track progress, identify high-risk populations, and compare with national trends.

39. Since April 1, 2025, New York State has experienced harm relating to CDC data about alcohol use. According to news reports, the entire team overseeing the Alcohol Program at CDC's Division of Population Health was laid off. CDC's Alcohol Program measures the impact of excessive alcohol use and related harms in the United States. The program also develops resources to help people drink less alcohol and to help communities and states create healthier environments that support individuals in drinking less alcohol. The Alcohol Program funds states to build and maintain capacity to conduct epidemiologic and surveillance activities related to alcohol use. The CDC-funded contract supporting a TA center, which helps states to evaluate their efforts under their cooperative agreements with CDC, has been suspended. Staff at CDC who provided technical review of NY-developed alcohol reports are no longer available to provide review, ensure alignment with the evidence base and provide feedback for improvement.

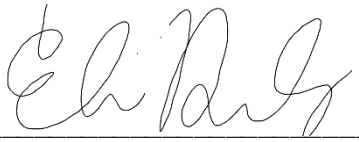
The CDC Alcohol Program provides support for the Alcohol Related Disease Impact (ARDI) application. ARDI is an online application that provides national and state estimates of alcohol-related health impacts, including deaths and years of potential life lost (YPLL). These estimates are calculated for 58 acute and chronic causes using alcohol-attributable fractions and are reported by age and sex. Without this application being updated, NY will lose its primary method for quantifying the health impact associated with alcohol use, which is a key risk factor for cancer and other acute and chronic health outcomes. Further, NY has been funded by CDC's Alcohol Program since 2021; this funding is the only support for NY's Alcohol Surveillance and Epidemiology Program. The future of that funding is uncertain.

40. On April 10, 2025, New York State has experienced harm related to the loss of program services following the abrupt termination of CDC-RFA-PS20-2003: STD/HIV Disease Intervention Training Centers (DITC). The reason given for the termination of funding was that CDC was "no longer able to provide programmatic technical assistance or project monitoring as required by law." Without this training center, there is increased risk of disease spread in New York State and throughout HHS Region II. A copy of the April 10, 2025 email stating the reason for the termination of funding is annexed hereto as **Exhibit C**.

Conclusion

41. As set forth in detail above, the significant cuts to HHS, the CDC, and SAMHSA have adversely impacted the work of NYSDOH and are preventing NYSDOH from carrying out its mission to protect and promote health and wellbeing of New Yorkers.

Date: 5/08/2025



ELI ROSENBERG

Exhibit A

From: DHDD OD Requests (CDC)
Cc: EHDI Co-op (CDC)
Subject: Updates for DD20-2006 EHDI Recipients
Date: Thursday, April 24, 2025 9:29:29 AM
Attachments: DataSubmissionChecklist.docx
HSFS_iEHDI_2023.xlsx
iEHDI_DD2006_final_ExhibitA_0722.xlsx

Hello DD20-2006 EHDI Recipients,

The Division that housed the EHDI program, Division for Human Development and Disability (DHDD) is sending this message during what has been a challenging time for the CDC EHDI team. Prior messages have indicated that all but one team member is on administrative leave as a result of the federal reduction in force (RIF). This is still the case. In turn, the typical functions of project officers, health/data scientists and evaluation scientists are not occurring. However, a primary requirement of your program's receipt of federal funding through DD20-2006 (attached) is data submission. Here are a few notes of guidance that we can offer at this time:

Workplans and Reporting

- We ask that you continue to complete workplan activities until the end of the period of performance.
- As with previous EHDI notice of funding opportunities (NOFO), a close out will be due 120 days after the end of the performance period (120 days after June 30, 2025) for due date for final progress reports due 10/30/2025.
- SAMS is still functional, so you can submit 2023 iEHDI data. **Final 2023 iEHDI data is due May 23, 2025.**
    - Please note that CDC will not be able to return data quality reports.
    - The data dictionary and data checklist are attached.
    - If you are having issues with accessing SAMS, please contact Yvette Dominique yad4@cdc.gov. Yvette, is a senior leader in DHDD that is currently supporting all IT-related requests for the Center. Please be patient if there is a delay in her response.
- The ehdico-op@cdc.gov mailbox is still functional but may be checked less frequently. Please send emails to both ehdico-op@cdc.gov and dhddodrequests@cdc.gov when sending correspondences.

Data Quality Review with CDC Foundation

- You may remember that CDC EHDI hosted office hours where the CDC Foundation (CDCF) was introduced as a group funded to support technical assistance analyzing iEHDI data. The CDCF's workplan includes reaching out to states, providing with 1:1 technical assistance to review missingness and overall data quality. Caitlin worked closely with this team to create SAS code and a slide deck specific for each state. CDCF will share with you a summary of the 2022 iEHDI data that you submitted to CDC. CDCF has access to a limited analytic dataset (not the full dataset) on our secure server. As a result, CDC EHDI followed all agreements within the DUA. Please collaborate with this expert team to learn more about your iEHDI data.

Applications for DD25-0157

- As a result of the RIF, the objective review for DD25-0157 Enhancing Timely Data Reporting, Quality, and Use in EHDI Surveillance is on hold. It is unclear whether a review of applications will occur.

This is all of the information we have to share at this time. If any funding-related changes occur, you will receive a notice in GMS. Thank you for your continued work and contributions to EHDI, even within the uncertainty. We appreciate your patience.

Sincerely,
DHDD Team

Exhibit B

[redacted]

From: Raman, Jayalakshmi (Jaya) (CDC/NCCDPHP/OD) <kva5@cdc.gov>
Sent: Wednesday, April 30, 2025 4:47 PM
To: Brown, Natalie (CDC/NCCDPHP/OD) <fmc7@cdc.gov>; Kroelinger, Charlan (CDC/NCCDPHP/DRH) <dwz8@cdc.gov>
Subject: PRAMS Update

Dear Recipient,

As you may be aware, CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS). CDC will share guidance for revision of workplans and budget documents for the Year 5 budget period starting May 1, 2025 through April 30, 2026 soon.

Please also note that there are new requirements for requesting payments in the Payment Management System (PMS). Going forward, you will be required to provide a justification for each payment request. The justification must accompany the request and will be sent to the CDC for approval. To help expedite the approval process, please include the following information in your justification:

1. Notice of Funding Opportunity Number
2. Grant Number
3. Budget Period
4. Payment Request Justification: Examples: Payroll and Fringe for Staff Payment Justification: Subcontractor Payments to ABC Industries, DEFG Solutions Payment Justification: Supplies – copies, paper Payment Justification: Other – publications, insurance, professional services
5. Summary total of the requested cost (e.g. Salaries - $1,000; supplies - $100, etc.)

When submitting your PMS drawdowns, please avoid using the same response for multiple payment justification entries. It is important to provide adequate justification; otherwise, your request may be rejected. It's recommended that you separate your payment request by awarding agency to prevent approval delays. **If additional information is needed, the assigned GMS/GMO will contact you directly. Additionally, you may need to email supporting documents to your GMS on a case-by-case basis, so please ensure they are readily available if requested by the GMO.** (For research recipients, GMS/GMO may contact

recipients directly for additional to be emailed as they are not able to upload into the GrantSolutions Grant Notes.)

Jayalakshmi Raman,
Health Scientist
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
770 488 6511

Exhibit C

View / Reply to Grant Message

Subject: CDC-RFA-PS20-2003: STD/HIV Disease Intervention Training Centers (DITC) will not be extended

Communication Type: Correspondence **Category:** Other

AUTHOR	MESSAGE	DATE / TIME	ACTIONS
Kenya Taylor	Dear Funded Partner, Last week CDC experienced a large reduction in force (RIF), in accordance with President Donald Trump's Executive Order 14210 and the Department of Health and Human Services' (HHS) broader reorganization strategy to improve its efficiency and effectiveness. This cooperative agreement CDC-RFA-PS20-2003: STD/HIV Disease Intervention Training Centers (DITC) will not be extended. Unfortunately, the Division of STD Prevention (DSTDP) is no longer able to provide programmatic technical assistance or project monitoring as required by law. Recipients have 120 calendar days from the project period end date, which is March 31, 2025, to liquidate all financial obligations and submit the required reports in GrantSolutions as a closeout amendment. This includes submitting a final Federal Financial Report (FFR) in the Payment Management System (PMS), a final progress report, and tangible and real property reports (if necessary), as outlined in the Terms and Conditions of the award. All closeout reports are due by July 29, 2025. Standard closeout reporting requirements can be found in the General Terms and Conditions published on the CDC website at https://www.cdc.gov/grants/federal-regulations-policies/index.html. If you have any questions regarding the closeout requirements, please contact the assigned Grants Management Specialist. For programmatic questions please contact Arin Williams at gpo4@cdc.gov . Kind Regards, Division of STD Prevention Show Less	04/10/2025 01:42 PM EST	

Add Reply

Exhibit 76

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF COLORADO; STATE OF RHODE ISLAND; STATE OF CALIFORNIA; STATE OF MINNESOTA; STATE OF WASHINGTON; STATE OF ARIZONA; STATE OF CONNECTICUT; STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; OFFICE OF THE GOVERNOR *EX REL.* ANDY BESHEAR, in his official capacity as Governor of the Commonwealth of Kentucky; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF WISCONSIN; JOSH SHAPIRO, in his official capacity as Governor of the Commonwealth of Pennsylvania, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the U.S. Department of Health and Human Services, Defendants.	C.A. No. 1:25-cv-00121-MSM-LDA

MEMORANDUM AND ORDER

Mary S. McElroy, United States District Judge.

Bracing for the financial impact of an unprecedented public health crisis, Congress appropriated billions of dollars in spending across six appropriation acts starting in March 2020. The U.S. Department of Health and Human Services ("HHS") administered that money to all fifty States through grant programs aimed at responding to the ongoing health crisis. After the pandemic's official end in 2023, Congress reviewed its COVID-era spending and rescinded some appropriations it no longer saw as necessary, and left others in place. Since then, HHS has continued to administer the funding without issue.

On March 24, 2025, HHS suddenly terminated $11 billion of the public health grants appropriated by Congress to fund certain health programs and services, effective immediately ("Public Health Funding Decision). HHS began sending mass termination notices which contained the same boilerplate explanation that "[t]he end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary." (ECF No. 4-40 Ex. A at 5.) Though Congress appropriated the funds during the pandemic, they did much more than address COVID-related public health concerns.

The terminations impact a wide range of the States' public health programs and services. The terminated funds addressed infectious disease outbreaks, including rising threats like measles and H5N1 (avian influenza). They ensured access to immunizations among vulnerable populations. They fortified emergency

preparedness for future public health threats. They provided mental health and substance abuse services. And they modernized critical public health infrastructure. Without the funds, these programs could not continue.

Challenging the Government's failure to comply with statutory and regulatory processes and fundamental Separation of Powers principles, a coalition of twenty-three States and the District of Columbia (the "States") sued in the District of Rhode Island.[1] The States now move for a preliminary injunction—a temporary court order requiring HHS to reinstate the funds, at least while their case is pending.

For the reasons discussed below, the Court GRANTS the States' Motion for a Preliminary Injunction (ECF No. 60). The Court DENIES the Defendants' Motion for Reconsideration and Request to Vacate the Temporary Restraining Order and Motion for a Stay Pending Appeal (ECF No. 56).

I. BACKGROUND

The Court begins with a preliminary statement of facts.

A. Congress's Appropriation of Public Health Funding

In March 2020, the world came to a screeching halt because of COVID-19. It sparked lockdowns across the globe, forced schools and businesses to shut their doors indefinitely, and quickly overwhelmed hospitals and healthcare providers.

[1] For ease of reading, the Court refers to the Defendants collectively as either "HHS" or "the Government." The Court refers to the Plaintiff-States collectively as "the States."

