UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

State of California, et al. ,

Plaintiffs,

v.

U.S. Department of Health and Human Services, et al.,

Defendants.

CA No.: 1:25-cv-12118

PLAINTIFF STATES' MOTION FOR A PRELIMINARY INJUNCTION

Pursuant to Rule 65(a) of the Federal Rules of Civil Procedure, Plaintiffs hereby move this Court to preliminarily enjoin Defendants from implementing or enforcing Section 71113 of the "One Big Beautiful Bill" or "federal budget bill," Pub. L. No. 119-21, § 44126, 138 Stat. 482 (2025), as against Plaintiffs, pending a final ruling on the merits of this case. The grounds for this motion are set forth in Plaintiffs' accompanying memorandum of law in support of their motion, and the challenged provision is set forth in the proposed order attached as an exhibit to this motion.

SA2025303982

Date: September 24, 2025

Respectfully Submitted,

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**Admitted Pro Hac Vice*

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LOCAL RULE 7.1 CERTIFICATE

I certify that on September 23, 2025 at 10:26 a.m. PDT, I contacted Diane Kelleher, Director, Federal Programs Branch, U.S. Department of Justice (diane.kelleher@usdoj.gov), Rayford Farquhar, Chief, Defensive Litigation, Civil Division, U.S. Attorney's Office for the District of Massachusetts (rayford.farquhar@usdoj.gov), Abraham George (abraham.george@usdoj.gov), and Brad Rosenberg (brad.rosenberg@usdoj.gov) by email in an attempt to meet and confer regarding the foregoing request for relief. Elizabeth J. Neylan with the Civil Division – Federal Programs Branch responded on behalf of Defendants. Plaintiffs and Defendants have met and conferred in good faith and have been unable to resolve or narrow the subject of this Motion.

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CERTIFICATE OF SERVICE

I, Erica Connolly, certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants.

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Exhibit : Proposed Order

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

State of California, et al. ,

Plaintiffs,

v.

U.S. Department of Health and Human Services, et al.,

Defendants.

CA No.: 1:25-cv-12118

[PROPOSED] ORDER GRANTING PRELIMINARY INJUNCTION

Pursuant to Rule 65(a) of the Federal Rules of Civil Procedure, and upon consideration of Plaintiffs' Motion for a Preliminary Injunction, and the parties' briefing thereon, it is hereby **ORDERED** that the motion is **GRANTED**; and it is further **ORDERED** that Defendants are preliminarily **ENJOINED** from implementing and enforcing Section 71113 of the "One Big Beautiful Bill" or "budget reconciliation bill," Pub. L. No. 119-21, § 44126, 138 Stat. 482 (2025) ("Section 71113"), as against the Plaintiff States, pending a final ruling on the merits of this case.

As grounds for this order, the Court finds that the Plaintiff States are likely to succeed on the merits of their claims; that Section 71113 is causing Plaintiff States ongoing and irreparable harm which is likely to continue if the order is not granted; and that the public interest and balance of equities weigh in favor of granting preliminary relief and postponing the effective date of Section 71113 against the Plaintiff States.

This Order shall remain in effect unless and until modified by the Court.

SO ORDERED this ___ day of _____, 2025

_____
By: Hon. Indira Talwani
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

State of California, et al. ,

Plaintiffs,

v.

U.S. Department of Health and Human Services, et al.,

Defendants.

CA No.: 1:25cv12118

PLAINTIFFS' REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs, the State of California, et al., request that the Court take judicial notice, pursuant to Rule 201 of the Federal Rules of Evidence, of the documents referenced below, which are submitted as exhibits to Plaintiffs' Preliminary Injunction Motion.

Ex. 1 Declaration of Kimberly Custer, *Planned Parenthood Fed'n of Am., Inc. v. Kennedy*, Case No. 1:25-CV-11913-IT, ECF No. 5-1 (D. Mass. July 7, 2025). A true and correct copy of the declaration is attached hereto as Exhibit 1.

Ex. 2 Declaration of Dominique Lee, *Planned Parenthood Fed'n of Am., Inc. v. Kennedy*, Case No. 1:25-CV-11913-IT, ECF No. 5-2 (D. Mass. July 7, 2025). A true and correct copy of the declaration is attached hereto as Exhibit 2.

Ex. 3 Declaration of Jenna Tosh, *Planned Parenthood Fed'n of Am., Inc. v. Kennedy*, Case No. 1:25-CV-11913-IT, ECF No. 5-4 (D. Mass. July 7, 2025). A true and correct copy of the declaration is attached hereto as Exhibit 3.

Ex. 4 U.S. Gov't Accountability Off., GAO-20-571R, Medicaid: Primer on Financing Arrangements (2020), https://www.gao.gov/assets/gao-20-571r.pdf. A true and correct copy of this report is attached hereto as Exhibit 4.

Ex. 5 Declaration of Evelyn Kieltyka, *The Family Planning Association of Maine v. United States Department of Health and Human Services et. al*., Case No. 1:25-cv-00364-LEW, ECF No. 5-2 (D. Me. July 16, 2025). A true and correct copy of this declaration is attached hereto as Exhibit 5.

Ex. 6 National Center for Chronic Disease Prevention and Health Promotion, Health and Economic Benefits of Breast Cancer Interventions (Aug. 15, 2025), https://www.cdc.gov/nccdphp/priorities/breast-cancer.html. A true and correct copy of this report is attached hereto as Exhibit 6.

Ex. 7 National Center for Chronic Disease Prevention and Health Promotion, Health and Economic Benefits of Cervical Cancer Interventions (Aug. 15, 2025), https://www.cdc.gov/nccdphp/priorities/cervical-cancer.html. A true and correct copy of this report is attached hereto as Exhibit 7.

Judicial notice is appropriate where a fact is not subject to reasonable dispute because it "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b)(2). Judicial notice by a court is mandatory "if a party requests it and the court is supplied with the necessary information." Fed. R. Evid. 201(c)(2).

Judicial notice of Exhibits 1 through 7 is appropriate because these documents were either filed in federal court or published on a Government website, and as such are not subject to reasonable dispute and are "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b); *see Rodrique v. Hearst Commc'ns, Inc*., 126 F.4th 85, 93 n.3 (1st Cir. 2025) ("We can take judicial notice of what information was available on government websites at a particular time."); *Medtronic Med. CR SRL v. Feliciano-Soto*, 59 F.4th 51, 53 n.2 (1st Cir. 2023) ("It is well-accepted that federal courts may take judicial notice of proceedings in other courts if those proceedings have relevance to the matters at hand.") (citation modified); *In re Papatones,* 143 F.3d 623, 624 n.3 (1st Cir. 1998) ("The court may take judicial notice of its own orders and of records in a case before the court, and of documents filed in another court.") (citation modified); *see also Gent v. CUNA Mut. Ins. Soc'y*, 611 F.3d 79, 84 n.5 (1st Cir. 2010) (taking "judicial notice of the relevant facts provided on the [Center for Disease Control's] website, which are 'not subject to reasonable dispute.'").

CONCLUSION

The Plaintiffs respectfully requests that the Court take judicial notice of the above referenced documents and further, that the Court consider the above referenced documents in connection with the Plaintiffs' Preliminary Injunction Motion.

SA2025303982

Date: September 24, 2025

Respectfully Submitted,

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EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES,

Defendants.

Case No. _____

DECLARATION OF KIMBERLY CUSTER
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Kimberly Custer, declare and state as follows:

1. I am employed by Planned Parenthood Federation of America, Inc. ("PPFA") as Executive Vice President and Senior Advisor to the President of PPFA. In this role, I am responsible for, among other things, advising the President on a variety of strategic and operational objectives, leading digital health strategy development and planning, and engaging with the independent members of Planned Parenthood Federation of America (each, a "Member" and collectively, the "Members" or "Membership"). I am involved in developing strategies to address the short- and long-term needs of PPFA's Members nationwide, and support them in their core mission of ensuring access to sexual and reproductive health care services, including abortion, regardless of income, insurance, gender identity, sexual orientation, or race.

2. I previously served as Executive Vice President and Chief Federation Engagement & Impact Officer from 2021 to 2025. In this role, I developed, led, and implemented PPFA's strategic framework for coordinating with Members and oversaw teams responsible for having a federation-wide impact. From 2015 to 2021, I served as Executive Vice President, Health Care Division overseeing PPFA's health care-related programs and strategies in support of Members, including those related to medical services, health education, research, contraceptive equity, health care operations, business analytics, accreditation, and evaluation for PPFA's Members, as well as support for Member governance and leadership. Before taking on these roles at PPFA, I worked at two different Planned Parenthood Member organizations. I served as Chief Executive Officer of Planned Parenthood Keystone from 2004 to 2015, and as Vice President of Community Affairs at Planned Parenthood of Orange and San Bernardino Counties from 1997 to 2004.

3. I am over the age of eighteen, and this declaration is based on my personal knowledge, a review of PPFA's business records, and the knowledge I have acquired in the course

of my service and duties with PPFA and Planned Parenthood Members. If called and sworn as a witness, I could and would testify competently thereto.

4. As discussed more fully below, Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision"), if allowed to remain in effect, will be devastating to the patients who rely on Planned Parenthood Member health centers for their sexual and reproductive health care. Indeed, the Defund Provision is already forcing Members to turn away patients enrolled in Medicaid. Nationwide, 51% of Planned Parenthood Member patients rely on Medicaid for their health care. And more than one-third of Members' total revenue is from Medicaid reimbursement for services the Members provide. Because the Defund Provision bars Planned Parenthood Members from receiving federal reimbursement under the Medicaid program for the care provided to these patients, if the Defund Provision is allowed to remain in effect, Planned Parenthood Members will have to severely curtail the services they provide to many of their low-income patients. Those patients will face great difficulty in finding, and in many cases will be unable to find, alternative providers of evidence-based sexual and reproductive health care in their communities. Because many Planned Parenthood Members will also have to close health centers and/or reduce the hours they serve patients, the care of many other Planned Parenthood Member patients will be jeopardized.

5. The Defund Provision will have a severe and disproportionate impact on Members' most vulnerable patient groups—low-income patients, individuals who live in rural and/or medically underserved areas, and communities of color. Other providers will not be able to fill the gap in services that will result, and many individuals who rely on Planned Parenthood Members will be deprived of the ability to obtain high-quality and often life-saving health care. At a minimum, over a million patients will lose their preferred health care provider and will face serious disruptions and discontinuities in their health care.