In response, Congress passed six appropriation acts to help people and businesses cope with the financial impact caused by the crisis. Congress enacted the laws to outline a path toward recovery, but also to better prepare the country for future public health threats. (ECF No. 60 at 3–4.) The funding was designed to strengthen healthcare outcomes and address gaps in the country's health system that were highlighted by the pandemic. *Id.*

Through these appropriations, Congress allocated large sums of money to HHS. HHS, in turn, was to distribute the money to the States by allocating certain amounts of the appropriated money to the Center for Disease Control ("CDC") and the Substance Abuse and Mental Health Services Administration ("SAMHSA"). (ECF No. 68 at 3-4.) As sub-agencies of HHS, both CDC and SAMHSA were responsible for allocating money to the States; they did so expeditiously through a variety of grant programs aimed at responding to the ongoing health crisis. *Id.* CDC and SAMHSA would either add the funds to existing awards to get the money to the States quickly or provide new grants to ensure the States could adequately respond to the pandemic. *Id.* at 4. The funds were largely used by the States, but in some cases, the agencies allowed for no-cost extensions of the grant awards if the funds could not be readily or timely used by the recipients. *Id.* As for CDC, some of the appropriations statutes direct a minimum amount of funding to be provided to state, tribal, local, and territorial entities, commonly referred to by HHS as "STLTs." (ECF No. 80-1 ¶ 7.)

Congress provided funds through six appropriation acts:

- Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, ("CPRSA") Pub. L. No. 116-123, 134 Stat. 146 (2020) ($8 billion);
- Families First Coronavirus Response Act, ("FFCRA") Pub. L. No. 116–127, 134 Stat. 178 (2020) ($15 billion);
- The Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281 (2020) ($2.1 trillion);
- The Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020) ($483 billion);
- The Coronavirus Response and Relief Supplemental Appropriations Act, (2021) Pub. L. No. 116-260, 134 Stat. 1182 (2020) ($900 billion); and
- The American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021) ($1.9 trillion).

Below, the Court describes with greater specificity what each act accomplished.

First, Congress passed CPRSA on March 6, 2020. Pub. L. No. 116-123, 134 Stat. 146 (2020). Title III of CPRSA specifically outlines the amount of money and purpose of the money being allocated to the CDC through HHS. *Id.* at 147–48. Congress specifically allocated $2,200,000,000 for "CDC-Wide Activities and Program Support" and further broke down that number into smaller allocations. For example, it required $950,000,000 be provided "for grants to or cooperative agreements with [STLTs] to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities[.]" *Id.* at 147.

Following the CPRSA, Congress passed the FFCRA on March 18, 2020. Pub. L. No. 116–127, 134 Stat. 178 (2020). FFCRA did not allocate any appropriations directly to CDC or SAMHSA; instead, the only allocations were $1,000,000,000, to

HHS, for the Public Health and Social Services Emergency Fund, "to remain available until expended." *Id.* at 182. It also gave $250,000,000 to HHS for Aging and Disability Services Programs. *Id.*

Next, Congress passed the CARES Act, which provided financial assistance to individuals, businesses, and local governments. CARES Act, Title VIII, 134 Stat. 281, 554–55 (2020). The Act includes provisions for direct payments to individuals, expanded unemployment benefits, and support for small businesses. *Id.* Additionally, it established the Coronavirus Relief Fund, which allocated $150,000,000,000 to help state and local governments manage the pandemic's impact. *Id.* at 554. The 2020 Supplemental Act further appropriated $950,000,000. 2020 Supplemental Act, Title III, 134 Stat. at 147. Together, these funds were for HHS to administer grant-in-aid programs with States and local jurisdictions to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities. Specifically, Congress appropriated $4,300,000,000 to CDC, of which $1,500,000,000 was appropriated for awards to STLTs, to remain available until September 30, 2024.[2] 134 Stat. 281 at 554. As of April 14, 2025, CDC made available $2,108,388,501 to the STLTs, and the STLTs spent $1,812,715,188 of the awarded CARES Act funds. (ECF No. 80-1 ¶ 10.)

[2] Pursuant to 31 U.S.C. §§ 1552(a), 1553(a), the States have until the fifth fiscal year after the period of availability for obligation to spend the funds.

Next, on April 24, 2020, Congress passed the Paycheck Protection Program and Health Care Enhancement Act ("PPP"), Pub. L. No. 116-139, 134 Stat. 620 (2020). Through the PPP, Congress appropriated $11,000,000,000 to HHS for STLTs in total. (ECF No. 80-1 ¶ 11.) Congress specified that $750,000,000 be appropriated for the Indian Health Service, resulting in $10,250,000,000 billion appropriated for non-Indian Health Service STLTs. *Id.* HHS also transferred another $282,311,516 to CDC, and Congress separately appropriated another $1,000,000,000 directly to CDC under the PPP. *Id.* As of April 14, 2025, CDC made available $11,652,785,823 to the STLTs, and the STLTs spent $10,029,206,313 of the awarded PPP funds. *Id.*

With the Coronavirus Response and Relief Supplemental Appropriations Act ("CRRSAA"), Congress appropriated $8,750,000,000 to CDC, of which $4,290,000,000 was specifically appropriated for awards to STLTs, to remain available until September 30, 2024. Pub. L. No. 116-260, 134 Stat. 1182, 1911 (2021). As of April 14, 2025, $5,426,073,054 was made available to the STLTs from CRRSAA funds, and the STLTs spent $3,811,438,554 of the awarded CRRSAA funds. (ECF No. 80-1 ¶ 12.) Congress appropriated $1,650,000,000 for the Substance Abuse Prevention and Treatment Block Grant and $1,650,000,000 for the Community Mental Health Services Block Grant. 134 Stat. 1182 at 1913. The CRRSAA directed that SAMHSA award no less than 50 percent of the CMHS Block Grant appropriation to community mental health centers. *Id.*

Lastly, through the American Rescue Plan Act of 2021 ("ARPA"), Congress appropriated $1,000,000,000 to the CDC. Pub. L. No. 117-2, 135 Stat. 4, 38 (2021).

CDC received another $17,964,597,077 from HHS and CMS under ARPA. *Id.* As of April 14, 2025, $18,964,597,077 was made available to the STLTs, and the STLTs had spent $12,241,082,518 of the awarded ARPA funds. (ECF No. 80-1 ¶ 13.) As of April 14, 2025, HHS records show $6,723,514,559 of unspent ARPA funds that had been awarded to STLTs. *Id.* Congress appropriated $1,500,000,000 for the Substance Abuse Prevention and Treatment Block Grant and $1,500,000,000 for the Community Mental Health Services Block Grant. 135 Stat. 4 at 45–46.

B. Congress's June 2023 Review of COVID-Era Funding Laws

Around a month after health officials declared that the pandemic was over, Congress undertook a review of its COVID-era spending, rescinding some appropriations and indicating others were to remain available. In June 2023, Congress passed the Fiscal Responsibility of Act of 2023, which canceled $27,000,000,000 in appropriations that were no longer necessary due to the end of the public health emergency. Pub. L. 118–5, Div. B, Sec. 1-81 (June 3, 2023). The rescissions included funds that had been appropriated under the laws at issue here, the 2020 Supplemental Act, Pub. L. No. 116-123, the Families First Coronavirus Response Act, Pub. L. No. 116-127, the CARES Act, Pub. L. No. 116-136, the Paycheck Protection Act, Pub. L. No. 116-139, the 2021 Supplemental Act, Pub. L. No. 116-260, and ARPA, Pub. L. No. 117-2. *Id.* In undergoing its June 2023 review, Congress clarified that certain funds were unnecessary, while others were to remain intact, such as the funding impacted by HHS' 2025 Public Health Funding Decision.

C. HHS' Administration of Funds

As Congress was busy handling appropriations during and after the pandemic, HHS worked diligently with the States. The money, which remained after congressional review, was funding various public health programs and services including treatment to those struggling with substance abuse and mental health issues, improvements to infectious disease tracking and response capability, and efforts to modernize the States' and their local jurisdictions' public health infrastructure. *See* ECF Nos. 4-13 ¶ 10; 4-6 ¶¶ 40–50; 4-27 ¶ 18. HHS even granted extensions to the States to draw down the funds, in some cases through June 2027, and issued guidance on how to appropriately use the funds beyond COVID-related concerns. *See* ECF Nos. 4-3 ¶¶ 10, 13, 21–22, 48; 4-24 ¶¶ 11, 22; 4-32 ¶ 19.

D. The Public Health Terminations

All that changed on March 24, 2025. Starting that day, the States' local health agencies began receiving termination notices from HHS, CDC, and SAMHSA revealing that their funding was cut ("Public Health Terminations"). (ECF No. 60-1 at 12).

According to the States, HHS' termination notices, distributed across various local programs and agencies, include the same basic components. *See e.g.*, ECF No. 4-40 at 16, 22, 28, 33, 38; ECF No. 4-41 at 52, 54; ECF No. 4-27 at 82, 95, 107, 125. The notices were issued on March 24 and 25 and provided no advanced notice to recipients. *See id.* The recipients were advised that the funding was terminated "for cause" and HHS referred to the end of the COVID-19 pandemic as the reason. *See*

id. Rather than explaining why the grantee had failed to comply with the terms and conditions or what for cause meant, the notices simply explained that the "end of the pandemic provides cause" to terminate the funds. (ECF No. 4-27 at 125.) Finally, the terminations were effective immediately, giving recipients no warning that they stand to lose the money.

Separately, CDC began sending termination notices that stated the following:

> The termination of this award is for cause. HHS regulations permit termination if "the non-Federal entity fails to comply with the terms and conditions of the award", or separately, "for cause." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of [this award] is effective as of the date set out in your Notice of Award.[3]

(ECF No. 4-40, Ex. A at 5.) Aside from this language, the notices executed by CDC did not provide any additional explanation to the recipients. (ECF No. 4-7 ¶ 59; 4-15 ¶ 15.) Prior to the termination, CDC did not notify the States that the grants were being administered in an unsatisfactory manner. *See, e.g.*, ECF No. 4-3 ¶¶ 19, 45; 4-7 ¶¶ 31, 43; 4-8 ¶ 18; 4-10 ¶ 36.

Although the CDC notices cited the end of the COVID-19 pandemic as cause for termination, many of the programs impacted by the Public Health Funding Decision were in place to advance health outcomes beyond the COVID-19 pandemic.

[3] The States note that while the terminations sent to their local programs and agencies do have minor, non-substantive variations, the gist of the language was the same. (ECF No. 60 at 10 n.2.)

These included funds to research labs investigating a listeria outbreak across multiple states (ECF No. 4-21 ¶ 27) and those preparing for future infectious disease threats such as avian influenza. (ECF No. 4-4 ¶¶ 7, 20; 4-7 ¶ 46; 4-8 ¶¶ 37, 43, 54; 4-24 ¶ 45.) And at times, CDC itself had extended the grants beyond the pandemic intentionally. *See, e.g.*, ECF No. 4-24 ¶¶ 11, 22; ECF No. 4-32 ¶ 19.

Similarly, SAMHSA implemented HHS' Public Health Funding Decision via notices that terminated block grants to the States and were effective immediately on March 24. (ECF Nos. 4-6 ¶ 11; 4-41 at 52.) The basis for the terminations was the same as the CDC notices—the end of the pandemic—and similarly, did not provide the recipients advanced notice or an opportunity for a hearing. *See id.* A few days later, SAMHSA issued superseding notices to recipients which stated:

> The termination of this award is for cause. The block grant provisions at 42 U.S.C. § 300x-55 permit termination if the state "has materially failed to comply with the agreements or other conditions required for the receipt of a grant under the program involved." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out.

(ECF No. 4-6 ¶ 12; ECF No. 4-41 Ex. D at 1.) Besides this explanation, the SAMHSA notices did not provide any additional detail. *See id.* Like the CDC terminations, SAMHSA did not notify the States that they were failing to administer the grants appropriately. And despite the rationale being the end of the pandemic, the terminated SAMHSA funding supported mental health and substance abuse treatment efforts far beyond pandemic-related care. For instance, the States were

using the funds to strengthen the 988 Suicide and Crisis Lifeline system; make Naloxone more widely available to prevent fatal overdoses; expand access to mental health treatment among rural communities; serve foster youth with mental health and substance related needs; provide crisis intervention training to law enforcement officials and first responders; and to train crisis counselors to serve those impacted by natural disasters. *See, e.g.*, ECF Nos. 4-6 ¶¶ 40, 41, 50; 4-26 ¶ 14; 4-28 ¶ 5; 4-41 ¶ 33.