6. The Defund Provision presents an existential threat to PPFA and its Members and their patients. PPFA estimates that a substantial number of Planned Parenthood Member health centers could eventually close if the Defund Provision remains in effect and if Members continue to be unable to provide care through the Medicaid program.

I. PPFA'S MISSION AND STRUCTURE

7. PPFA is a 501(c)(3) not-for-profit corporation organized under the laws of New York. PPFA is a membership organization whose forty-seven Members are non-profit health care providers with health centers in forty-seven states and the District of Columbia, as well as a telehealth presence in all fifty states. PPFA does not itself provide health care services but supports its health care-providing Members in a variety of ways.

8. Because PPFA is not a health care provider, it does not participate in Medicaid.

9. Planned Parenthood Members are separately incorporated and independently governed 501(c)(3) non-profit corporations, each with its own CEO; governance structure, including a board of directors; staff; books; and operations. Each Planned Parenthood Member provides health care and educational services directly to the public in a distinct geographic area.

10. As part of their membership rights, PPFA Members elect PPFA's board of directors; approve changes to PPFA's bylaws and membership standards; approve PPFA's long-range goals; and determine the amount each Member pays in annual dues to PPFA.

11. As a condition of membership, PPFA requires each Member to agree to meet its membership standards (outlined in PPFA's bylaws and set by the Membership) and provides them with support and services to ensure that they are able to provide high-quality care consistent with evidence-based standards.

12. PPFA and its Members share a mission of ensuring that regardless of income, insurance, gender identity, sexual orientation, or race, people can receive high-quality, inclusive,

and comprehensive sexual and reproductive health care; providing related educational services; promoting research on sexual and reproductive health; and advocating for public policies that guarantee access to such services. For more than a century, millions of patients have turned to Planned Parenthood Members for vital health care services, sex education, and sexual health information.

13. PPFA provides support, leadership, and guidance to its Members to ensure that Members are able to provide high-quality health care and educational services directly to the public. For example, PPFA administers accreditation standards for the Membership, promulgates certain shared medical standards and guidelines, and provides leadership around certain shared policy and program initiatives. PPFA also provides practical support such as technical assistance and consultant service, programmatic grants, and fundraising support. While Members receive some grant and other funding through PPFA—an average of less than 7% annually for each Member—overall, the vast majority of each Member's revenue comes from sources other than PPFA.

14. PPFA licenses the use of the Planned Parenthood name and well-known trademark to each Member.

15. PPFA membership is important to Members' ability to fulfill their missions. The Planned Parenthood name sends a powerful message to the community that the Member stands for certain values and provides high-quality health care and educational services in furtherance of the shared Planned Parenthood mission. Planned Parenthood Members are viewed in communities throughout the country as providing nonjudgmental, welcoming, and compassionate care to patients seeking health care, including sexual and reproductive health care.

16. In addition to maintaining separate corporate structures, PPFA and its Members maintain separate finances and day-to-day operations. For example, PPFA and each Member

maintain separate general ledgers and file taxes separately from one another. Each has separate payrolls and employee rosters, and PPFA has no role in its Members' respective staffing or employment decisions.

17. Their structural independence means that no Member has control over the operations or decision-making processes of another. The actions or policies of one Planned Parenthood Member do not legally or operationally bind the others.

18. Similarly, PPFA does not exercise control over any Member, or vice versa.

19. Working in furtherance of the shared Planned Parenthood mission, PPFA and its Members also advocate to shape the national, state, and local landscape to create the most favorable conditions for people everywhere to have equitable access to the vital sexual and reproductive health care, including abortion, provided by Planned Parenthood Members and other non-profit sexual and reproductive health care providers. Hearing directly from Planned Parenthood Member patients and with the backing of 19 million supporters, PPFA and its Members are uniquely situated and bear a special responsibility to lead the defense against attacks on sexual and reproductive health care and to shape a national narrative that shifts public opinion while advancing the policies and systems that will preserve and improve access to care—for Planned Parenthood Member patients and all people seeking sexual and reproductive health care. Separately, each Member may have a related 501(c)(4) tax-exempt entity with its own board that works in furtherance of the Planned Parenthood mission, and PPFA has a related 501(c)(4) organization called Planned Parenthood Action Fund. These independent, separately incorporated non-profit social welfare organizations each engage in education, advocacy, and limited electoral activities that work to further the Planned Parenthood mission.

II. HEALTH CARE SERVICES PROVIDED BY PLANNED PARENTHOOD MEMBERS

20. Collectively, Planned Parenthood Members have health centers in forty-seven states and the District of Columbia and a telehealth presence in all fifty states.

21. Taken together, PPFA's forty-seven Members provide sexual and reproductive health care to more people in the United States than any other provider. Planned Parenthood Members provide medical services through nearly 600 health centers throughout the nation, serving more than two million patients each year. One out of every three women and one in ten men nationally has received care from a PPFA Member at least once in their lifetime; this number is even higher among individuals with Medicaid, 43% of whom have received services from a Member health center.[1] In 2021 alone, one in ten reproductive-aged Medicaid beneficiaries who received family planning services went to a Planned Parenthood Member health center for that care.[2] And in 2020, Planned Parenthood Member health centers served 33% of the total contraceptive clients served by safety-net providers—roughly 1.6 million people.[3] PPFA Members play a particularly important role in providing sexual and reproductive and other health care to low-income people.

22. All PPFA Members offer a wide range of family planning services and reproductive health care, although the specific services that PPFA Members offer vary depending on the needs of the communities in which they operate and the resources available. Members typically provide

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[1] Brittni Frederiksen et al., *Major Federal and State Funding Cuts Facing Planned Parenthood*, KFF (May 15, 2025), https://www.kff.org/womens-health-policy/issue-brief/major-federal-and-state-funding-cuts-facing-planned-parenthood/.

[2] Brittni Frederiksen et al., *The Impact of Medicaid and Title X on Planned Parenthood*, KFF (Apr. 16, 2025), https://www.kff.org/medicaid/issue-brief/the-impact-of-medicaid-and-title-x-on-planned-parenthood/.

[3] Guttmacher Inst., *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood* (June 4, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

contraception (including long-acting reversible contraceptives ("LARCs")), contraceptive counseling, physical exams, cancer screenings, gender-affirming hormone therapy, testing and treatment for sexually transmitted infections ("STIs"), pregnancy testing and counseling, vasectomies, colposcopies, abortion where legal, and health education services.

23. During the federal fiscal year 2023, Planned Parenthood Members served approximately 2.08 million patients and provided more than 9.4 million total services.[4] The care Planned Parenthood Members that year included over 2.2 million birth control services, more than 5.1 million STI tests, over 400,000 abortions, and over 426,000 cancer screenings and prevention services.[5] Abortions comprise a small fraction—approximately 4%—of Members' services nationwide.[6] Members also reached approximately 1.3 million people through education programming, outreach, and trainings.[7]

24. PPFA Members have a special mission to provide sexual and reproductive health care, including abortion, to historically underserved patients and communities. In many communities, a Planned Parenthood Member health center is the only place that a patient can turn to for high-quality, compassionate, and low-cost (or free) reproductive health care. Sixty-four percent of Planned Parenthood Member health centers are located in rural areas, Health Professional Shortage Areas, or Medically Underserved Areas.[8]

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[4] Planned Parenthood Fed'n of Am., *2023-2024 Annual Report*, at 6, 23 (2024), https://www.plannedparenthood.org/uploads/filer_public/ec/6d/ec6da0d6-98e5-4278-8d11-99a5cba8e615/2024-ppfa-annualreport-c3-digital.pdf [hereinafter PPFA Annual Report].

[5] *Id.* at 6, 23.

[6] *Id.* at 22.

[7] *Id.* at 14.

[8] Health Professional Shortage Areas—as designated by the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services—are designated as having shortages of primary medical care, dental, or mental health providers. Medically Underserved Areas have a shortage of primary care health services for residents

25. Of the Planned Parenthood Member patients who report their income, 65% have incomes at or below 150% of the federal poverty level.[9]

26. Planned Parenthood Member health centers play a critical role in serving communities of color, and in many cases are the only health centers providing sexual and reproductive health care in the communities they serve. In the 2023 to 2024 reporting period, approximately 34% of Planned Parenthood Members' patients were white, 27% were Latino/a, 17% were Black, 12% did not disclose their race or their race was unknown, 4% were Asian American/Pacific Islander, 0.5% were American Indian/Alaskan Native, 4% were another race, and 2% were multiracial. As this data shows, Planned Parenthood Members serve a disproportionate number of patients of color as compared to the U.S. population.[10]

27. Patients choose to receive care from Planned Parenthood Members for numerous reasons.

28. Planned Parenthood Member health centers offer a range of comprehensive services that many other providers do not, such as LARCs. LARCs are the most effective methods of preventing pregnancy—they are more than 99% effective,[11] leading to a dramatic reduction in unintended pregnancies. Once in place, they can prevent pregnancy for up to twelve years. Member

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within a geographic area. Health Res. & Servs. Admin., *What Is Shortage Designation?* (June 2023), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[9] *See generally* U.S. Dep't of Health & Hum. Servs., Office of the Assistant Sec'y for Plan. & Evaluation, *2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii),* https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf (last visited July 5, 2025) (the 2025 poverty level for a single individual is $15,650 and is $32,150 for a family of four).

[10] *See generally* U.S. Census Bureau, *Quick Facts*, https://www.census.gov/quickfacts/fact/table/US/PST045223 (last visited July 5, 2025).

[11] Am. Coll. of Obstetricians & Gynecologists, *FAQs: Long-Acting Reversible Contraception (LARC): Intrauterine Device (IUD) and Implant*, https://www.acog.org/womens-health/faqs/long-acting-reversible-contraception-iud-and-implant (last visited July 5, 2025).

health centers typically offer three categories of LARCs: birth control implants, hormonal intrauterine devices ("IUDs"), and non-hormonal IUDs. They also typically provide LARCs in a single visit to reduce barriers to access, whereas many providers require patients to return for a second visit.

29. Many Planned Parenthood Member health centers have language services for patients who are not proficient in English, a service that other health clinics are often not able to provide. Many Member health centers also have bilingual or multilingual staff, as well as access to interpretation and translation services. PPFA and its Members often provide educational materials in English, Spanish, and other languages commonly spoken by the patients served in particular areas.

30. Planned Parenthood Member health centers have staff trained to help patients experiencing intimate partner violence ("IPV"), and clinicians are trained to screen patients for IPV. The training includes ways to identify if a patient is experiencing reproductive or sexual coercion, such as attempts to impregnate a partner against their will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods.[12] Clinicians are also specifically trained to screen for signs of abuse or coercion during telehealth visits. PPFA and its Members also provide educational resources related to healthy relationships, consent, and sexual assault.

31. Planned Parenthood Members are viewed in communities throughout the country as providing nonjudgmental, welcoming, culturally-sensitive, and compassionate care to patients seeking health care, including sexual and reproductive health care. Topics of this sort can be highly

[12] Am. Coll. Obstetricians & Gynecologists, *ACOG Committee Opinion Number 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013).

sensitive for patients, some of whom may find it difficult to discuss issues of sexuality or to seek treatment for reproductive- or sex-related conditions, such as STIs.

32. Indeed, because of their concerns about privacy and being judged, many individuals use Planned Parenthood Members as their provider for sexual and reproductive health care services even when they use other providers for their other health care needs. Moreover, Planned Parenthood Members' expertise and specialization in family planning, evidence-based practices, and technology often make them the top choice for individuals seeking high-quality medical care.

33. Planned Parenthood Member health centers are also often much more convenient for and accessible to their patients than other providers of sexual and reproductive health care—even when such alternative providers are available, which is often not the case. Planned Parenthood Members are usually able to see patients quickly and in many cases on a walk-in basis. In contrast, patients seeking sexual and reproductive health care services often face long wait times for appointments at other providers. Wait times can be a serious barrier to care, especially for low-income patients, many of whom have inflexible schedules due to work and/or child care responsibilities.

34. Most Planned Parenthood Member health centers offer extended (early morning, evening, or weekend) hours. The majority offer evening appointments at least one day per week, as well as weekend appointments. Again, these extended hours are very important to patients who have inflexible schedules and have difficulty in attending medical appointments during the traditional 9-to-5 workday.

35. In addition, all Planned Parenthood Members offer online scheduling for appointments and provide health services (including appointments for contraceptives) via telehealth, which makes such services more accessible to patients with disabilities, in remote areas, who lack access to reliable transportation, and/or who have inflexible schedules. In the 2023

federal fiscal year, Planned Parenthood Member health centers provided over 296,000 telehealth appointments to patients.

36. In recent years, many Planned Parenthood Members have served an increased and critically important role with respect to the provision of care to LGBTQ+ individuals. LGBTQ+ people face lower rates of health insurance coverage, higher rates of HIV/AIDS and cancer, and higher rates of discrimination from medical providers.[13] All Planned Parenthood Members offer HIV prevention tools like pre- or post-exposure prophylaxis ("PrEP" and "PEP," respectively), a daily drug regimen to help prevent HIV. As of the 2024 federal fiscal year, 90% of Member health centers offer PrEP, and 77% offer PEP. Many Planned Parenthood Member health centers have programs for LGBTQ+ youth and allies, providing safe and supportive environments that allow youth to get the information and support they need to make healthy decisions and feel comfortable in their identities.

37. Planned Parenthood Member health centers are a critical source of care for transgender people nationwide. They are often the only place that transgender individuals can receive care without facing discrimination or judgment. Members provide gender-affirming hormone therapy to treat gender dysphoria as well as other services in a trans-affirming manner.

38. PPFA and its Members provide education and information to Members' patients and the general public about sexual and reproductive health, risks, and preventive measures, reaching approximately 1.3 million individuals[14] in person with education and information in their communities—and even more people online. Planned Parenthood Member educators also train

[13] Planned Parenthood Fed'n of Am., *This is Who Planned Parenthood Is* (Sept. 2017), https://www.plannedparenthood.org/uploads/filer_public/16/3f/163fe02e-2c2d-4bcf-92f5-63386b4c4065/who_we_are_lgbtq_community_september_2017.pdf.

[14] PPFA Annual Report, *supra* note 4, at 14.

teachers, school staff, and other youth-serving professionals within their communities on critical topics such as age-appropriate youth pregnancy prevention and STI prevention.

39. Planned Parenthood Members have been at the forefront of responding to recent public health crises. For example, in response to the COVID-19 pandemic, Members expanded their use of telehealth, including for medication abortion. They made changes to workflows and operations to minimize or eliminate physical contact with patients and time in the health center, including the adoption of telehealth for various components of the medication abortion care process, such as pre-abortion counseling and follow up appointments. And after the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* led to the implementation of abortion bans in many states, Planned Parenthood Members responded to the abortion access crisis by opening health centers in states where abortion remained legal close to the borders of states with abortion bans, as well as by expanding staffing and hours in access states.

40. PPFA and its Members are committed to supporting the advancement of research and technology in sexual and reproductive health, and are well situated to do so because of the millions of patients Members serve and the range of care they provide. In the 2024 PPFA fiscal year, 69% of Members participated in at least one research study for a total of 73 unique studies between PPFA and its Members. For example, PPFA and its Members have led and participated in research concerning contraceptive methods, such as contraceptive patches, IUDs, and emergency contraception, as well as human papillomavirus ("HPV") vaccine, sharing this research in journal articles and presentations at conferences ranging from the American Public Health Association to the American Congress of Obstetricians and Gynecologists.

III. PLANNED PARENTHOOD MEMBERS' SERVICE TO MEDICAID PATIENTS

41. The Medicaid program provides health coverage for eligible low-income families and individuals. The majority of the funding for Medicaid is provided by the federal government,

but the program is administered at the state level; the amount of state funding and the exact way in which the program is administered varies from state to state. In general, the program operates by reimbursing health care providers for health care services that they have provided to enrolled Medicaid patients.

42. Medicaid reimbursement rates vary by state but are generally well below Medicare and commercial insurance rates, so many providers do not accept Medicaid patients or effectively limit the number of Medicaid patients they see.[15] In many states, Medicaid reimbursement rates are significantly lower than the actual cost of delivering care.

43. Despite this, Planned Parenthood Members see Medicaid patients as part of their longstanding commitment to providing quality health care to underserved patients. As part of that commitment, Planned Parenthood Members participate in Medicaid programs in every state where they are able, a total of forty-six of forty-seven Members across forty-three states.[16] No Member limits the number of Medicaid patients that it will see. Approximately 51% of Planned Parenthood Members' patients rely on Medicaid for their health care, and half of visits to Planned Parenthood Member health centers are covered by Medicaid.

44. Medicaid reimbursements for reproductive health care services, preventive care screenings, and treatment make up a large portion of Planned Parenthood Members' revenue. In

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[15] Cindy Mann & Adam Striar, *How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost*, Commonwealth Fund (Aug. 17, 2022), https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact.

[16] The Member who participated only in the Texas Medicaid program is not able to provide care through Medicaid. Texas terminated Planned Parenthood Members from its Medicaid program; the termination was enjoined for several years based on the district court's determination that there was not "even a scintilla of evidence" supporting the terminations, but that injunction was subsequently reversed on procedural grounds. *See Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Smith*, 236 F. Supp. 3d 974, 998 (W.D. Tex. 2017), *vacated sub nom. Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347 (5th Cir. 2020).

federal fiscal year 2023, in the aggregate, more than one-third of Members' total revenue was from Medicaid reimbursements for health care services the Members provided. That year, more than half of PPFA's Members received 25% or more of their health care revenue in the form of Medicaid reimbursements. Because of the great unmet need for high-quality Medicaid providers of sexual and reproductive health care, some of those Members received the vast majority (over three quarters) of their health services revenue from Medicaid reimbursements that year.[17]

45. Federal law has long prohibited federal funds, including Medicaid funds, being used for abortion (except in narrow circumstances of rape, incest, and when the life of the pregnant person is in danger). This provision of federal law—commonly known as the Hyde Amendment—means that Medicaid does not cover abortion, except within these narrow exceptions. Accordingly, Planned Parenthood Members do not receive Medicaid reimbursements or any other federal funds for abortion services (other than in those very narrow circumstances).

46. For many Planned Parenthood Member patients enrolled in Medicaid, a Planned Parenthood Member is their only health care provider. In a survey of patients of publicly-funded clinics, like Planned Parenthood Member health centers, for the years 2015 to 2019, two-thirds of patients reported that the clinics were their primary source of medical care.[18] And based on a survey of 725 patients of two Planned Parenthood Member health centers in Kentucky and

[17] While the federal government regulates the services for which federal Medicaid funds can be used, states can, and in many cases do, cover additional services through their Medicaid programs with state-only funds. While the vast majority of Members' Medicaid reimbursements are for services reimbursed using federal funds—i.e., the federal funding that will be lost under the Defund Provision—the percentages above also include reimbursements that Members receive for services reimbursed using state-only funds.

[18] Jennifer J. Frost et al., *Trends and Differentials in Receipt of Sexual and Reproductive Health Services in the United States: Services Received and Sources of Care, 2006–2019*, Guttmacher Inst. (June 2021), https://www.guttmacher.org/sites/default/files/report_pdf/sexual-reproductive-health-services-in-us-sources-care-2006-2019.pdf.

Louisiana, 60% did not have a regular source of health care besides a Planned Parenthood Member, and nearly 40% reported "instability" with their health insurance.[19]

IV. THE DEVASTATING IMPACT OF THE DEFUND PROVISION ON PPFA, ITS MEMBERS, AND MEMBERS' PATIENTS

47. I have reviewed the Defund Provision and understand that it bars certain Planned Parenthood Members from receiving federal Medicaid reimbursements for the care provided to Medicaid patients. If it is not enjoined, the Defund Provision will have a devastating impact on PPFA, its Members, and the patients and communities that Members serve.