E. This Case

On April 1, 2025, twenty-three States and the District of Columbia sued for declaratory and injunctive relief against HHS and Secretary Kennedy, initially that the terminations violate the Administrative Procedure Act ("APA"), 5 U.S.C. § 701. (ECF No. 1 ¶¶ 3.) The States simultaneously moved for a temporary restraining order ("TRO") to restrain HHS "from enforcing or implementing the public health terminations for Plaintiff States and their local health jurisdictions." (ECF No. 4 at 3.)

On April 3, the Court heard the parties on the TRO and, at the hearing's conclusion granted it.[4] A written order detailing the Court's reasoning soon followed. The Court found that "the States have established a strong likelihood of success on

[4] At the TRO hearing, the Court heard from the States and HHS, though counsel for HHS did not make any substantive arguments, instead objecting to the issuance of the TRO and requesting that the Court to impose a bond. The Court granted the TRO and asked the States to prepare a proposed order and to confer with the Defendants as to any objections. The parties promptly complied and submitted a proposed TRO on April 4.

the merits, irreparable harm, and that the balance of equities and public interest favor the States." (ECF No. 54 at 13.) The TRO made clear that the Government was "fully restrained from implementing or enforcing funding terminations that were issued to Plaintiff States . . . or from issuing new funding terminations to Plaintiff States." *Id.* at 14.

Meanwhile, on April 4, the Supreme Court granted an emergency stay application in *Department of Education v. California*, 145 S. Ct. 966 (2025) (per curiam). That case concerned a district court's TRO enjoining the Government from terminating two education-related grant programs. HHS quickly moved for reconsideration of the TRO, arguing that *California* divested this Court of jurisdiction. (ECF No. 56 at 2-3.)[5]

On April 8, the States filed an Amended Complaint, which asserted several additional constitutional claims, and a Motion for a Preliminary Injunction. (ECF Nos. 59, 60.) The States insist that this Court has jurisdiction over their claims, despite the Supreme Court's recent decision in *California*. *Id.* at 22. They also claim that they have established a likelihood of success on the merits because the Public Health Funding Decision was contrary to law, arbitrary and capricious, and violates the Separation of Powers. *Id.* at 2-3. Furthermore, the States submit that absent a preliminary injunction, they stand to suffer immediate, irreparable harm to their

[5] After hearing the parties' arguments during the preliminary injunction hearing, the Court determined that it would address the Defendants' Motion for Reconsideration along with the States' Motion for Preliminary Injunction.

local public health programs, services, and initiatives. *Id.* at 3. Lastly, the States claim that the public interest and balance of the equities strongly favor a preliminary injunction in their favor. *Id.* A preliminary injunction hearing was held on April 17.[6]

II. PRELIMINARY INJUNCTION STANDARD

"A request for a preliminary injunction is a request for extraordinary relief." *Cushing v. Packard*, 30 F.4th 27, 35 (1st Cir. 2022). "To secure a preliminary injunction, a plaintiff must show '(1) a substantial likelihood of success on the merits, (2) a significant risk of irreparable harm if the injunction is withheld, (3) a favorable balance of hardships, and (4) a fit (or lack of friction) between the injunction and the public interest.'" *NuVasive, Inc. v. Day*, 954 F.3d 439, 443 (1st Cir. 2020) (cleaned up). In evaluating whether the plaintiffs have met the most important requirement of likelihood of success on the merits, a court must keep in mind that the merits need not be "conclusively" determined; instead, at this stage, decisions "are to be understood as statements of probable outcomes only." *Akebia Therapeutics, Inc. v. Azar*, 976 F.3d 86, 93 (1st Cir. 2020) (cleaned up). "To demonstrate likelihood of success on the merits, plaintiffs must show more than mere possibility of success–rather, they must establish a strong likelihood that they will ultimately prevail."

[6] Because the Government did not brief the States' constitutional claims in its original briefing—due to the States' amended complaint amid a tight briefing schedule—the Court granted it leave to file additional briefing for the Court's benefit. It did so on April 24, and the States responded on April 29. *See* ECF No. 80, ECF No. 81.

Sindicato Puertorriqueño de Trabajadores, SEIU Loc. 1996 v. Fortuño, 699 F.3d 1, 10 (1st Cir. 2012) (per curiam) (cleaned up).

III. DISCUSSION

A. Jurisdiction

Before addressing the merits, the Court must assure itself of jurisdiction. The Government does not dispute in its papers that the States have established Article III standing to challenge the Public Health Funding Decision. *See* ECF No. 68, ECF No. 80. The Court is satisfied that the States have demonstrated standing to challenge HHS' actions. *See Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367, 380 (2024).

To start, HHS argues that the Court of Federal Claims has exclusive jurisdiction here because the States' claims are essentially contract actions that fall under the Tucker Act, rather than claims for equitable relief brought under the APA. (ECF No. 68 at 9, 14.) Challenging HHS' actions as contrary to regulatory, statutory, and constitutional law, and asking purely for prospective equitable relief, the States maintain that their claims are properly before the Court. (ECF No. 60 at 21.)

Congress has waived the United States' sovereign immunity and permitted judicial review under the APA in suits challenging agency actions that seek "relief other than money damages." 5 U.S.C. § 702. So when a plaintiff sues the federal government for breach of contract—an action seeking money damages—that claim "falls outside of § 702's waiver of sovereign immunity." *Dep't of Army v. Blue Fox, Inc.*, 525 U.S. 255, 263 (1999). Instead, the Tucker Act "confers jurisdiction upon the

Court of Federal Claims" for contract claims against the United States. *Fisher v. United States*, 402 F.3d 1167, 1172 (Fed. Cir. 2005). It vests jurisdiction there for "any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491(a)(1); *see Maine Cmty. Health Options v. United States*, 590 U.S. 296, 327 (2020). And in suits seeking more than $10,000 in damages, the Court of Federal Claims' jurisdiction is exclusive of the federal district courts. *See, e.g.*, *Burgos v. Milton*, 709 F.2d 1, 3 (1st Cir. 1983).

The "jurisdictional boundary" between the Tucker Act and the APA is well-traversed by litigants seeking relief against the federal government. *Suburban Mortg. Assocs., Inc. v. U.S. Dep't of Hous. & Urb. Dev.*, 480 F.3d 1116, 1117 (Fed. Cir. 2007). But the boundary's precise contours remain elusive. *See id.* at 1124 (listing cases treading the jurisdictional line); *Bublitz v. Brownlee*, 309 F. Supp. 2d 1, 6 (D.D.C. 2004) (noting that "[t]he bright-line rule" between monetary and equitable relief in the Tucker Act–APA context "turns out to be rather dim . . . ."). Plaintiffs at times try to "avoid Tucker Act jurisdiction by converting complaints which at their essence seek money damages from the government into complaints requesting injunctive relief or declaratory actions." *Martin v. Donley*, 886 F. Supp. 2d 1, 8 (D.D.C. 2012) (cleaned up).

But not every "failure to perform an obligation" by the federal government "creates a right to monetary relief" only under the Tucker Act. *United States v.*

Bormes, 568 U.S. 6, 16 (2012). Just because "a judicial remedy may require one party to pay money to another is not a sufficient reason to characterize the relief as 'money damages.'" *Bowen v. Massachusetts*, 487 U.S. 879, 893 (1988). The Supreme Court has "long recognized the distinction between an action at law for damages—which are intended to provide a victim with monetary compensation for an injury to his person, property, or reputation—and an equitable action for specific relief." *Id.* (explaining that "insofar as the complaints sought declaratory and injunctive relief, they were certainly not actions for money damages"). And "although the Tucker Act is not expressly limited to claims for money damages, it has long been construed as authorizing *only actions for money judgments* and not suits for equitable relief." *Id.* at 914 (Scalia, J., dissenting) (cleaned up) (emphasis added).

All that is to say: "when traversing the Tucker Act–APA jurisdictional boundary, courts must look beyond the form of the pleadings to the substance of the claim to determine whether the essence of the action is in contract." *Woonasquatucket River Watershed Council v. U.S. Dep't of Agric.*, No. 1:25-CV-00097-MSM-PAS, 2025 WL 1116157, at *12 (D.R.I. Apr. 15, 2025). And the "essence" of an action encompasses two components: the "source of the rights upon which the plaintiff bases its claim" and "the type of relief sought (or appropriate)." *Piñeiro v. United States*, No. 08-CV-2402, 2010 WL 11545698, at *5 (D.P.R. Jan. 26, 2010) (cleaned up).

The Court addresses the elements of this framework in turn below.[7]

1. Source of the Rights

First, the Court considers the source of the States' rights. After examining the Complaint, the Court finds that, like in *Woonasquatucket* and *Massachusetts v. NIH*, the "gravamen" of the States' allegations "does not turn on terms of a contract between the parties; it turns" largely "on federal statutes and regulations put in place by Congress" and HHS. *Woonasquatucket*, 2025 WL 1116157, at *13; *Massachusetts v. NIH*, 2025 WL 702163, at *6 (D. Mass. Mar. 5. 2025.). And this case is even clearer than either *Woonasquatucket* or *Massachusetts* because the States also assert constitutional claims alongside its APA claims.

To be more precise: the source of the States' claims do not arise in any contract, but the APA—particularly its provisions forbidding arbitrary and capricious action, action contrary to law, and action in excess of statutory authority and the Constitution's Spending Clause and underlying separation of powers principles.[8] These are precisely the type of claims that belong in district court. *See, e.g.*, *K-Mar*

[7] While the First Circuit has not formally adopted the "rights and remedies" test that several other circuits have, district courts within it have used the test to determine whether the "essence" of an action is truly contractual. *See Woonasquatucket*, 2025 WL 1116175, at *12–15; *Massachusetts v. NIH*, No. 25-CV-10338, 2025 WL 702163, at *4–*8 (D. Mass. Mar. 5, 2025); *R.I. Hous. & Mortg. Fin. Corp.*, 618 F. Supp. 2d at 138; *Piñeiro*, 2010 WL 11545698, at *5.

[8] HHS goes on at length about the States' attempts to avoid jurisdiction by amending their complaint. (ECF No. 68 at 14–18.) But the States' motivation for exercising their right under the Federal Rules of Civil Procedure to amend is none of the Court's concern. Fed. R. Civ. P. 15 (a)(1). Before the Court are claims arising from violations of regulations, statutes, and the Constitution.

Indus., Inc. v. U.S. Dep't of Def., 752 F. Supp. 2d 1207, 1214 (W.D. Okla. 2010) ("The source of the rights alleged in this action is not contractual, it is the procedures put in place by the defendants.") To illustrate the point: throughout their briefing, the States have not pointed the Court to specific terms and conditions in their grant agreements. Instead, the States challenge the process HHS undertook in implementing the Public Health Funding Decision based on HHS' alleged violations of federal law. Ultimately, this case concerns the process the Government undertook when terminating the funding based on the end of the pandemic, meaning that the States have not put the specific terms and conditions of their agreements at issue.

To be clear, the fact that there are underlying contractual relationships between the States and HHS does not automatically "convert a claim asserting rights based on federal regulations into one which is, at its essence, a contract claim." *Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urb. Dev.*, 554 F.3d 1290, 1299 (10th Cir. 2009) (cleaned up). As in *Massachusetts* and *Woonasquatucket*, the States "have not requested the Court to examine any contract or grant agreement created between the parties." *Massachusetts*, 2025 WL 702163, at *6; *Woonasquatucket*, 2025 WL 1116157, at *13. Instead, they "have asked this Court to review and interpret the governing federal statute and regulations." *Id.*

2. Type of Relief Sought

Having recognized that the source of the States' rights is based on federal law rather than on contract, the Court now turns to the relief sought. There is a "distinction between an action at law for damages," which provides monetary

compensation, and "an equitable action for specific relief," which might still require monetary relief. *Bowen*, 487 U.S. at 893; *see Great-W. Life & Annuity Ins. v. Knudson*, 534 U.S. 204, 213 (2002) ("Whether [restitution] is legal or equitable depends on the basis for [the plaintiff's] claim and the nature of the underlying remedies sought.") (cleaned up).