48. This is not the first time the federal government has attempted to "defund Planned Parenthood." In 2017, the House introduced a bill initially targeting entities that provided abortions and received more than $350 million in Medicaid funds in fiscal year 2014 for exclusion from Medicaid. Collectively, Members received over $350 million in Medicaid funds that year. My understanding is that the 2017 House bill would not have defunded any abortion providers other than Planned Parenthood Members.[20]

49. The Defund Provision is already affecting patients at Planned Parenthood Member health centers. It is forcing some Members to turn away patients enrolled in Medicaid; to attempt to refer them to other providers; or to offer Medicaid patients (who, by criteria of the program, have low incomes) the option to pay out-of-pocket for services where state law allows. Paying for care may be impossible for some Medicaid patients and may force some to forego other necessities such as paying for food or rent.

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[19] Anna Newton-Levinson et al., *Influences on Women's Care Seeking at Planned Parenthood Health Centers in Two Southern States*, 31 Women's Health Issues 485 (2021).

[20] *See* Paige Winfield Cunningham, *Planned Parenthood Defunded for One Year Under GOP Health Bill*, Wash. Post (May 4, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/05/04/planned-parenthood-defunded-for-one-year-under-gop-health-bill/.

50. If the Defund Provision is not enjoined, many Medicaid patients will no longer be able to receive care at their chosen provider. In many cases, they will not be able to access equivalent care elsewhere, and in some cases, they may not be able to access health care at all. This is especially true for those who already face systemic barriers to getting care and who have worse health outcomes as a result. This particularly includes groups who face systemic discrimination and barriers to economic advancement—e.g., people of color, LGBTQ+ people, and women—all of whom Members disproportionately serve and who are more likely than others to have low incomes and qualify for Medicaid coverage.

51. Even those patients who are still able to access care at a Member health center could experience longer wait times and increased costs of health care.

52. I understand that proponents of the Defund Provision have argued that there will not be a reduction in access to reproductive health care because services will be available through community health centers or other publicly funded health care providers, such as federally qualified health centers. But it is clear that other health centers will not fill the gaps left by the closure and reduced capacity of Planned Parenthood Member health centers.[21]

53. Many existing publicly funded health care providers, such as public health departments, do not provide the services that Planned Parenthood Members provide, and certainly do not provide the full range of high-quality services for lower-income patients with minimal wait times, convenient hours, and access for people with limited English proficiency. Moreover, these providers are stretched to their capacity now, and cannot serve the more than one million people who will no longer be able to obtain care at Planned Parenthood Member health centers as a result of the Defund Provision. Nor do such providers offer the nonjudgmental, welcoming, culturally-sensitive, and compassionate care that Planned Parenthood Members provide their patients.

[21] Guttmacher Inst., *supra* note 3.

54. The Defund Provision will have a dramatic and devastating impact on PPFA Members' ability to provide necessary and often life-saving health care to their patients throughout the country, especially their most vulnerable patients who are in need of affordable, high-quality health care. Moreover, in many cases the Defund Provision will also require Members to reduce hours at their health centers or close some health centers altogether—with serious adverse consequences for the many patients served there, Medicaid and non-Medicaid alike.

55. Of the nearly 600 Planned Parenthood Member health centers, a substantial number could be at risk of closing if the Defund Provision is allowed to remain in effect, many of which are located in Medically Underserved Areas, primary care Health Professional Shortage Areas, or rural areas. At minimum it creates grave instability at a time when as many as 17 million people could lose access to Medicaid or other health insurance.[22]

56. The Defund Provision would be particularly devastating to patients in Medically Underserved Areas, many of whom would likely not be able to obtain health care from alternative providers in their communities. Even those who are fortunate enough to be able to obtain care from an alternative provider will likely face delays in care, as other providers scramble to serve the more than one million Planned Parenthood Members' patients who may have to go elsewhere for health care. Delays and gaps in the care that Planned Parenthood Members provide are particularly devastating, as they can lead to undetected STIs, undetected cancers, complications in pregnancies, missed use of contraception, and other serious health conditions.

57. Due to the demographics of Planned Parenthood Members' patient populations, barring Members from receiving federal Medicaid reimbursements would have a disproportionate

[22] Cynthia Cox, *About 17 Million More People Could be Uninsured due to the Big Beautiful Bill and Other Policy Changes*, KFF (July 1, 2025), https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/.

adverse impact on communities of color. Such communities already face barriers to quality health care that would only increase if Planned Parenthood Member health centers—many of which are one of the only providers in communities where they are located—were forced to close or reduce services.

58. The Defund Provision comes on the heels of the Trump administration's ending of Title X funding for many Planned Parenthood Members. Title X is a federally funded family-planning grant program that enables grantees to provide certain family planning services to low-income patients based on a sliding fee scale. Title X services include some, but not all, of the reproductive health care services that are available under Medicaid, and the criteria for eligibility to receive services under Title X are different from those under Medicaid. Several Planned Parenthood Members received more than 15% of their health services revenue from Title X until recently. Without Title X funds to fill some of the coverage gaps for patients with low incomes caused by the Defund Provision, the impacts will be even greater than if just one revenue stream had been cut.

59. The Defund Provision will harm PPFA's mission of ensuring access to comprehensive sexual and reproductive health care for all individuals, regardless of their ability to pay. Although PPFA does not directly operate health centers, all of its Members do, and—at minimum—they will be forced to reduce services to their patients as a result of being excluded from receiving federal funds under Medicaid. That injury to PPFA's Members also harms PPFA's mission, and PPFA will suffer substantial reputational and operational injury if the Defund Provision is not enjoined.

A. Harm to Certain Planned Parenthood Members

60. In addition to the harms to Planned Parenthood League of Massachusetts, Planned Parenthood Association of Utah, and the Planned Parenthood Members in California, all Planned

Parenthood Members enrolled in Medicaid will suffer revenue losses as a result of the Defund Provision, and their Medicaid patients may not be able to access services at a Member health center.

61. Eight Members will lose between 25 and 49% of their revenue as a result of the Defund Provision. For example, in the federal fiscal year 2023, Planned Parenthood of Wisconsin ("PPWI") received 49% of its total revenue—$17.6 million—from Medicaid. In the 2024 federal fiscal year, Medicaid patients made more than 35,000 visits to PPWI, representing more than half of the total visits at PPWI that year. The Guttmacher Institute estimates that publicly-supported clinics in Wisconsin would have to more than double their caseloads to meet the needs of patients currently served by PPWI.[23] Furthermore, 21% of Medicaid beneficiaries who received family planning services in Wisconsin went to PPWI.[24]

62. An additional ten Members will lose between 15 and 24% of their total revenue, and eleven Members will lose less than 15% of their total revenue because of the Defunding Provision.

63. Based on my understanding of the definition of in the Defund Provision, ten Members who are enrolled in Medicaid do not independently meet the definition of "prohibited entity" because they do not provide abortions, did not receive more than $800,000 in Medicaid reimbursements for federal fiscal year 2023, or both. Three of these Members (Planned Parenthood Gulf Coast, Planned Parenthood Greater Texas, and Planned Parenthood of Tennessee and North Mississippi) do not provide abortions because it is not legal in any state where their health centers are located. Other Members, including Plaintiff Planned Parenthood Association of Utah, received less than $800,000 in Medicaid reimbursements in federal fiscal year 2023.

[23] Guttmacher Inst., *supra* note 3.

[24] Frederiksen et al., *supra* note 2.

64. For example, in federal fiscal year 2023, Planned Parenthood of Delaware ("PPDE") received approximately $273,000 in Medicaid funding, or 6% of its total revenue. In 2024, roughly 20% of PPDE patients were enrolled in Medicaid or Medicare.[25]

B. The Experiences in States That Have Excluded Planned Parenthood Members from Medicaid or Other Government Health Care Programs Preview the Dire Harms to Come.

65. Multiple states have weaponized their animus towards Planned Parenthood and excluded Members from their Medicaid programs or from other publicly-funded health care programs—to the detriment of their own citizens. This state-level defunding has shown how harmful the exclusion of Planned Parenthood Members from Medicaid actually is—painting a dangerous picture of what will happen if the Defund Provision is not enjoined.

66. For example, beginning in 2011, Texas lawmakers took steps to remove Planned Parenthood Members in the state from receiving state and federal funds to provide health care. In 2011, Texas cut $73 million from a joint federal-state family planning program, through which Planned Parenthood Member health centers served more than 40% of participants.[26]

67. In 2012, Texas tried to block patients from getting care at Planned Parenthood Member health centers and other abortion providers in its federally-funded Medicaid family planning program—Women's Health Program ("WHP")—while still retaining federal funding for that program. After this attempt was blocked by the Obama administration in 2013, Texas

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[25] Planned Parenthood of Del., *2024 Annual Report* (May 12, 2025), https://www.plannedparenthood.org/uploads/filer_public/b8/99/b8997f4e-0f93-4be5-aff7-26657e808b2f/2024_annual_report_final.pdf.

[26] Planned Parenthood Fed'n of Am., *The Harm of Defunding Planned Parenthood Health Centers* (Apr. 2025), https://www.plannedparenthood.org/uploads/filer_public/60/22/6022aa2f-caed-4946-966f-7186b9751e3c/defunding_state_cases_20_pdf.pdf?. Texas targeted Planned Parenthood by targeting "providers 'affiliated' with clinics that perform abortions. (By this logic, because some Planned Parenthood clinics provide abortions, none of them can receive state money.)." Emily Ramshaw, *Lawmakers Could Restore Family Planning Funds*, Tex. Trib. (Dec. 7, 2012, 6:00 AM), https://www.texastribune.org/2012/12/07/lawmakers-could-restore-family-planning-funds/.

lawmakers instead opted to forego federal funding altogether for the state's family planning program and were thus able to block WHP enrollees from getting care at Planned Parenthood Member health centers and from other abortion providers in the state.[27]

68. In 2020, the Trump administration approved federal funding for a new version of WHP called Healthy Texas Women ("HTW") and allowed Texas to continue excluding Planned Parenthood Members from the program. And in 2021, Texas blocked Medicaid enrollees from getting care at Planned Parenthood Member health centers by terminating all three Members in Texas from the state Medicaid program.[28]

69. All of these actions led to worse health outcomes for Texans, including less access to contraceptive care, STI testing, and cancer screening, as well as the closure of Member health centers.[29] Whereas 90% of HTW enrollees were able to access care in 2011 when Planned Parenthood Members were still in the program, that number dropped to 59% in 2023.[30] Birth control use also declined by 56% during that same period.[31]

70. Politicized attacks on Planned Parenthood Members in other states have also harmed patients. In 2017, Iowa, like Texas, ended its federally-funded Medicaid family planning waiver program, replacing it with a state-funded program that prevented Medicaid enrollees from

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[27] Planned Parenthood Fed'n of Am., *supra* note 26. Like the 2011 action, the 2012 action targeted clinics "affiliated with abortion providers." Alana Rocha, *Judge's Order Allows Planned Parenthood to Remain in Women's Health Program*, Tex. Trib. (Oct. 26, 2012, 2 PM), https://www.texastribune.org/2012/10/26/planned-parenthood-suing-over-affiliate-ban-rule/.