Simply because "a judicial remedy may require one party to pay money to another" does not necessarily "characterize the relief as money damages." *Bowen*, 487 U.S. at 893. A hallmark of such equitable actions is the existence of prospective relief in ongoing relationships. *Compare Bowen*, 487 U.S. at 905 (holding that the district court had jurisdiction because declaratory or injunctive relief was appropriate to clarify petitioner state's ongoing obligations under the Medicaid plan), *with Me. Cmty. Health Options v. United States*, 590 U.S. 296, 298 (2020) (holding that petitioners properly relied on the Tucker Act to sue for damages in the Court of Federal Claims because plaintiffs were strictly concerned with "specific sums already calculated, past due, and designed to compensate for completed labors").

The States dispel HHS' attempts to categorize their relief sought as "money damages," which would fall outside the APA's waiver of sovereign immunity under § 702, by highlighting that they have asked the Court for purely prospective, equitable relief. (ECF No. 60 at 22—23.) Rather than seeking compensation for past harm, the States ask the Court to enjoin HHS' likely unlawful termination of promised public health funding. Merely because their requested equitable relief would result in the

disbursement of money is not a sufficient reason to characterize the relief as money damages. *Bowen*, 487 U.S. at 893.

The Government's efforts to categorize the States' relief as money damages are to no avail when they have asked for a specific equitable remedy—an injunction to halt an agency's likely unlawful termination of critical public health funding. The States have asked this Court to vacate the unlawful terminations of grant money under the APA to access federal funds that were already appropriated. When a consequence of "a judicial remedy may require one party to pay money to another," it does not necessarily "characterize the relief as money damages." *Bowen*, 487 U.S. at 893. Absent equitable relief, the States stand to suffer devastating consequences to their public health systems and initiatives. It is clear that the States' primary purpose in bringing their claims is to secure an injunction, and not money damages arising out of a breach of contract claim.

The Court finds that this case does not concern contractual obligations or money damages for past harm. Rather, the States ask for a review of an agency's alleged unlawful action and seek prospective relief based on their ongoing relationship with the federal government to prevent harm to their local health jurisdictions.

3. *Department of Education v. California*

HHS argues that the U.S. Supreme Court's recent stay order in *Department of Education v. California*, 145 S. Ct. 996 (Apr. 4, 2025), makes its Tucker Act argument even clearer. The Court disagrees. True, the Supreme Court noted that noted the

APA's waiver of sovereign immunity does not apply to claims seeking money damages, but it also reaffirmed the general rule that "a district court's jurisdiction 'is not barred by the possibility' that an order setting aside an agency's action may result in the disbursement of funds." *Id.* at 968 (quoting *Bowen*, 487 U.S. at 910). The Government overreads the three-page stay order. *See Nken v. Holder*, 556 U.S. 418, 434 (2009) (explaining that the issuance of a stay "is dependent upon the circumstances of the particular case"). The Supreme Court's brief treatment of *Bowen* and *Great-West Life* in *California* and the cursory mention of potential jurisdictional issues do not appear to settle all jurisdictional issues here, despite HHS' arguments to the contrary.[9]

The Court recognizes the tension between *Bowen* and *California*. But the Court is not positioned to disregard *Bowen* and its progeny, even if it appears that it is now in tension with *California*. *See Mallory v. Norfolk S. Ry. Co.*, 600 U.S. 122, 136 (2023) (explaining that district courts "should follow the case which directly controls, leaving to [the Supreme] Court the prerogative of overruling its own decisions."). This holds true even when the lower court "thinks the precedent is in tension with some other line of decisions"—or here, rather than an entire competing

[9] Notably, the States point out that in *California*, the Supreme Court weighed the potential harm to the government because the grantees had not promised to return withdrawn funds if the terminations were reinstated and found that the recipients did not stand to suffer irreparable harm while the case played out because they could recover any wrongfully withheld funds in the proper forum. *See California*, 145 S. Ct. at 967. And the States maintain that is not the case here because unlike the plaintiffs in *California*, they do not have the financial wherewithal to keep their public health programs running in the meantime. (ECF No. 65 at 8.)

"line of decisions," a single three-page per curiam order granting a stay.[10] *See Merrill v. Milligan*, 142 S. Ct. 879, 879 (2022) (Kavanaugh, J., concurring) ("The Court's stay order is not a decision on the merits"). The case that "directly controls," and the one that the Court must follow, is *Bowen*.[11]

B. Likelihood of Success on the Merits

The Court now turns to the States' likelihood of success on the merits. They bring seven total claims.[12] The first four claims arise under the APA. Under Count I, the States argue that HHS' sudden termination of $10 billion in grants exceeds its statutory authority—in other words, a violation of the Major Questions Doctrine. (ECF No. 59 ¶¶ 101-102.) Under Counts II and III, the States allege that HHS' termination of two subsets of grants—those for SAMHSA and CDC—ran afoul of statutory and regulatory requirements. *Id.* ¶¶ 111, 126–127. In abruptly terminating the SAMHSA grants, HHS violated three provisions of § 300x-55: its provision

[10] In its supplemental briefing, HHS submits that the Court should treat the Supreme Court's decision in *California* as binding precedent on whether there is jurisdiction. (ECF No. 80 at 2 n.1.) Still, the Supreme Court's limited analysis in *California* is not a decision on the merits. And the source of the plaintiff-states' rights and their requested relief in *California* bears key differences from the States' claims here.

[11] District courts adjudicating similar claims agree that *California* did not divest them of jurisdiction. *See Woonasquatucket,* 2025 WL 1116157, at *14; *Maine v. United States Dep't of Agric.*, No. 1:25-CV-00131-JAW, 2025 WL 1088946, at *19 (D. Me. April 11, 2025); *New York v. Trump*, No. 25-cv-39-JJM-PAS, ECF No. 182 at 5–9 (D.R.I. Apr. 14, 2025); *State of Rhode Island, et al. v. Trump et al*, No. 25-cv-128-JJM-LDA, ECF No. 57 at 14—18.

[12] At this stage, the States need only show a substantial likelihood of success on one of their seven claims. *See, e.g.*, *Worthley v. Sch. Comm. of Gloucester*, 652 F. Supp. 3d 204, 215 (D. Mass. 2023) (collecting cases).

limiting funding terminations to cases where states, "materially failed to comply" with the grant agreements, as well as separate requirements for pre-termination investigation and hearing. *Id.* ¶ 111. And in abruptly canceling the CDC grants, HHS ran afoul of its own regulations, as laid out in 45 C.F.R. § 75.372(a)(2). *Id.* ¶¶ 126–27. Finally, under Count IV, the States allege that HHS' termination was arbitrary and capricious. *Id.* ¶¶ 134. They raise a host of arguments under this count, but their overarching point is that the decision was neither "reasonable" nor "reasonably explained," and each is independently fatal to its viability. *See id.*; *Ohio v. EPA*, 603 U.S. 279, 292 (2024).

The last three claims are constitutional. Under Count V, the States argue that the Executive's actions are an attempt to "unilaterally decline to spend funds," in violation of fundamental Separation of Powers principles and the Take Care Clause. *Id.* ¶ 149-150. Under Count VI, the States argue that the terminations violate the Spending Clause, because they improperly altered the relationship between the States and Congress. *Id.* ¶ 157. Finally, under Count VII, the States argue generally that HHS "lacked statutory or constitutional authority" to terminate the funds, so an injunction is necessary. *Id.* ¶ 164.

The States argue that they have shown a strong likelihood of success on the merits because HHS' Public Health Funding Decision and its implementation was contrary to law, arbitrary and capricious, and violates the Constitution. (ECF No. 60 at 23.) In turn, HHS reaffirms its position that this Court lacks jurisdiction over the States' claims, and that they cannot succeed on the merits. (ECF No. 68 at 21.) Even

aside from those "jurisdictional obstacles," HHS insists that the States have failed to show a likelihood of success on the merits because its actions "were not contrary to law or arbitrary and capricious, nor did they violate the Constitution." *Id.*

1. Threshold APA Issues

Before reaching the merits of the APA claims, though, the Court must determine two more threshold issues. First is whether HHS' actions constitute "final agency action," and second is whether, even if so, HHS' actions were of the narrow category "committed to agency discretion" and thus unreviewable under the APA.

A "final agency action" under 5 U.S.C. § 704 has two components: first, it "marks the consummation of the agency's decision-making process" and second, it is either an action "by which rights or obligations have been determined, or from which legal consequences will flow." *Corner Post, Inc. v. Bd. of Governors of Fed. Rsrv. Sys.*, 603 U.S. 799, 808 (2024) (cleaned up).

As to the first element, the States argue that HHS' actions "announce[d] the agency's final decision on the matter," and were effective as of the date set out in the Notice of Award, which was either March 24 or 25. (ECF No. 60 at 24, ECF No. 4-40, Ex. A at 1, 5.) As to the second prong, the States reason that there are "clear legal consequences" because the States immediately lost funding in the wake of HHS' Public Health Funding Decision. (ECF No. 60 at 24.) They also contend that the APA does not preclude bringing this challenge as a single action. *Id.*

Not directly contesting that its actions constituted final agency action, HHS instead argues that its "terminations were consistent with the applicable statutory

and regulatory provisions," meaning that "no further review under the APA is available." (ECF No. 68 at 18.) Even if these claims were reviewable under the APA, HHS says that the terminations were "quintessential agency actions" and "committed to agency discretion by law" under § 701(a)(2). *Id.* In response, the States explain that HHS' actions do not belong in the narrow class of agency actions which are "committed to agency discretion by law" and that "there are applicable statutory or regulatory standards that cabin agency discretion" and "meaningful standard[s] by which to judge the [agency]'s action." (ECF No. 60 at 24.) Thus, the States maintain that HHS' Public Health Terminations are reviewable by this Court. *Id.*

On both fronts, the States have the better of the argument. First, HHS' actions in terminating the public health funding at issue satisfy both prongs of the final agency test. The termination notices announced HHS' decision to cut the funding immediately. An immediate termination of funds surely marks the culmination of HHS' decision to cut the funding; there are no further steps HHS needs to take to determine whether it would cut the funding. As to the second prong, there are clear legal consequences of HHS' Public Health Terminations: the States cannot access previously available funds and consequently, will be forced to lay off highly trained specialists, disband infectious disease research teams, and eliminate public health programs that were created to vaccinate vulnerable populations and rural communities, and to treat those struggling with mental health or substance abuse related issues. *See, e.g.*, ECF Nos. 4-3 ¶ 48; 4-6 ¶¶ 4-7; 4-15 ¶ 17; 4-40 ¶ 11; 4-41 ¶ 3.

As to HHS' other argument: the Court disagrees that the Public Health Terminations were "committed to agency discretion by law" under § 701(a)(2) and thus unreviewable. To start, the APA "embodies a basic presumption of judicial review," and it "instructs reviewing courts to set aside agency action that is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Dep't of Com. v. New York*, 588 U.S. 752, 771 (2019) (cleaned up) (citing 5 U.S.C. § 706(2)(A)). And the Supreme Court has read the "committed to agency discretion" exception to judicial review for actions committed to agency discretion "quite narrowly." *Id.* It is restricted to only "rare circumstances" where a court "would have no meaningful standard against which to judge the agency's exercise of discretion." *Id.* (cleaned up).

That is not the case here. There are applicable constitutional, statutory, and regulatory standards that cabin HHS' discretion as an agency. Whether HHS had the requisite authority to implement the Public Health Terminations is exactly the type of legal question district courts are well-equipped to handle. Whether HHS exceeded statutory authority or violated the Constitution by eliminating Congressionally appropriated funds cannot be committed to agency discretion. *See California v. U.S. Dep't of Educ.*, 132 F.4th 92, 97–98 (1st Cir. 2025) *opinion stayed on other grounds*, (explaining that "applicable regulations cabin the [agency's] discretion as to when it can terminate existing grants" which creates a meaningful standard for the court to judge the agency's action); *see also Pol'y & Rsch., LLC v. HHS*, 313 F. Supp. 3d 62, 75–78 (D.D.C. 2018) (concluding that agency's sudden halt on funding to a program was reviewable under the APA because applicable

regulations cabin its termination authority and consequently, provide a standard for judicial review).