[28] Planned Parenthood Fed'n of Am., *supra* note 26.

[29] *Id*.

[30] *See, e.g.,* Every Texan, *Limited Access: How Provider Exclusion Has Reshaped Care for Texas Women* 1 (May 2025), https://everytexan.org/wp-content/uploads/2025/06/ProviderExclusion_Report_EveryTexan_May2025.pdf.

[31] *Id*.

accessing family planning providers who perform abortions, including Planned Parenthood Members. Four Planned Parenthood Member health centers closed as a result of the defunding.[32]

71. After Indiana enacted a 2011 law that barred Planned Parenthood Member health centers from receiving federal STI prevention funding, five Member health centers were forced to close, including one in Scott County. By 2015, Scott County had an unprecedented HIV outbreak, leading then-Governor Mike Pence to declare a public health emergency.[33]

72. When Kansas blocked non-profit family planning centers, including Planned Parenthood Member health centers, from receiving Title X funds in 2011, more than 14,000 people lost access to birth control, cancer screenings, STI tests, annual pelvic exams, and other care. As a result of the cuts, one Member health center in Hays, Kansas was forced to close, leaving the area without a dedicated family planning provider.[34]

73. In 2011, Tennessee diverted Title X funds from a Planned Parenthood Member in Shelby County—an area that ranks especially high in unintended teen pregnancies—to a faith-based entity that did not have the same capacity to see patients. By 2012, family planning services provided to women in Shelby County had dropped by 93%.[35]

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[32] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g.,* Michaela Ramm, *Iowa's Family Planning Service Use Plummets 85 Percent After Switch to New Program*, Gazette (Dec. 10, 2019, 5:31 PM), https://www.thegazette.com/health-care-medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

[33] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g., Indiana Governor Declares Public Health Emergency to Battle Worst HIV Outbreak in State History*, ABC News (Mar. 26, 2015, 10:28 AM), https://abcnews.go.com/Health/indiana-hit-worst-hiv-outbreak-state-history/story?id=29921662.

[34] Planned Parenthood Fed'n of Am., *supra* note 26; *see, e.g.,* Roxana Hegeman, *Feds Push Back on States Targeting Planned Parenthood Funds*, Associated Press (Sept. 24, 2016), https://apnews.com/domestic-news-domestic-news-general-news-03c09aa8420a4bce98a413449129d2f8 ("The number of Kansans who received Title X services fell from 38,461 in 2011 to 24,047 in 2015 — a decrease of more than 37 percent, according to HHS.").

[35] Planned Parenthood Fed'n of Am., *supra* note 26; *see also, e.g.,* Tara Culp-Ressler, *Defunding Planned Parenthood Caused Women's Services to Drop by 93 Percent in Tennessee County*,

VI. THE DEFUND PROVISION WILL ALSO HAVE DIRE IMPACTS ON ABORTION ACCESS OUTSIDE THE MEDICAID PROGRAM.

74. As providers of a comprehensive range of sexual and reproductive health care, Planned Parenthood Members offer safe and legal abortion services in states where abortion is legal. Planned Parenthood Members collectively provide approximately 40% of all of the abortions performed in the United States. Providing abortion is critical to PPFA's and its Members' mission of ensuring access to sexual and reproductive health care, including abortion.

75. PPFA and its Members, along with national, state, and local Planned Parenthood 501(c)(4) social welfare organizations, have long been at the forefront of the movement for sexual and reproductive rights, including access to abortion. As the nation's leading advocates for sexual and reproductive health care and education, Planned Parenthood organizations advocate at the federal, state, and local levels to protect and expand access to services and information. Before Congress, PPFA has pushed to codify the rights to abortion and contraception, block abortion bans, and repeal the Hyde Amendment.[36] PPFA has also advocated for access to emergency contraception and medication abortion.[37] Planned Parenthood Members, and when appropriate

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Think Progress (Sept. 6, 2012, 6:46 PM), https://archive.thinkprogress.org/defunding-planned-parenthood-caused-womens-services-to-drop-by-93-percent-in-tennessee-county-bc0562be7a7f/.

[36] Planned Parenthood Fed'n of Am., *Tell the Senate: Vote YES on the Women's Health Protection Act*, https://www.plannedparenthood.org/get-involved/campaigns/congress-protect-safe-legal-abortion (last visited July 5, 2025); Planned Parenthood Fed'n of Am., *House Passes Right to Contraception Bill, Critical Step in Protecting Essential Right* (July 21, 2022), https://www.plannedparenthood.org/about-us/newsroom/press-releases/house-passes-right-to-contraception-bill-critical-step-in-protecting-essential-right; Planned Parenthood Fed'n of Am., *Planned Parenthood President on 45th Anniversary of the Hyde Amendment* (Sept. 30, 2021), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-president-on-45th-anniversary-of-the-hyde-amendment; Planned Parenthood Fed'n of Am., *Planned Parenthood Denounces House Committee Passage of National 20-Week Abortion Ban* (Jan. 30, 2014), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-denounces-house-committee-passage-national-20-week-abortion-ban.

[37] Planned Parenthood Fed'n of Am., *Planned Parenthood Applauds FDA Expansion of Access to Over-The-Counter Emergency Contraception* (Nov. 6, 2014), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-applauds-fda-expansion-of-access-to-over-the-counter-emergency-contraception; Planned Parenthood Fed'n of Am., *FDA Reaffirms*

PPFA, are active litigants fighting to secure abortion access and rights for their patients in federal and state courts across the country. Planned Parenthood Action Fund, a related 501(c)(4) organization, advocates for policies that protect care for Planned Parenthood Member patients and seeks to hold members of Congress accountable to their constituents through its congressional scorecard, communicating with and activating constituents to educate their lawmakers about the importance of sexual and reproductive health care.[38] Planned Parenthood Members and their related 501(c)(4) organizations play similar roles, respectively, in advocating for sexual and reproductive rights in states across the nation. Additionally, together with Members' related 501(c)(4) organizations, Planned Parenthood Action Fund has actively supported successful campaigns for reproductive freedom ballot initiatives since the Supreme Court's ruling in *Dobbs*. Separately, Planned Parenthood Action Fund and other national and local Planned Parenthood advocacy and political organizations, work to elect federal, state, and local elected officials who will support reproductive freedom and access to abortion.

76. As explained above, Medicaid does not cover abortion (except under narrow circumstances authorized by federal law) and accordingly, Members do not receive any federal funds for providing these abortions.

77. Many Planned Parenthood Member health centers primarily provide contraception, physical exams, STI testing and treatment, gender-affirming hormone therapy, and cancer screenings but also provide abortions. Although Planned Parenthood Member health clinics provide abortion through separate funding streams and entirely outside the federally-subsidized

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Safety of Mifepristone, Approves New Label for Medication Abortion (Mar. 30, 2016), https://www.plannedparenthood.org/about-us/newsroom/press-releases/fda-reaffirms-safety-of-mifepristone-approves-new-label-for-medication-abortion.

[38] Planned Parenthood Action Fund, *Congressional Scorecard*, https://www.plannedparenthoodaction.org/congressional-scorecard (last visited July 5, 2025).

Medicaid program, the closure of clinics because of the Defund Provision will also impact the various non-Medicaid services Planned Parenthood Members offer, including abortion—since a clinic that no longer exists obviously cannot provide any services at all. Thus, the Defund Provision will force Planned Parenthood Members to provide fewer abortion services in states where abortion is legal because they will have to close health centers and reduce staff.

78. If Planned Parenthood Members were to stop performing abortions, people across the Nation would face drastic hardship in obtaining safe and high-quality abortion care. There is no way that the remaining abortion providers in this country could find the capacity to meet the need for abortion services no longer met by Planned Parenthood Members. Moreover, discontinuing of abortion services would be inconsistent with the core mission of Members and PPFA to ensure access to sexual and reproductive health care, including abortion, for all.

79. Cutting off access to abortion puts pregnant people at risk and strips people of their rights to build their families and futures as they see fit. When abortion is not accessible, women and children suffer the most. States with more abortion restrictions tend to have poorer health outcomes for women and children than other states, including higher rates of maternal and infant mortality.[39] According to a recent study, after *Dobbs*, mothers living in a state that banned abortion were three times more likely to die during pregnancy, childbirth, or soon after giving birth.[40] Patients who are unable to access a wanted abortion are more likely to receive public assistance

[39] *See* Ibis Reprod. Health & Ctr. for Reprod. Rights, *Evaluating Priorities: Measuring Women's and Children's Health and Well-being Against Abortion Restrictions in the States* 23 (2017), https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf.

[40] Gender Equity Pol'y Inst., *The State of Reproductive Health in the United States* (Jan. 19, 2023), https://thegepi.org/wp-content/uploads/2024/05/GEPI-State-of-Repro-Health-Report-US.pdf.

and lack full-time employment six months after being unable to obtain an abortion.[41] These economic consequences impact individuals, their families, and their communities for years to come. Furthermore, in states with laws impeding access to abortion or limiting the number of abortion clinics, both women and men have a decreased likelihood of transitioning from unemployment to employment.[42] In contrast, when given access to abortion, women's health outcomes and economic security improve. Women living in states with policies that support women's access to health care have higher earnings and are more integrated into the workforce than women in other states.[43]

80. This abortion care crisis is made worse by the fact that nineteen states have an abortion ban in effect.[44] As a result, health centers across these states have shuttered, making it more difficult for patients to access a variety of other health care, including preventative health services. In 2024, 155,000 people traveled out of their home state for abortion care.[45] The closure of additional Planned Parenthood Member health centers as a result of the Defund Provision will

[41] Diane Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018).

[42] Kate Bahn et al., *Linking Reproductive Health Care Access to Labor Market Opportunities for Women*, Ctr. for Am. Progress (Nov. 21, 2017), https://www.americanprogress.org/issues/women/reports/2017/11/21/442653/linking-reproductive-health-care-access-labor-market-opportunities-women/.

[43] *Id*. *See also* Asha Banerjee, The Economics of Abortion Bans, Econ. Pol'y Inst. (Jan. 18, 2023), https://www.epi.org/publication/economics-of-abortion-bans/ ("While the effect of abortion denial is overwhelmingly negative economically, mentally, and physically, there is also strong evidence for the flip side of this argument: that access to abortion is associated with positive economic outcomes, including lower rates of teen births and teen marriages").

[44] KFF, *Abortion in the United States Dashboard* (June 2, 2025), https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard.

[45] Guttmacher Inst., *Guttmacher Institute Releases Data on State of Residence of US Abortion Patients Traveling for Care in 2024* (June 24, 2025), https://www.guttmacher.org/news-release/2025/guttmacher-institute-releases-data-state-residence-us-abortion-patients-traveling.

only make it harder for patients to access abortion in states where it is legal, as well as other health services.

81. As discussed above, defunding Planned Parenthood Members from Medicaid puts a substantial number of Planned Parenthood Member health centers at risk of closure. The vast majority of the health centers at risk of closure are in states where abortion is legal. An overwhelming majority of the Planned Parenthood Member health centers at risk of closure provide abortion care, meaning it will be much harder to get an abortion, in addition to other sexual and reproductive health care.

VII. INJUNCTION BOND

82. PPFA, a not-for-profit organization, is not capable of posting a bond in the amount of the federal funds that its Members receive in Medicaid reimbursements. If PPFA were required to post an injunction bond in such an amount, it would be foreclosed from pursuing judicial relief on behalf of its Members.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 6, 2025.

Kimberly Custer

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No. _____

DECLARATION OF DOMINIQUE LEE
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

1. I am currently employed by Planned Parenthood League of Massachusetts ("PPLM") as President and Chief Executive Officer. PPLM is a not-for-profit corporation registered to do business in Massachusetts. I have served in this role since September of 2023. I have also served at other Planned Parenthood affiliates, including as Chief Operating Officer of Planned Parenthood Mar Monte, which operates thirty-five health centers in California and Nevada and is the largest affiliate in the nation. In that role, I led enterprise-wide implementation of telehealth services across thirty-five health centers, serving more than 250,000 patients annually.

This system-wide rollout ensured the continuation of care during the COVID-19 pandemic and required rapidly adapting clinical operations to shifting public health guidance, patient needs, and regulatory requirements to preserve access to essential reproductive and primary health services. I have nearly twenty years of experience in sexual and reproductive health care, including direct oversight of clinical operations, regulatory compliance, and access to abortion and contraceptive services. I have led responses to rapidly changing landscapes, including state restrictions, funding threats, and operational challenges across multiple states. My work has included ensuring continuity of care under emergency conditions, navigating Medicaid and commercial payer systems, and advising on operational implications of federal and state policy changes. I hold a Master of Business Administration from Northwestern, Kellogg School of Management, as well as a Master of Public Health from Dartmouth College, where I currently serve as an Adjunct Lecturer in the Institute for Health Policy and Clinical Practice.

2. In my role as PPLM's President and Chief Executive Officer, I am responsible for PPLM's management. As such, I am familiar with the types of care we provide, patient demographics, operations, and staff needs and concerns. I lead PPLM's executive team, interface with its Board of Directors, and am responsible for a wide array of operational and strategic decisions.

3. I am over the age of eighteen and have personal knowledge of the matters herein or have acquired such knowledge by personally examining the business records kept in the normal course of business by PPLM. If called upon to testify, I could and would testify to the facts in this declaration.

4. As I explain below, Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (the "Defund Provision") will cause immediate and irreparable harm

to PPLM and the patients it serves—including and especially people with low incomes who lack alternative access to expert, reliable reproductive health care. If PPLM remains prohibited from receiving federal Medicaid reimbursements, its health centers' operations will be immediately and potentially irrevocably upended and our patient relationships threatened as we face losing 40% of our gross operating revenue. PPLM and its patients are already experiencing harm in the few days since the Defund Provision has gone into effect. When Section 71113 went into effect on July 4, we immediately began preparing for the impact this would have when our health centers opened on Monday. We have nearly 150 scheduled appointments for Medicaid patients across our health centers on July 7 and July 8 alone, and have been reaching out to inform these patients they cannot use their Medicaid coverage for services at PPLM. We are discussing options with patients to try to ensure their access to care, but we know that many patients cannot afford to self-pay for their care and will not be able to get timely, high-quality care at another provider that accepts Medicaid. PPLM has already had to disrupt and reorganize dozens of workflows that direct, among other things, patient intake, general patient communication, and billing. We have translated new communications materials and worked with community partners to shore up referral systems–all while trying to reassure our staff that they will still have jobs next week.

5. PPLM clinics in recent years have served a significant portion of patients who seek reproductive healthcare from publicly funded clinics in Massachusetts, including 54% of Massachusetts patients that received family planning services through Medicaid. Because alternative providers in the State are already significantly overstretched, PPLM's ejection from the Medicaid program will have seriously adverse public health consequences for the State as a whole,

including a precipitous rise in unwanted pregnancies, sexually transmitted infections ("STIs"), and abortions.[1]

6. Furthermore, unless an injunction is quickly granted, the Defund Provision will likely have a significant effect on PPLM's financial viability. While the exact financial impact is still being assessed, early estimates indicate that the Defund Provision will jeopardize 35–40% of our annual health care revenue. This could force PPLM to make substantial reductions to services, programs, and staffing, potentially up to 20–25%, and may ultimately put our health centers at risk of closure. We have determined that these reductions will need to start within three months absent injunctive relief.

I. ORGANIZATION

7. PPLM is a nonprofit corporation organized under the laws of the Commonwealth of Massachusetts, with its principal office located in Boston, Massachusetts.

8. PPLM is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. Each of its clinics is an essential community provider, 45 C.F.R. § 156.235, that is primarily engaged in family planning services, reproductive health, and related medical care.

9. PPLM's mission is to ensure that every person in the State has access to sexual and reproductive health care and education no matter who they are, where they live, or who they love. Our work is informed by research, powered by advocacy, and conducted with compassion and respect. For ninety-four years, PPLM has been the leading provider of high-quality, comprehensive, compassionate, safe, and confidential family planning, reproductive health care,

[1] Usha Ranji et al., *5 Key Facts About Medicaid and Family Planning*, KFF (May 29, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-family-planning/#:~:text=The%20Medicaid%20program%20has%20a,for%20other%20health%20care%20services.

and education for all people in Massachusetts. PPLM's staff and network of clinics work to ensure that families and communities have the resources they need to achieve positive reproductive health outcomes, regardless of their ability to pay for services.

10. PPLM is an independently incorporated entity with its own CEO, Board of Directors, and management. PPLM has its own infrastructure and approximately 200 staff members manage the day-to-day operations of our health centers and educational services. As the premier provider of sexual and reproductive health care in Massachusetts, PPLM implements operational and advocacy strategies to meet the reproductive health needs in the state. This includes PPLM's ASPIRE Center for Sexual And Reproductive Health which engages in clinical and social science research, professional education, and clinical training independently and in partnership with academic institutions in Massachusetts, and teaching hospitals, especially in the greater Boston area.

11. In order to better serve its mission, PPLM also is a member of Planned Parenthood Federation of America, Inc. ("PPFA"). PPLM pays annual dues to PPFA to maintain its membership status. As a member of PPFA, PPLM receives the right to use the Planned Parenthood name and service mark and to participate in programs organized by PPFA. PPLM's membership in PPFA helps to serve PPLM's core mission. PPFA lends valuable advice and technical support in areas including clinical research, compliance with the medical standards and guidelines, revenue management, development, public affairs, communications, and advocacy. In addition, because only providers who meet PPFA's stringent accreditation standards are permitted to use the Planned Parenthood name, patients know that they can trust Planned Parenthood members for expert, nonjudgmental care.

II. PPLM'S ROLE IN PROMOTING PUBLIC HEALTH

12. PPLM provides a range of sexual, reproductive, and wellness care at its four physical health centers in Boston (the Greater Boston Health Center), Marlborough (The Metro West Health Center), Springfield (the Western Massachusetts Health Center), and Worcester (the Central Massachusetts Health Center), and through its virtual health center that offers telehealth services via phone and video.

13. PPLM's health centers offer birth control, pregnancy testing and prenatal referrals, testing and treatment for STIs, Pre-Exposure Prophylaxis ("PrEP"), Post-Exposure Prophylaxis ("PEP"), clinical breast exams, breast and cervical cancer screenings, colposcopy and biopsy, condyloma treatment, and gender affirming care.

14. PPLM also provides critical health education to its patients, including education about breast and cervical cancer screening, diagnosis, follow-up, and referral to medical specialists in the community. PPLM develops health educational services for the general public as well, offering age-appropriate and medically accurate sexual education programs in public schools and in partnership with community-based organizations that provide guidance and support. Furthermore, by offering peer education and lay health advisor programs, PPLM trains youth and adults to respond to cultural and linguistic barriers that often keep members of their communities from seeking and receiving the health care they need.

15. PPLM delivers health care to more than 30,000 unique patients each year. In 2024 alone, PPLM provided patients with more than 20,500 birth control methods, including nearly 5,000 long-acting reversible contraceptives ("LARCs"), which are the most effective forms of birth control. In that same year, PPLM performed more than 65,000 STI tests, which comprises a substantial portion of the STI tests performed in PPLM's service areas.

16. Three of PPLM's health centers are in communities classified by the federal government as Medical Care Health Professional Shortage Areas ("HPSAs") for individuals with low incomes, and a substantial part of its education services are provided to individuals in communities experiencing significant health disparities.[2] Unlike most family planning providers in its service areas, PPLM's health centers offer early morning, limited evening, and weekend hours. Additionally, we offer walk-in appointments and same-day contraception, including highly effective LARCs—services that are often not offered by other providers in the area—and without the burdensome wait times or multiple visits that are often encountered elsewhere.

17. Because PPLM's health care centers offer same-day and walk-in visits for most services and for urgent care needs, they serve as an alternative to the emergency room for many of their patients. For example, patients come to PPLM's health centers for treatment following miscarriages and for treatment of urinary tract infections. By offering those services, PPLM alleviates the burden on emergency rooms and primary care providers.