While the Government relies on *Lincoln v. Vigil*, 508 U.S. 182 (1993), to support its position that "[a]n agency's determination of how to allot appropriated funds among competing priorities and recipients is classic discretionary agency action that is not susceptible to APA review," the States respond that this case does not concern the allocation of lump-sum appropriations. (ECF No. 68 at 19, ECF No. 69 at 11.) The determination of whether HHS had the authority to eliminate the Congressionally appropriated funds based on its own assessment that the appropriations were "no longer necessary" due to the end of the COVID-19 pandemic is certainly not a question about agency discretion. *See In re Aiken Cnty.*, 725 F.3d 255, 261 n.1 (D.C. Cir. 2013) (explaining that the Executive "does not have unilateral authority" to refuse to spend funds appropriated by Congress). Similarly, HHS' implementation of the terminations of public health grants already allocated and awarded concerns the application of statutory and regulatory "for cause" provisions, an analysis which district courts "routinely perform." *Pol'y & Rsch., LLC*, 313 F. at 83 (Jackson, J.).

The Supreme Court clarified in *Lincoln* that "an agency is not free simply to disregard statutory responsibilities: Congress may always circumscribe agency discretion to allocate resources by putting restrictions in the operative statutes." *Lincoln*, 508 U.S. at 193 (labeling an action unreviewable because Congress left the decision about how to spend the money up to the agency's discretion). With that in

mind, courts have held that § 701(a)(2) does not apply when the agency's actions contravene (1) appropriations laws and (2) other applicable regulatory and statutory authority. *California*, 132 F.4th at 97–98; *Pol'y & Rsch., LLC*, 313 F. at 75–78. The States claim that judicial review is proper under both grounds. (ECF No. 69 at 12.)

The Court agrees. First, Congress directed HHS to spend the appropriated funds on specific initiatives per the applicable statutes. Nor is this a case where Congress expressly delegated discretion to HHS. Notably, when reviewing the statutory authority for tribal grants under the CARES Act, the D.C. Circuit concluded that it was "nothing like the statutes at issue in *Lincoln*," and thus not entitled to a presumption of non-reviewability. *See Shawnee Tribe v. Mnuchin*, 984 F.3d 94, 100 (D.C. Cir. 2021) ("Congress has not left the Secretary any flexibility to shift funds within a particular appropriation account so that [he] can make necessary adjustments for unforeseen developments and changing requirements.") (internal quotation marks omitted). So too here.

Second, unlike the lump-sum appropriations in *Lincoln* which were left to agency discretion, HHS' decision to terminate is clearly reviewable when applicable statutory and regulatory language provide a clear standard for the Court's review. *See, e.g.*, 45 C.F.R. § 75.372(a)(2) ("[An] award may be terminated . . . for cause"); 42 U.S.C. § 300x-55(a) (A grant may be "terminated for cause" when "a State has materially failed to comply with the agreements or other conditions"). This is not one of "those rare circumstances where the relevant statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of

discretion." *Dep't of Com.*, 588 U.S. at 772. The Government's attempt to frame the Public Health Terminations as matters where it had discretion to choose how Congressionally appropriated funds are spent among competing priorities is without merit. *See Pol'y & Rsch., LLC*, 313 F. Supp. at 75–78.

Having held that the States are likely to establish that the Public Health Terminations constitute a "final agency action" under the APA and that they are not "committed to agency discretion by law," the Court moves to the merits.

2. Count I: Public Health Funding Decision

The States first argue that HHS' Public Health Funding Decision violated the APA in two ways. First, in determining that the congressionally appropriated funds were no longer necessary, the States argue that HHS overstepped its statutory authority. And second, the States maintain that HHS acted contrary to law in terminating the grants "for cause" for two reasons: (1) the States complied with the terms and conditions of their awards and HHS has not alleged otherwise and (2) HHS has not pointed to relevant authority which allows termination for cause based on the end of the pandemic, which was over two years ago. In turn, HHS insists that there is "no question" it had the express authority to terminate the public health grants for cause by applicable regulations. (ECF No. 68 at 23.)

Starting with the "excess of statutory authority" argument, the States say that HHS, in unilaterally terminating the programs despite Congress's decision not to, violated the major questions doctrine. Their argument goes like this: starting in 2020, Congress appropriated funds to grant-in-aid programs and provided specific

purposes and instructions on how to spend the money. In doing so, Congress expressly tied certain programs and funding to the end of the pandemic. And in 2023, Congress reviewed COVID-related appropriation statutes after the pandemic ended and rescinded $27 billion of appropriations. *See* Fiscal Responsibility Act, Pub. L. No. 118-5 137 Stat. 10 (2023) Div. B, § 2(3) (rescinding certain unobligated funds "with the exception of $2,127,000,000 and—(A) any funds that were transferred and merged with the Covered Countermeasure Process Fund"). Since then, Congress did not revoke any of the funding at issue here; it reviewed it and left it in place. As a result, the States insist that leaving the funding in place signaled Congress's determination that the end of the pandemic did not mean that certain programs and appropriated funds were no longer needed.

The Court presumes that "Congress intends to make major policy decisions itself" rather than leaving those decisions to agencies. *West Virginia v. EPA*, 597 U.S. 697, 723 (2022). Congress must "speak clearly" if it wishes to charge an agency with a decision of "vast economic and political significance." *Alabama Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 594 U.S. 758, 764, (2021) (cleaned up). Thus, an agency "literally has no power to act—including under its regulations—unless and until Congress authorizes it to do so by statute." *FEC v. Cruz*, 596 U.S. 289, 301 (2022). And "where the statute at issue is one that confers authority upon an administrative agency, that inquiry must be shaped, at least in some measure, by the nature of the question presented—whether Congress in fact meant to confer the power the agency has asserted." *W. Virginia v. EPA*, 597 U.S. 697, 721 (2022).

The power that HHS has asserted here is a broad one: terminating $11 billion worth of funding based on its determination that the money is no longer necessary. The Court cannot see how it can claim that power based on the history of congressional action described above. *See Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 324 (2014).

The Court recognizes that is not the typical "major questions doctrine" case, where the parties can point to—and argue about—one specific grant of power in one part of one statute. *Cf. Biden v. Nebraska*, 600 U.S. 477, 494 (2023) ("We hold today that the Act allows the Secretary to 'waive or modify' existing statutory or regulatory provisions applicable to financial assistance programs under the Education Act, not to rewrite that statute from the ground up."); *Alabama Ass'n of Realtors*, 594 U.S. at 763 ("The Government contends that the first sentence of § 361(a) gives the CDC broad authority to take whatever measures it deems necessary to control the spread of COVID–19, including issuing the moratorium.").

But that is a problem of HHS' making. In fact, it makes the States' case even clearer, given that no specific language satisfies the "speak clearly" test with regard to the $10 billion decision affecting funds across six statutes made here. And in any event, broader context including "background legal conventions," constitutional structure, and even "common sense," should inform the Court's analysis of an agency's assertion of power. *Biden v. Nebraska*, 600 U.S. at 510–513 (Barrett, J., concurring). That is true even without a single textual hook.

All three factors—background legal conventions, constitutional structure, and common sense—caution against accepting HHS' assertion of authority. Congress already considered the appropriations at issue here and clearly determined that some programs and services were still necessary, no matter when the pandemic ended. More importantly, when undertaking this review in June 2023, Congress did not grant HHS authority to rescind or reallocate the funds, nor did it authorize such drastic action. In the interpretation of statutes, the express mention of one thing is to the exclusion of others. *See, e.g.*, *N.L.R.B. v. SW Gen., Inc.*, 580 U.S. 288, 302 (2017) ("If a sign at the entrance to a zoo says, 'come see the elephant, lion, hippo, and giraffe,' and a temporary sign is added saying 'the giraffe is sick,' you would reasonably assume that the others are in good health.") Thus, Congress's express decision to eliminate some COVID-era public health funding, but leave alone the funding at issue here, signals its intent to continue that funding.

Consequently, HHS' Public Health Funding Decision usurped Congress's power to control these public health appropriations. If Congress intended to charge HHS with such a determination, it would have done so at some point—like in June 2023, when it went line-by-line and rescinded some COVID-era funding but left other funding in place. With that in mind, the Court holds that the States are likely to succeed on Count I.

3. Count II: SAMHSA Terminations

The States next assert that the SAMHSA terminations were contrary to law and in excess of statutory authority. Their argument is that HHS departed from

three key statutory requirements governing SAMHSA funding under § 300x-55. (ECF No. 60 at 27.) And in the States' view, each is sufficient to establish a successful claim. The Court lays out these three arguments below before addressing them.

First, under 42 U.S.C. § 300x-55(a), the Secretary may "terminate the grant for cause" only "if the Secretary determines that a State has materially failed to comply with the agreements or other conditions required for the receipt of a grant." Despite this requirement, the States claim that HHS "never asserted that any grantee materially failed to comply with agreements or other required conditions." *Id.*; *see, e.g.*, ECF. Nos. 4-6 ¶ 12., 4-41 ¶ 42. Rather, HHS merely stated that "[t]he end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary." (ECF. No. 4-6, 4-41.)

Second, under § 300x-55(e), the Secretary shall provide to the State involved adequate notice and an opportunity for a hearing" "[b]efore taking action against a State . . . ." The States submit that HHS did not provide notice to the States or an opportunity for a hearing before taking action to terminate the grant funding, contrary to statutory requirements.

Finally, § 300x-55(g) bars HHS from withholding any funds without "an investigation concerning whether the State has expended payments under the program involved in accordance with the agreements required under the program." The States argue that HHS ignored this requirement. Just as there was no notice, in violation of § 300x55(e), there was also no investigation. HHS claims that it

terminated the SAMHSA funding "for cause" that is, the end of the pandemic, and consequently, the statutory requirements for non-compliance are inapplicable.

On this record, it is clear that HHS ignored multiple statutory requirements that govern the termination of block grant programs. HHS argues that Section 300x-55 does not apply to the terminations here because that section is only implicated upon a determination that a State has materially failed to comply with the grant terms or conditions. (ECF No. 68 at 27-28.) But that is a puzzling argument given that HHS relied on Section 300x-55 as its authority to terminate the funding when it issued the termination letters. *See* ECF No. 4-6 ¶ 12; 4-41 Ex. D at 1.

Because § 300x-55 applies, the Court struggles to see how the Government's decision to terminate the funds as "no longer necessary" satisfies the process laid out in the statute.[13]

The Government's argument that the States' material failure to comply is based on the notion that they were "not spending the money that had been allocated for COVID-19 relief purposes" is unavailing. (ECF No. 68 at 28.) Congress did not expressly limit the funds to COVID-19 related programs and services. *See* ARPA,

[13] To be sure, each State receives a block grant under SAMHSA based on a statutory formula. *See* 42 U.S.C. § 300x(a) (the Secretary "shall make an allotment each fiscal year for each State in an amount determined in accordance with section 300x–7"). With respect to block grants, agencies have no discretion and must distribute the funds based on the statutory formula. *See City of Providence v. Barr*, 954 F.3d 23, 27 (1st Cir. 2020). Regarding SAMHSA, Congress outlined specific circumstances in which HHS is not required to spend the funds. *See* § 300x-55(a) (A grant may be "terminated for cause" when "a State has materially failed to comply with the agreements or other conditions."). Accordingly, HHS lacked the requisite authority to refuse to spend the funds for any other reason.

Pub. L. No. 117-2, §§ 2701, 2702, 135 Stat. 4, 45-46 (2021) (appropriating $1.5 billion for services related to mental health and $1.5 billion for services related to substance abuse "to remain available until expended"); Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (Div. M of the Consolidated Appropriations Act, 2021), Pub. L. No. 116-260, 134 Stat. 1182 (2020) ("$1,650,000,000 shall be for grants for the substance abuse prevention and treatment block grant program" and "$1,650,000,000 shall be for grants for the community mental health services block grant program"). If Congress intended to tie these funds to the end of the pandemic, it would have done so.