18. In addition, PPLM manages an active clinical training program through partnerships with local academic institutions, hospitals, and other organizations. This program includes both clinical observations and hands-on rotations for medical students, residents, fellows, and advanced practice clinicians to train in all of the services PPLM provides. We are also in year three of our ASPIRE Center's sexual and reproductive health residency program for nurse practitioners, physician assistants, and certified nurse midwives. The residency program is based at our Central Massachusetts health center in Worcester and is supported by funding from the Massachusetts Department of Public Health.

[2] HPSAs are designated by the Health Resources and Services Administration ("HRSA"), an agency of the U.S. Department of Health and Human Services ("HHS"), as having shortages of primary medical care, dental, or mental health providers.

19. PPLM also partners with Brigham and Women's Hospital to co-host the MassGeneralBrigham-Harvard Medical School Complex Family Planning Fellowship (MGB-HMS CFP). The MGB-HMS CFP program is a nationwide training program for obstetrician-gynecologists to receive subspecialty clinical training in abortion and contraception care, training in clinical research methods and public health, and exposure to policy and advocacy work. This Fellowship program works to create the next generation of leaders in the research and provision of sexual and reproductive health care, with specific expertise in serving patients with complex issues. Our professional education programs are vital to the provision of sexual and reproductive health care in the state, serving as a pipeline of trained providers to areas in Massachusetts where there is a shortage of sexual and reproductive health care providers, including Springfield and Worcester.

20. In 2024, PPLM referred more than 2,100 patients to other providers for a variety of types of care, including diagnosis and management of chronic diseases including cancer, diabetes, cardiovascular disease, mental health, obstetric and breast specialist care, human immunodeficiency virus ("HIV") care, infertility, and dermatology. Many of those patients initially came to PPLM health care centers for other medical needs, including family planning services, and would likely not have received treatment for their illnesses if not for the PPLM staff, who were able to accurately diagnose their conditions and connect them with appropriate medical professionals.

21. A core part of PPLM's mission is to deliver reproductive health care to individuals with low incomes, including individuals who rely on Medicaid. The vast majority of PPLM's patients are economically disadvantaged and come from at-risk communities. Two of PPLM's four clinics—the Greater Boston and Central Massachusetts Health Centers—are in communities

classified as Medically Underserved Areas, which are areas designated by HHS as having major shortages in primary health service providers relative to the health care needs of the community. As noted above, Worcester, where the Central Massachusetts Health Center is located, and Springfield, where the Western Massachusetts Health Center is located, are both designated by HHS as primary care HPSAs.

22. In patient surveys, PPLM is consistently highly ranked as a leading provider of sexual and reproductive health care. Specifically, our Medicaid patients have scored PPLM an average of 93/100 in overall patient experience, overall access, and convenience of our hours. They have also scored our care providers an average of 95/100 and 96/100 when asked if the services they were offered met their needs. In particular, patients often report that they choose PPLM because of the confidential and nonjudgmental care we provide. Many patients come to PPLM out of concern that their local or family provider may judge them or fail to respect their privacy.

23. The Commonwealth of Massachusetts is in great need of the services PPLM provides. According to the last comprehensive study published in 2020 by the Guttmacher Institute, the nation's leading research organization regarding reproductive health care, there are 1,498,680 women of reproductive age (13–44) in Massachusetts, of which 947,850 are in need of contraceptive services and supplies.[3] Of those, 332,670 women need publicly supported contraceptive services, because they either have an income below 250% of the Federal Poverty Level (68%) or are younger than 20 years of age (32%). In Massachusetts, 34% of all pregnancies

[3] Blades N et al., *Publicly Supported Family Planning Services in the United States, 2020—Tables and Appendix Tables*, Guttmacher Inst. (May 2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020tables-and-appendix-tables.pdf.

are unintended, indicating an ongoing and urgent need for accessible family planning and reproductive health services.[4]

24. Based on 2022 data from Massachusetts Department of Public Health, the birth rate for female youth aged 15–19 is 5.7 per 1,000.[5] The need for PPLM's services is particularly acute in Worcester, Springfield, and Marlborough, where the birth rates (per 1000) of female youth aged 15–19 are 9.5, 19.8, and 16.3 respectively.[6] Further, for youth under the age of 18 in Worcester and Springfield 27.8% and 23.5% (respectively) received inadequate prenatal care, based on the Adequacy of Prenatal Care Utilization Index.[7]

25. Between 2021 to 2023, the state rates of chlamydia, gonorrhea, and HIV increased, and there was only a slight decrease in confirmed and probable infectious syphilis cases.[8] In areas such as Hampden County, the rates for chlamydia, gonorrhea, and early syphilis (per 100,000 people) all surpassed the state rates.[9] County data collected from 2012 to 2022 demonstrated that in the counties of Hampden, Worcester, and Middlesex there was an overall increase in chlamydia,

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[4] Kathryn Kost et al., *Pregnancies and Pregnancy Desires at the State Level: Estimates for 2017 and Trends Since 2012*, Guttmacher Inst. (Sept. 2021), https://data.guttmacher.org/states/table?topics=191&dataset=data&state=MA.

[5] Registry of Vital Recs. & Stats., Mass. Dep't of Pub. Health, *Massachusetts Births 2022*, at 17 (Nov. 2024), https://www.mass.gov/doc/2022-birth-report/download.

[6] *Id.* at 16, 29.

[7] *Id.* at 24, 30.

[8] Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *2023 Massachusetts Integrated HIV, STI, and Viral Hepatitis Surveillance Report* (Dec. 2024), https://www.mass.gov/doc/2020-integrated-hivaids-std-and-viralhepatitis-report/download; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Surveillance Data Overview of Sexually Transmitted Infections, Massachusetts, 2000-2023* (Mar. 2024), https://www.mass.gov/doc/surveillance-data-overview-of-sexually-transmitted-infections-massachusetts-2000-2023-slide-set/download.

[9] Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Hampden County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary- for-hampden-county-2022/download.

gonorrhea, and early syphilis.[10] Yet, while the need for reproductive health services in Western Massachusetts and the Worcester area is significant, the availability of those services there is sparse.

26. As part of its commitment to ensuring that all people have access to comprehensive reproductive health care, three of PPLM's clinics—the Greater Boston Health Center, the Central Massachusetts Health Center, and the Western Massachusetts Health Center—provide abortion services to patients who choose to terminate a pregnancy. PPLM's Western Massachusetts Health Center in Springfield and the Central Massachusetts Health Center in Worcester provide over 90% of abortion care in their regions. Without those clinics, many patients in Massachusetts would have no access to an abortion provider. As federal law requires, no federal funds under the Medicaid program are used to reimburse PPLM for the cost of providing those abortion services (except under the very limited circumstances permitted by federal law).

27. PPLM is dedicated to ensuring that every person should have equitable access to abortion—without shame, stigma, or delay—because sexual and reproductive health is essential to every person's overall health, well-being, and happiness. PPLM was one of the first health care organizations in Massachusetts to offer medication abortion through telehealth. And while abortion remains legal and protected in Massachusetts, PPLM continues to advocate for improved access to abortion, especially in regions with limited abortion providers, such as southeastern Massachusetts. In 2024, PPLM established referral partnerships with eleven public colleges to ensure students have accurate information and access to abortion services.

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[10] *Id.*; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Worcester County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary-for-worcester-county-2022/download; Bureau of Infectious Disease & Lab'y Scis., Mass. Dep't of Pub. Health, *Summary for Middlesex County, Massachusetts, 2022* (2022), https://www.mass.gov/doc/summary-for-middlesex-county- 2022/download.

28. Further, PPLM contributes to expanding abortion access through our groundbreaking social science and clinical research. Added in 2016, our social science research program employs rigorous methodologies to identify and disrupt barriers to and inequities in care. For the past two decades, our clinical research arm has been steadfast in its commitment to actively pushing patient care forward and expanding access to abortion and contraception through the conduct of high-quality, award-winning clinical research that directly addresses the needs of our patients. By approaching research questions from these different perspectives and using a variety of methodologies, we have been able to broaden the impact of our research program on the field of sexual and reproductive health.

III. SERIOUS ADVERSE CONSEQUENCES OF THE DEFUND PROVISION

29. It is my understanding that PPLM is a "prohibited entity" under the Defund Provision because, among other things, PPLM received $4,744,699.47 in Medicaid payments during fiscal year 2023. Prohibiting PPLM from receiving Medicaid reimbursement will have dire consequences for PPLM and its patients.

30. In 2024, PPLM provided services to approximately 10,822 patients who were enrolled in Medicaid—nearly 35% of PPLM's patient base. In 2024, PPLM received a significant portion of its patient revenue (approximately 39%) from Medicaid reimbursements.

31. In 2024 alone, PPLM provided, through Medicaid, more than 5,237 units of contraception (including 1,255 LARCs), 242 cervical screenings, 257 breast cancer exams, and 21,463 STI tests (yielding over 500 positive results that would have otherwise gone undiagnosed).

32. It is my understanding that, as a direct result of the Defund Provision, PPLM will be prohibited from receiving federal Medicaid reimbursement for any of the health care services it provides.

33. Medicaid provides free or very low-cost health coverage for eligible families and individuals with low incomes. It is a joint federal-State program under which the federal government provides financial assistance to participating States to help them furnish care to needy persons. A State is not required to participate, but once it does, it must comply with a range of federal statutes and regulations.

34. Health care providers are not required to accept Medicaid, and many providers do not participate in the Medicaid program or strictly limit the number of Medicaid patients they will treat. For those participating health care providers, like PPLM, Medicaid works by reimbursement: specifically, the program reimburses PPLM for providing covered services to enrolled Medicaid patients. So, for example, a patient with Medicaid coverage will come to a PPLM clinic for preventive care. That patient receives birth control, an STI test, a Pap smear, or other Medicaid-covered care—likely at no cost. The PPLM clinic then submits to Medicaid a reimbursement claim for the services it provided.

35. With the Defund Provision in effect, patients are no longer able to receive health care services through the Medicaid program at PPLM clinics. On July 7 and 8 alone, 148 of PPLM's booked appointments across our health centers are for Medicaid patients. These Medicaid patients, who are close to or below the federal poverty level, are unlikely to be able to afford fees for the services they require, and PPLM clinics cannot afford to provide those services free of charge.