And HHS' offering a hearing after terminating the funds only serves to strengthen the States' position that the Government acted contrary to law. Recall that under § 300x-55(e), the Secretary must provide the State involved adequate notice and an opportunity for a hearing "[b]efore taking action." Without that hearing prior to termination, HHS' Public Health Funding Decision and its implementation ran contrary to the States' statutory rights.

4. Count III: CDC Terminations

The States claim that HHS' termination of CDC grants "had no legal basis for its actions because of the end of the pandemic nearly two years ago. Defendants acted contrary to law and in excess of statutory authority." (ECF No. 60 at 28, 30.) According to the States, the CDC funding was terminated "for cause" based on "HHS regulations," presumably 45 C.F.R. § 75.372(a)(2). *Id.* at 28. The States say that the end of the pandemic, nearly two years ago, surely does not qualify when it has

previously construed "for cause" as a material failure to comply. *Id.* In turn, HHS says that the "for cause" provision is distinct from non-compliance, and that it was permitted to terminate the grants. (ECF No. 68 at 23.)

Again, the States have the better of the argument. The Court sees no reason to accept HHS' novel interpretation of the "for cause" termination requirement in its regulations, particularly in light of the Supreme Court's guidance on similar questions. *See Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 155–56 (explaining that "an agency's interpretation of its own ambiguous regulation" should not receive deference when the agency's interpretation "is nothing more than a convenient litigating position" or a "post hoc rationalization advanced by an agency seeking to defend past agency action against attack," or when it would cause an "unfair surprise" to the regulated parties).

When examining the "for cause" language in the past, HHS has generally construed it to involve a failure to comply with a grant's terms and conditions.[14] *Id.* Similarly, "for cause" has been construed as substantially the same as "failure to comply." *See* OMB, Guidance for Grants and Agreements, 85 Fed. Reg. 49506,49508 (Aug. 13, 2020). What's more, HHS has signaled its intent to adopt the OMB's

[14] *See R.I. Substance Abuse Task Force Ass'n*, DAB No. 1642 (1998), 1998 WL 42538, at *1 (H.H.S. January 15, 1998) ("When a grantee has materially failed to comply with the terms and conditions of the grant, [the Public Health Service] may . . . terminate the grant for cause."); *Child Care Ass'n of Wichita/Sedgwick Cnty.*, DAB No. 308 (1982), 1982 WL 189587 at *2 (H.H.S. June 8, 1982) ("'For cause' means a grantee has materially failed to comply with the terms of the grant."). This is consistent with the standard application of "for cause" terminations in statute and regulation. *See, e.g.*, 42 U.S.§ 300x-55(a); 10 C.F.R § 600.25 (allowing "for cause" award termination on the basis of noncompliance or debarment).

interpretation and eliminate the "for cause" provisions, illustrating how it has admitted that it sees the provision as an unnecessarily duplicative part of its regulatory scheme *See* HHS, Health and Human Services Adoption of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 89 Fed. Reg. 80055, 80055 (Oct. 2, 2024) (effective October 2025) ("for cause" regulation substantially duplicative of "failure to comply regulation"). Nor would the end of the pandemic nearly two years ago seem to require termination when the appropriation statutes at issue extended the funding for purposes beyond the pandemic and Congress determined not to rescind the funds at issue in June 2023.

The States have thus shown a strong likelihood of success in proving that the CDC terminations were contrary to law.

5. Count IV: "Arbitrary and Capricious" Claim

Next, the States argue that the Public Health Funding Decision was arbitrary and capricious because the Government's termination of critical public health funding based on the end of the pandemic nearly two years ago is not substantively reasonable nor was it reasonably explained. (ECF No. 60 at 30.) In turn, HHS says that its conduct is not reviewable under the APA and even so, it did not act arbitrarily and capriciously because its decision to terminate the funds was lawful and agencies have discretion on how to allocate funds thus, the decision did not require any additional explanation. (ECF No. 60 at 31-32.)

The APA requires reviewing courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in

accordance with law." 5 U.S.C. § 706(2)(A). An agency action is arbitrary or capricious "if it is not reasonable and reasonably explained." *Ohio v. EPA*, 603 U.S. 279, 292 (2024). The Court cannot "substitute its judgment for that of the agency," but it must take care to "ensure" that the agency has "offered a satisfactory explanation for its action, including a rational connection between the facts found and the choice made." *Id.* (cleaned up). And "an agency cannot simply ignore an important aspect of the problem." *Id.* (cleaned up).

First, the States argue that HHS failed to provide a rational basis for the Public Health Funding Decision. Merely relying on a conclusory explanation that the funds are no longer necessary because the pandemic is over does not demonstrate a "rational connection between the facts found and the choice made." *Ohio*, 603 U.S. at 292. The Government's determination was unreasonable in light of Congress's direction that the appropriations at issue be used beyond the pandemic and to better prepare for future public health threats. *See, e.g.*, ARPA, §§ 2402, 2404, 2501, 135 Stat. at 41-42.

This holds particularly true when Congress expressly limited some appropriations to the end of the pandemic. *See Russello v. United States*, 464 U.S. 16, 23 (1983) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.") Even so, in June 2023, Congress undertook a review of COVID-era spending and passed the Fiscal Responsibility Act of 2023 and rescinded $27 billion of

appropriations that were no longer necessary due to the end of the public health emergency. *See* Pub. L. No. 118-5 Div. B, Title I (2023). Given Congress's clear intent to keep the appropriations at issue intact, the Court cannot say HHS provided any rational basis to justify its decision to terminate the funds based on the end of the pandemic. That is sufficient to end the analysis, but to be thorough, the Court will address additional "arbitrary and capricious" arguments.

Next, the States claim that HHS' actions were arbitrary and capricious because it failed to undertake an individualized assessment or acknowledge the important public health initiatives supported by the grants, failing "to consider an important aspect of the problem." (ECF No. 60 at 32.) (quoting *State Farm*, 463 U.S. at 43)). In turn, HHS says that "it is not arbitrary and capricious for an agency to provide the same explanation across multiple decisions." (ECF No. 68 at 32.)

Still, the determination that funding appropriated by Congress is no longer necessary requires an assessment of the grantees' compliance with the agreements, which HHS declined to do. Recall that § 300x-55(g) bars HHS from withholding any SAMHSA funds without "an investigation concerning whether the State has expended payments under the program involved in accordance with the agreements required under the program." And based on its own interpretations, HHS may terminate awards "for cause" when a party has failed to comply with the terms and conditions of the grant under § 75.372(a). There is no evidence that happened here.

Third, the States allege that HHS failed to provide a reasoned explanation for its sudden change in position that appropriations Congress determined were needed

to fund public health initiatives beyond the pandemic were no longer necessary. Such a drastic change of course would require HHS to "show that there are good reasons for the new policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). While HHS acknowledged its change of position, it provided no explanation to the States as to why it did so suddenly and contrary to Congress's will that certain COVID-era spending was needed beyond the immediate public health emergency that ended in May 2023.

Fourth, HHS' Public Health Funding Decision was arbitrary and capricious because it failed to consider the States' reliance interests on the funds and the devastating consequences that would result from abruptly terminating critical public health appropriations. The Government asserts that is an "incorrect premise" because the States "failed to draw down over $160 million of the funds while they were available" and thus, cannot now claim they relied on the funds. (ECF No. 68 at 33.) That said, agencies must consider reliance interests when changing course because "longstanding policies may have engendered serious reliance interests that must be taken into account." *Dep't of Homeland Sec.*, 591 U.S. at 30 (cleaned up); *Fox Television Stations*, 556 U.S. at 515 (explaining that it is arbitrary and capricious to ignore reliance interests). The States and their local agencies and programs relied on this funding and had no reason to suspect that it would be abruptly canceled without process or explanation. The States were granted extensions in some cases through June 2027, and HHS issued guidance on how to appropriately use the funds beyond COVID-related initiatives. *See* ECF Nos. 4-3 ¶¶ 10, 13, 21–22, 48; 4-24 ¶¶

11, 22; 4-32 ¶ 19. Indeed, it appears HHS gave no consideration to the programs and services that would be impacted by these terminations when it decided the funds were no longer necessary based on the end of the pandemic.

HHS maintains that the Court should ignore the States' claimed reliance on these appropriations for two reasons: certain funds were not yet obligated or drawn down by the States and HHS allocated the funds that were statutorily required. (ECF No. 68 at 33.) Indeed, HHS says that it identified over $86 million in SAMHSA funding and nearly $79 million in CDC grants that had not yet been obligated or drawn down while available. *Id.* Still, Congress has already spoken. With respect to SAMHSA, the States had until September 2025 to spend the funds. Pub. L. 117-2, §§ 2701, 2702, 135 Stat. 4, 45-46. And with CDC, the funds were to be obligated by September 2024, but the States have an additional five years to spend those funds. *See* CARES Act Title VIII, 134 Stat. 281, 554; 31 U.S.C. §§ 1552(a), 1553(a).

The Government's decision to allocate, in some cases, more than it was statutorily required to does not alleviate HHS of its obligation to expend the appropriated funds under legislative directives. Notably, in the CARES Act, Congress even outlined specific purposes for the appropriated funds to be used beyond the pandemic including public health data surveillance, infrastructure modernization, disease detection, and emergency response, and surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities. *See* CARES Act Title VIII, 134 Stat. 281, 554–555. Based on Congress's direction that the funds remain available, the

Government's argument that it met some of the statutory requirements in the appropriation acts is irrelevant; it is certainly not dispositive of any questions about its refusal to spend the remaining funds because it believes the money is no longer necessary.

Lastly, the States insist that the Government's conduct was arbitrary and capricious because it violated statutory and regulatory authority as HHS never alleged that the States failed to comply with the terms and conditions of the awards. *See* ECF No. 60 at 33. They also say that HHS did not explain its sudden departure from its longstanding position that the funds would extend beyond the pandemic and Congress's express decision to leave the funding in place. *Id.*

The Court agrees that HHS acted arbitrarily and capriciously when it applied "for cause" terminations here because contrary to statutory and regulatory authority, HHS never claimed any failure on part of the States to comply with their grant agreements. *See* § 300x-55(g); § 75.372(a). Instead, HHS merely relied on the end of the pandemic as "cause" to terminate the funds, despite this application being contrary to statutory and regulatory authority and inconsistent with Congress's directive that the funds remain available beyond the pandemic.

Once again, the States have demonstrated a strong likelihood of success on their claim that these terminations were arbitrary and capricious in violation of the APA.

6. Count V: Separation of Powers

Finally, the States are likely to succeed on the merits of their claim that HHS' Public Health Terminations and its implementation violate Separation of Powers. The States argue that, drawing analogies to cases directly about presidential power, HHS is operating at its "lowest ebb," because no constitutional or statutory provision authorizes HHS, as an agent of the Executive Branch, to unilaterally terminate funding appropriated by Congress. (ECF No. 60 at 34.) Rather, "the Executive has taken measures that are incompatible with the express will of Congress related to public health appropriations." *Id.* For their part, HHS insists that it had "inherent authority to spend the money that Congress allocates consistent with the limits Congress sets." (ECF No. 80 at 10.) As such, HHS says that its decision to exercise its discretion within those confines "is entirely consistent with separation-of-powers principles and is an action committed to agency discretion by law for which the APA does not provide an avenue for review. *Id.*

It is axiomatic that "[t]he United States Constitution exclusively grants the power of the purse to Congress, not the President." *City & Cnty. of San Francisco v. Trump*, 897 F.3d 1225, 1231 (9th Cir. 2018); U.S. Const. art. I, § 9, cl. 7 (Appropriations Clause)1; U.S. Const. art. I, § 8, cl. 1 (Spending Clause). It naturally follows that the same is true of the President's agents. "Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by conditioning receipt of federal moneys upon

compliance by the recipient with federal statutory and administrative directives.'" *Id.* at 1232 (quoting *South Dakota v. Dole*, 483 U.S. 203, 206–07 (1987)).

In contrast, "[t]here is no provision in the Constitution that authorizes the President to enact, to amend, or to repeal statutes." *Id.* (quoting *Clinton v. City of New York*, 524 U.S. 417, 438 (1998)). Simply put, "the President is without authority to thwart congressional will by canceling appropriations passed by Congress" and "does not have unilateral authority to refuse to spend the funds." *Id.* Nor may the President "decline to follow a statutory mandate or prohibition simply because of policy objections." *Id.* "No matter the context, the President's authority to act necessarily 'stem[s] either from an act of Congress or from the Constitution itself.'" *Trump v. United States*, 603 U.S. 593, 607 (2024) (quoting *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 634 (1952) (Jackson, J., concurring)). And again, the same is true of the Executive's agents. The Separation of Powers and these core principles are integral to our democracy. Meaning that, "liberty is threatened" when "the decision to spend [is] determined by the Executive alone." *Clinton*, 524 U.S. at 451 (Kennedy, J., concurring).

HHS' actions here clearly usurped Congress's authority to spend and allocate funds how it deems appropriate. *See City & Cnty. of S.F. v. Trump*, 897 F.3d 1225, 1235 (9th Cir. 2018) (explaining that without authorization from Congress, "the Administration may not redistribute or withhold properly appropriated funds in order to effectuate its own policy goals.") The power to spend lies solely with the Legislative branch. *See id.* at 1231-32; *see also* U.S. Const. art. I, § 9, cl. 7

(Appropriations Clause); U.S. Const. art. I, § 8, cl. 1 (Spending Clause). With this comes the "exclusive power" to impose conditions on appropriated funds. *Id.* at 1231. In contrast, the Executive's role is to "take care that the laws be faithfully executed," and agencies are there to serve that same end. U.S. Const. art. II, § 3.

As a federal agency, HHS "can spend, award, or suspend money based only on the power Congress has given to them—they have no other spending power." *New York v. Trump*, No. 25-CV-39-JJM-PAS, 2025 WL 715621, at *1 (D.R.I. Mar. 6, 2025), *denying stay pending appeal*, 2025 WL 914788 (1st Cir. Mar. 26, 2025). HHS' Public Health Funding Decision contradicts Congress's decision to appropriate funds to the States to address public health concerns. The Government had no statutory authority to decide that the funds were no longer necessary, particularly considering the Legislative's clear intent that the funds remain available beyond the pandemic. The Government's decision to allocate, in some cases, more than it was statutorily required to does not alleviate HHS of its obligation to expend the appropriated funds pursuant to Congress's intent. Indeed, the Legislature even outlined specific purposes for the appropriated funds to be used beyond the time of the pandemic to better prepare the country for future public health threats. Congress intended that the States have until September 30, 2025, to expend the SAMHSA funds and until 2029 with respect to the CDC grants. HHS even granted extensions to the States, in some cases through June 2027, and issued guidance on how to appropriately use the funds beyond COVID-related concerns. *See* ECF Nos. 4-3 ¶¶ 10, 13, 21–22, 48; 4-24

¶¶ 11, 22; 4-32 ¶ 19. As an agent of the Executive, HHS had "literally has no power to act" unless Congress authorized it to do so. *FEC,* 596 U.S. at 301.

In sum, the Government's unilateral determination that these funds were no longer needed based on the end of the pandemic violated core Separation-of-Powers principals because Congress made its directives clear in the appropriations statutes and once again when it chose not to rescind the funds in June 2023. The States have therefore demonstrated a strong likelihood of success on the merits of their claim that HHS' actions violated the Separation of Powers.

7. Count VI and Count VII

Having held that the States are likely to succeed on five of their seven claims, including a constitutional claim, the Court declines to address the sixth and seventh for purposes of resolving this motion for preliminary relief. *See Woonasquatucket*, 2025 WL 1116157, at *13; *Worthley*, 652 F. Supp. 3d at 215.

C. Irreparable Harm

While HHS insists that the States' motion "should be denied solely because they have failed to demonstrate irreparable harm," the Court disagrees. (ECF No. 68 at 35–36.) The States have submitted copious examples of irreparable harm flowing directly from HHS' decision to terminate this funding directly to their local health jurisdictions. *See* ECF Nos. 4-1—4-48.

Plaintiffs seeking preliminary injunctive relief face an uphill battle and must demonstrate "that irreparable injury is likely in the absence of an injunction." *Winter v. NRDC, Inc.*, 555 U.S. 7, 22 (2008) (emphasis omitted). True, "[p]reliminary

injunctions are strong medicine, and they should not issue merely to calm the imaginings of the movant." *Matos ex rel. Matos v. Clinton Sch. Dist.*, 367 F.3d 68, 73 (1st Cir. 2004). Harm that is "unlikely to materialize or purely theoretical will not do." *Id.* Rather, irreparable harm is based on "something more than conjecture, surmise, or a party's unsubstantiated fears of what the future may have in store." *Charlesbank Equity Fund II v. Blinds To Go, Inc.*, 370 F.3d 151, 162 (1st Cir. 2004).

Preliminary relief is appropriate when the alleged injuries cannot adequately be compensated "either by a later-issued permanent injunction, after a full adjudication on the merits, or by a later-issued damages remedy." *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 76 (1st Cir. 2005); *see also Ross-Simons of Warwick, Inc. v. Baccarat, Inc.*, 217 F.3d 8, 13 (1st Cir. 2000) (*Ross-Simons II*). "The necessary concomitant of irreparable harm is the inadequacy of traditional legal remedies. The two are flip sides of the same coin: if money damages will fully alleviate harm, then the harm cannot be said to be irreparable." *K-Mart Corp. v. Oriental Plaza, Inc.*, 875 F.2d 907, 914 (1st Cir. 1989). District courts have "broad discretion to evaluate the irreparability of alleged harm." *Ross-Simons II*, 217 F.3d at 13 (cleaned up).

Before the Court is an extensive record from the States detailing the harm they stand to suffer in the wake of HHS' Public Health Funding Decision. The States divide these examples to three categories: protecting public health, the elimination of healthcare services, and impact on public health infrastructure. The Court discusses each below.

1. Protecting Public Health

The States assert that the termination in funding would impair their ability to protect public health because it will cause layoffs of essential staff. (ECF No. 60 at 38.) "Threats to public health and safety constitute irreparable harm that will support an injunction." *Cigar Masters Providence, Inc. v. Omni Rhode Island, LLC*, No. CV 16-471-WES, 2017 WL 4081899, at *14 (D.R.I. Sept. 14, 2017); *Sierra Club v. U.S. Dep't of Agric., Rural Utilities Serv.*, 841 F. Supp. 2d 349, 358 (D.D.C. 2012).

The Minnesota Department of Health ("MDH") will be required to layoff approximately 200 employees, or 12 percent of its staff. (ECF No. 4-24 ¶ 41.) These layoffs will include "epidemiologists, research scientists, and other highly skilled and trained workers." *Id.* There is a risk that MDH will not be able to hire back all staff who were separated, many of whom have subject matter expertise that would be difficult to replace. *Id.* Loss of funds and workforce has significant and immediate implications for programs fulfilling critical public health functions in Minnesota. *E.g.*, the ELC supplemental funds[15] impact MDH's ability to perform disease surveillance and monitoring work for COVID-19 variants, including wastewater surveillance. *Id.* ¶ 44.

Washington state stands to lose 200 employees, including 150 full-time employees that are responsible for planning and responding to communicable disease

[15] The CDC established the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases ("ELC") Cooperative Agreement to fund the country's ability to detect, prevent, and respond to infectious disease outbreaks. (ECF Nos. 4-4 ¶ 7; 4-13 ¶ 8; 4-21 ¶ 22.)

cases and outbreaks and related laboratory testing and disease surveillance. (ECF No. 4-40 ¶¶ 5, 8–9.) Without these employees, the state would be at greater risk for a variety of infectious diseases, some of which cause severe illness, disability, or death. *Id.* ¶ 17.

Colorado will lose all but one of the employees in its Immunization Program. (ECF No. 4-10 ¶ 53.) "The loss in staff will result in the loss of customer service for our vaccine providers through the immunization information system help desk, and the loss of the ability to provide notification to parents and patients regarding the need for both COVID-19 and routine vaccinations, including flue and the measles, mumps, and rubella (MMR) vaccine during a time of increased measles cases and outbreaks in the U.S." *Id.*

Termination of the funding will also reduce staffing and capacity and resources in programs that address gaps in vaccine access by supporting mobile and community-based clinics, particularly in communities that are underserved and experience barriers in access to care and can be deployed for emergency response such as testing and post-exposure prophylaxis during outbreaks. *Id.* ¶¶ 55–56. Decreased access to and education regarding routine vaccinations will increase cases and outbreaks, which result in lives lost and increased health care costs for those infected. *Id.* ¶ 57.

In Delaware, the termination of a community health worker grant will end support for "33.5 [Community Health Worker] positions across six organizations, including federally qualified health centers and community-based organizations."

(ECF No. 4-14.) And here in Rhode Island, health officials will have to dismantle the Project Firstline team, which would stop the state's Department of Health from providing infection control education to healthcare facilities to prevent outbreaks. (ECF No. 4-39 ¶ 34.) The loss of Epidemiology and Laboratory Capacity Enhancing Detection Expansion funds will also impact the staffing of nurses, epidemiologists, and disease intervention specialists, and the funding of equipment and support software. *Id.* ¶¶ 31–32, 38–39.

Absent an injunction, HHS' termination of this funding will leave the States no choice but to shutter their programs and begin layoffs of highly trained and specialized employees that will be difficult to hire back. *See, e.g.*, ECF Nos. 4-3 ¶ 38; 4-7 ¶¶ 12–13, 42, 46, 54; 4-8 ¶¶ 23, 26, 31–37, 44, 54; 4-9 ¶¶ 49–50, 53, 56, 59–60, 80–81, 108; 4-10 ¶ 20.

2. Elimination of Healthcare Services to States

Next, the States submit that the loss of critical funding will curtail their healthcare services to residents. This includes treatment to those struggling with mental health and substance use disorder, the funding of vaccines to vulnerable populations, and services to address infectious disease outbreaks.

a. Mental Health and Substance Abuse Services

In Connecticut, the termination of the Department of Mental Health and Addiction Services' SAMHSA grants will eliminate "housing and employment supports, regional suicide advisory boards, harm reduction, perinatal screening,

early-stage treatments, and increased access to medication assisted treatment." (ECF No. 4-12 ¶¶ 16, 29.)

In Illinois, the termination of mental health block grants means that providers will be unable to provide services through the state's "mobile crisis response units that assist people at risk of suicide." (ECF No. 4-17 ¶ 16.) And without that funding, "providers will simply be unable to help people in suicidal crisis." *Id.*

In New Mexico, the terminated mental health care block grants will cut funding to fifty-four providers who treat over 64,000 people for critical behavioral and mental health services. (ECF No. 4-28 ¶ 14.)

In California, the termination of the substance use disorder prevention and early intervention services for youth in at least eighteen of its counties risk increased substance use among young people. (ECF No. 4-6 ¶ 61).

New Jersey stands to lose funds that support forty-five direct care treatment programs which provide critical live saving services, including crisis intervention and behavioral health treatment services that allow intervention for individuals experiencing mental health and or substance use crises. (ECF No. 4-26 ¶ 7)

And in North Carolina, the termination of SAMHSA funds has halted the work of mental health professionals including therapists and substance use treatment specialists. (ECF No. 4-25 ¶ 7) The loss of funds has also led to termination of a program that helps address substance use recovery and mental health in local universities and colleges. *Id.* ¶ 8. And the termination of funding will also impact

programs designed to address the opioid epidemic by providing naloxone kits and support to opioid community clinics. *Id.*

b. States' Public Health Programs

Without the funding, California's Immunization and Vaccines for Children program will not be able to provide vaccines for measles, influenza, and COVID-19 to approximately 4.5 million children, roughly half of California's youth population. (ECF No. 4-3 ¶ 17.)

In Minnesota, the funding was being used to address "gaps in infection control practices, training, and resources, identified during the COVID-19 pandemic as a major concern of the operators of long-term care facilities serving older adults." (ECF No. 4-24 ¶ 48.) Because of the terminations, the Minnesota Department of Health had to cancel grants that would have provided infection prevention and control training to more than sixty skilled nursing facilities across the state, potentially exposing over 3,000 long-term care residents to a greater risk of infection. *Id.* Likewise, the terminations forced the cancelation of infection prevention and control training programs for 150 nursing and assisted living facilities, "potentially impacting 7,000 long-term care residents." *Id.*

In Rhode Island, the loss of the Health Disparities grant will curtail efforts to support "community education, mitigation, and response efforts in the state's hardest hit communities" including preparedness and response capacity to the state's designated rural community, Block Island. (ECF No. 4-38 ¶ 17(a).) The loss of COVID-19 vaccination supplemental funding will impact a planned vaccination clinic

for vulnerable populations in Rhode Island, including those living in nursing homes and assisted living communities. *Id.* ¶ 25.

Consequently, HHS' Public Health Funding Decision is not merely an economic loss when it threatens the "very existence" of key mental health, substance abuse, and other healthcare programs in the States, worsening public health outcomes and placing their residents at risk. *See Packard Elevator v. I.C.C.*, 782 F.2d 112, 115 (8th Cir. 1986) (explaining that "economic loss does not, in and of itself, constitute irreparable harm . . . [r]ecoverable monetary loss may constitute irreparable harm only where the loss threatens the very existence of the [programs]").

3. Impact on States' Public Health Infrastructure Projects

Lastly, while these funds were initially awarded to help with the COVID-19 pandemic, CDC recognized that most States lacked the necessary disease surveillance and laboratory infrastructure to respond to future health threats, so it encouraged and allowed States to invest these funds in strengthening these capacities. (ECF No. 60 at 17.) The States insist they have "long relied on the CDC's ELC support for infectious disease programs and projects." *Id.*

For instance, some of the funds supported data systems upgrades that facilitate better disease reporting and surveillance. (ECF No. 4-40 ¶ 13.) Washington DOH had planned to use the funding to bring a new system online over the next fourteen months after investing more than $12 million of CDC funding in its development. *Id.* Stopping now would be a loss of the benefits of that investment. *Id.* In Connecticut, the loss of funding impacts data system upgrades for infectious

disease and symptom surveillance. *See* ECF 4-13 ¶ 20 ("tens of millions of dollars spent to date [in updating data systems] will be wasted"). Similarly, Hawaii used the funds to make long overdue investments in its health department's efficiency, effectiveness, and capacity to effectively respond to current and future disease threats. (ECF No. 4-45 ¶¶ 15-17.) Abrupt termination of these funds will result in waste of government resources if the systems being developed cannot be implemented as planned. *Id.* Lastly, ELC funds were budgeted by New Jersey through July 2026 including the Communicable Disease Reporting and Surveillance System ("CDRSS"), an electronic web-enabled system where public health partners timely report and rack incidences of communicable diseases, which is critical for responding to current and future public health threats. (ECF No. 4-27 ¶ 24.) There are needed enhancements for security and improvement and with the loss of ELC funding, NJDOH will not be able to keep CDRSS operation. *Id.*

The Court could go on. The States have clearly demonstrated they are likely to suffer irreparable harm absent preliminary injunctive relief. Here, there is ample evidence to support the States' position that the Public Health Funding Decision is causing immediate damage to their healthcare programs and the safety of their residents. While the Court acknowledges HHS' position that it may be unable to recover the grant funds if it later prevails, Congress's direction that the funds remain intact and the States' reliance on the continuation of the funding overshadows that argument. (ECF No. 68 at 39.) And unlike in *California*, the States here cannot keep their critical public health programs and services running in the meantime, so much

that a later award for money damages would be wholly inappropriate. *See California*, 145 S. Ct. at 967; ECF No. 60 at 14; ECF No. 65 at 8.

D. Balance of the Equities and Public Interest

To conclude, the balance of the equities and public interest strongly favor preliminary relief for the States. Not only do the States have a substantial interest in the effective operation of their public health systems, but the States have also represented that HHS' Public Health Decision, and its implementation, would result in devastating consequences to their local jurisdictions. (ECF No. 60 at 39.) As discussed in the preceding sections, the healthcare funding terminations would constrain the States' infectious disease research, thwart treatment efforts to those struggling with mental health and addiction, and impact the availability of vaccines to children, the elderly, and those living in rural communities. *See, e.g.*, ECF Nos. 4-3 ¶ 48; 4-6 ¶¶ 4-7; 4-15 ¶ 17; 4-40 ¶ 11; 4-41 ¶ 3. Not to mention that the terminations were effective immediately, ignoring the States' reliance on the funds. As a result, the States submit that they will be forced to "take immediate action to curtail their public health programs and undergo massive layoffs of highly trained employees and contractors." (ECF No. 60 at 40.) In comparison, the Government's argument that it is the one who stands to suffer irreparable harm in the meantime is unavailing. (ECF. 68 at 40.)

The Court weighs the "balancing of the equities and analysis of the public interest together, as they 'merge when the [g]overnment is the opposing party.'" *Does 1-6 v. Mills*, 16 F.4th 20, 37 (1st Cir. 2021) (quoting *Nken v. Holder*, 556 U.S. 418,

435, 129 S.Ct. 1749, 173 L.Ed.2d 550 (2009)). The States' interest in safeguarding its public health systems is clearly paramount.

While the Court acknowledges the Government's position that it may be forced to spend money inconsistent with the Executive's agenda, an injunction would strongly serve the public interest in maintaining the States' healthcare systems and initiatives. (ECF No. 68 at 40-41.) "[T]he wisdom" of the Executive's decisions "[are] none of our concern." *Dep't of Homeland Sec.*, 591 U.S. at 35 (cleaned up). Rather, this case is one "about the procedure" (or lack thereof) that HHS followed in trying to enact the Executive's policies. *Id.* Agencies do not have unfettered power to further a President's agenda, particularly when Congress appropriated this money to the States to fund their public health systems and initiatives. Thus, when the Court weighs an agency's unreasoned, unsubstantiated, and likely unlawful determination that funding was "no longer necessary," against the States' interest and reliance on the funds to safeguard their public health outcomes, the balance of the equities and public interest are undeniably in the States' favor.

E. Bond

Federal Rule of Civil Procedure 65(c) states that the court may issue a preliminary injunction "only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." The Government asks the Court to require the States to provide a bond. (ECF No. 68 at 45–46.) The Court declines.

Rule 65(c) "has been read to vest broad discretion in the district court to determine the appropriate amount of an injunction bond," *DSE, Inc. v. United States*, 169 F.3d 21, 33 (D.C. Cir. 1999), "including the discretion to require no bond at all," *P.J.E.S. ex rel. Escobar Francisco v. Wolf*, 502 F. Supp. 3d 492, 520 (D.D.C. 2020) (internal quotation omitted). A bond "is not necessary where requiring [one] would have the effect of denying the plaintiffs their right to judicial review of administrative action." *Nat. Res. Def. Council, Inc. v. Morton*, 337 F. Supp. 167, 168 (D.D.C. 1971) (collecting cases); *cf. Nat'l Ass'n of Diversity Officers in Higher Educ. v. Trump*, No. 25-CV-333, 2025 WL 573764, at *30 (D. Md. Feb. 21, 2025) (setting a nominal bond of zero dollars because granting the defendants' request "would essentially forestall [the] [p]laintiffs' access to judicial review"). In a case where HHS is alleged to have unlawfully terminated large sums of appropriated and committed funds to numerous recipients against Congress's will and in excess of HHS' statutory authority, it "would defy logic—and contravene the very basis of this opinion—to hold" the States "hostage for the resulting harm." *Woonasquatucket*, 2025 WL 1116157, at *24.

IV. PRELIMINARY INJUNCTION

Upon consideration of the States' Motion for a Preliminary Injunction (ECF No. 60), it is hereby ORDERED:

1) Defendants and all their respective officers, agents, servants, employees and attorneys, and any persons in active concert or participation with them who receive actual notice of this order (collectively "Enjoined Parties") are hereby preliminarily enjoined from implementing or enforcing through any

means the decision made on or about March 24, 2025 that numerous health programs and appropriations responsible for $11 billion of critical federal financial assistance were "no longer necessary" because the "COVID-19 pandemic is over" ("Public Health Funding Decision"), including any funding terminations, or from taking any action to reinstitute the Public Health Funding Decision for the same or similar reasons. This injunction is limited to funding for Plaintiff States, including their local health jurisdictions and any bona fide fiscal agents of Plaintiff States or their local health jurisdictions.

2) The Enjoined Parties shall immediately treat any actions taken to implement or enforce the Public Health Funding Decision, including any funding terminations, as null and void and rescinded. The Enjoined Parties must immediately take every step necessary to effectuate this order, including clearing any administrative, operational, or technical hurdles to implementation.

3) Defendants' counsel shall provide written notice of this order to all Defendants and agencies and their employees, contractors, and grantees by the end of the day on Tuesday, May 20, 2025.

4) By the end of the day on Tuesday, May 20, 2025, the Defendants SHALL FILE on the Court's electronic docket a Status Report documenting the actions that they have taken to comply with this Order, including a copy of the notice and an explanation as to whom the notice was sent.

5) For the reasons stated in the Court's Order, the Court finds that a bond is not mandatory under these circumstances and exercises its discretion not to require one.

IT IS SO ORDERED.

Mary S. McElroy,
United States District Judge

Date: May 16, 2025

Exhibit 77

Government Executive

CDC to cut one employee for each it is recalling from layoffs

By Eric Katz

May 14, 2025

While the Trump administration has walked back a small number of its layoffs in the public health field, it did so only after requiring an equal number of employees to be cut going forward.

The Centers for Disease Control and Prevention on Tuesday brought back around 300 employees it had dismissed through a reduction in force. It will now provide a one-to-one "substitution" to even out the rescinded reductions in force with new cuts, according to an internal email obtained by *Government Executive*.

“These additional substitutions will occur as soon a[s] legally possible in the coming days,” said Thomas Nagy, the head of human resources for the Health and Human Services Department.

The email was addressed to Rachel Riley, one of the Department of Government Efficiency representatives at HHS. Nagy was confirming the policy with Matt Buzzelli, CDC’s chief of staff.

CDC’s RIF rescissions impacted staff at the National Institute for Occupational Safety and Health. It was not clear whether the new cuts will also come from NIOSH or elsewhere within CDC, though NIOSH had few staff remaining after the Trump administration had gutted nearly the entire office. Congress created NIOSH in 1970 to investigate outbreaks and illnesses within the workplace.

An HHS official confirmed the policy and said it was necessary to "maintain the integrity and legality of the RIF.” Operating divisions within CDC provided feedback to HHS that they needed specialized workers, but the agency determined it was legally necessary to offset those RIF rescissions.

Those recalled included select units within the Office of the Director; the Respiratory Health Division; the Division of Safety Research; the Division of Compensation and Analysis Support; the National Personal Protective Technology Laboratory; and part of the Division of Field Studies and Surveillance.

NIOSH Director John Howard, who had himself been part of the original layoffs, said in a message to staff he was hopeful that “we can continue to make the case for reinstating everyone” at the agency.

After the employees received their layoff rescission notices on Tuesday, U.S. Judge Irene Berger for the Southern District of West Virginia ruled that HHS violated the law by ending the Coal Workers' Health Surveillance Program and mandated that all employees in NIOSH's Respiratory Health Division be reinstated.

The National Institutes of Health has also recalled employees on a limited basis, according to an official there, and similarly required that a new RIF for each person brought back so the total impacted would remain unchanged.

While HHS suggested it would carry out the new round of cuts as soon as legally possible and in the coming days, the department is currently facing a separate prohibition on issuing any layoffs as part of a temporary restraining order in another court case. That order is set to last through May 23 but could get extended into a preliminary injunction.

HHS is currently facing a third lawsuit from 19 states that have argued the department had “no constitutional or statutory authority” to carry out the 10,000 staffing cuts it has so far implemented.

By Eric Katz

May 14, 2025

https://www.govexec.com/workforce/2025/05/CDC-cut-one-employee-each-it-recalling-layoffs/405336/