36. Some of PPLM's Medicaid patients who will no longer be able to obtain health care at PPLM clinics may try to find some services at Federally Qualified Health Centers ("FQHCs") or community health centers. Those safety net providers, however, generally do not specialize in reproductive health, and thus do not offer the full range of high-quality services provided by PPLM. Additionally, many FQHCs cannot offer the same immediate availability that PPLM offers.

37. Given the volume of Medicaid patients PPLM's health centers serve, even if alternative providers were theoretically available, they could not take on the dramatic influx of patients who would lose service at PPLM. In addition, as discussed above, many health care centers cap the number of Medicaid patients they see, and many private physicians see few, if any, Medicaid patients.

38. Many of PPLM's patients will therefore be unable to find another provider or will face such lengthy wait times that they will be forced to forgo services. In the greater Boston area, in particular, patients face some of the highest wait times to see a family medicine provider (an average wait time of sixty-nine days) or gynecologist (an average wait time of eighty-four days).[11] For patients waiting to see a provider, this will increase their risk of unintended pregnancy, STIs (both to themselves and their sexual partners), and undetected cancer.

39. Even those patients who can find another provider will suffer significant harm from losing access to their provider of choice, with whom they already have an established relationship. Patients covered through Medicaid choose PPLM health centers as their health care provider over other providers for numerous reasons—including PPLM's accessibility, commitment to evidence-

[11] AMN Healthcare, *2025 Survey of Physician Appointment Wait Times and Medicare and Healthcare Technology Medicaid Acceptance Rates*, http://online.flippingbook.com /view/83050962/ (last visited July 5, 2025).

based practices, use of leading-edge technology, wide range of reproductive health services and contraception options, and compassionate care. Moreover, as noted above, many patients who receive some health services elsewhere nonetheless choose PPLM for their reproductive health care because they are concerned about their privacy and fear of being judged by other providers. These essential aspects of treatment will be lost, even if a Medicaid patient can find a new provider.

40. With the Defund Provision in effect, there will be serious consequences for PPLM's ability to continue operating its health centers and provide the care our patients rely on. While we are still evaluating the full scope of the impact, early projections suggest we may need to reduce overall costs by 20–25%, which could include scaling back both health care services and staff. We may also be forced to make significant reductions to PPLM's educational and advocacy programs. These are difficult possibilities that we are expending resources to actively plan for as we assess all available options to preserve access to care.

41. While PPLM would try to preserve as many of its services and health care centers for as long as possible by reducing hours and staff, that is unlikely to provide a long-term solution. Without any access to federal Medicaid funding, within one year, we likely would have to close at least one health center. Based on current projections, PPLM currently anticipates that the Marlborough Health Center would have to close within about twelve months after losing Medicaid funds. Even then, that closure may still be insufficient to cover the revenue shortfall caused by the loss of Medicaid funds. Ultimately, even PPLM's remaining clinics would be forced to lay off additional staff and reduce operational hours, including the reduction or elimination of weekend clinic hours.

42. Closing the Marlborough Health Center would lead to almost 3,500 patients losing their reproductive health care provider of choice. Alternative providers in these areas are already

overstretched, with some having wait times of more than a week for even basic but essential services like oral birth control. The closure of PPLM clinics in these areas would overwhelm the capacity of these alternative providers, which are too small to provide services to thousands of new patients.

IV. INJUNCTION BOND

43. PPLM, a nonprofit organization, would be incapable of posting a bond in the amount of the federal funds it receives without severely curtailing its services and compromising its organizational mission. If PPLM were required to post an injunction bond, it would be foreclosed from pursuing judicial relief.

I declare under penalty of perjury that the foregoing is true and correct. Executed on July 7, 2025.

_____	July 7, 2025
Dominique Lee	Date

EXHIBIT 3

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS; and PLANNED PARENTHOOD ASSOCIATION OF UTAH, Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; MEHMET OZ, in his official capacity as ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; and CENTERS FOR MEDICARE & MEDICAID SERVICES, Defendants.	Case No.

DECLARATION OF JENNA TOSH
IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Jenna Tosh, PhD, declare and state as follows:

1. I am the President and CEO for Planned Parenthood California Central Coast ("PPCCC"), a Planned Parenthood Federation of America ("PPFA") member with health care centers in Santa Barbara, Ventura, and San Luis Obispo counties in California. I am also the Chair of the Board of California Planned Parenthood Education Fund ("CPPEF"), the statewide entity

that represents the seven separately incorporated, independent Planned Parenthood members providing comprehensive sexual and reproductive health care services in the State of California (collectively, the "Planned Parenthood Members").

2. This declaration is based on my personal knowledge, a review of data and studies compiled by CPPEF, a review of CPPEF's business records, and the knowledge obtained in the course of my twenty years of service at Planned Parenthood entities. Statements about the other California Planned Parenthood Members I make are based on information I have received from them in connection with my role at CPPEF. If called and sworn as a witness, I could and would testify competently to the information in this declaration.

3. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction, which seeks to prevent the implementation of Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("PP Defund" or "Section 71113"), which prohibits federal Medicaid funding from being used for payments for services provided by Planned Parenthood Members' health care in California's Medicaid program ("Medi-Cal"). I am familiar with the PP Defund provision.

4. As explained more fully below, the PP Defund will have devastating consequences for Planned Parenthood Members in California and their health centers, as well as Californians who rely on them for comprehensive sexual and reproductive health and family planning care. Over 80% of patients who visit Planned Parenthood Members' health centers in California rely on Medi-Cal for access to health care. Planned Parenthood Members' health centers serve over 25,000 patients every week in California, including one in four California women of reproductive age who need publicly funded family planning services.[1]

[1] Nakeisha Blades et al., *Publicly Supported Family Planning Services in the United States, 2020:*

5. The PP Defund abruptly cuts off payments for all services Planned Parenthood Members' health centers provide to patients in Medi-Cal programs, including the State's family planning services program, the Family Planning, Access, Care, and Treatment ("Family PACT") Program, for a period of one year. This sudden loss of revenue has led to uncertainty around the continued ability of Planned Parenthood Members' health centers to serve the 25,000 patients a week that rely on them for care.

6. As a result of the PP Defund, the seven California Planned Parenthood Members anticipate they will need to close health centers, drastically cut their health centers' hours and days of operation, reduce their workforces, and scale back the services they provide. Unless a temporary restraining order is granted, the California Members will need to scale their health care services back immediately. This means every patient who relies on Planned Parenthood Members' health centers in California will have more difficulty accessing services including family planning, screening and treatment for sexually transmitted infections ("STIs"), and cancer screenings. In the Medi-Cal provider network, Californians will find it especially difficult to access sexual and reproductive health care services and education throughout the State, and patients from California and those who come from out of state will have fewer options to receive care. Every day that this continues, CPPEF's seven Planned Parenthood Members and their patients are irreparably harmed.

I. EMPLOYMENT AND EDUCATION BACKGROUND

7. I received my Bachelor of Arts in Political Science from the University of Florida, magna cum laude, in 2004. I then earned my Master's in Political Science from the University of

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Tables and Appendix Tables, Guttmacher Inst. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf; Cal. Dep't of Health Care Servs., *Family Pact Program Report*, https://familypact.org/wp-content/uploads/2023/05/FPACT-Program-Report-FY19-20.pdf (last visited July 5, 2025).

Central Florida in 2008. I did my thesis on "Sex Education Policy in Florida: Strategies for Change," which earned an award for Outstanding Political Science Master's Thesis. In 2015, I earned my PhD in Public Affairs, on the Governance and Policy Research Track, from the University of Central Florida. My dissertation was titled: "State Adolescent Health Policies and their Impact on Teen Pregnancy Outcomes."

8. I began my career as a Family Case Manager for Kids Hope United then moved to Planned Parenthood of Greater Orlando, where I served as the Director of Education and Advocacy from 2006 to 2009. In 2012, I was appointed President and CEO of Planned Parenthood of Greater Orlando. I served in that capacity until becoming President and CEO of PPCCC in February 2015.

9. PPCCC is the Planned Parenthood member with health centers in Santa Barbara, Ventura, and San Luis Obispo counties. It provides approximately 64,000 patient visits annually over three counties with six health center locations.

10. As the President and CEO of PPCCC, I serve on the board of directors of CPPEF along with the CEOs of the other California members. As of July 1, 2025, I am the chair of the CPPEF Board of Directors, a position I served previously in 2017 to 2019. In my role as CPPEF's Board Chair, I work closely with the CPPEF President and CEO to help shape policy advocacy and provide support at the statewide level on behalf of the seven separately incorporated Planned Parenthood Members operating health centers in California.

II. ORGANIZATION MISSION AND STRUCTURE

11. CPPEF is a California not-for-profit organization that provides statewide policy analysis, advocacy, and legal support to its members and works alongside government agencies, coalition partners, and stakeholders on issues related to access to comprehensive sexual and reproductive health, health care operations, and equitable access to quality health care for all

Californians, especially for people who have low incomes or who are from underserved communities.

12. CPPEF's mission is to ensure that all individuals have the freedom to make reproductive decisions and, for people to make healthy decisions, they should have access to comprehensive information and services related to sexuality, reproduction, methods of contraception, fertility control, and parenthood.

13. CPPEF is a membership organization consisting of the seven California Planned Parenthood Members. Each CPPEF member is a separately incorporated, independent non-profit organization, with its own Chief Executive Officer, Board of Directors, management, and staff. Each member provides health care and educational services in a distinct geographic region throughout California. The seven members are: PPCCC, Planned Parenthood Northern California ("PPNorCal"); Planned Parenthood Mar Monte ("PPMM"); Planned Parenthood Los Angeles ("PPLA"); Planned Parenthood Pasadena and San Gabriel Valley ("PPPSGV"); Planned Parenthood Orange and San Bernardino Counties ("PPOSBC"); and Planned Parenthood Pacific Southwest ("PPPSW").

14. While CPPEF is dedicated to ensuring access to comprehensive sexual and reproductive health care services in California, CPPEF itself does not provide medical services. Medical services are provided by CPPEF's seven California members through the 114 health centers they independently operate throughout the State, collectively providing over 1.3 million patient visits each year to patients from all 58 counties in California as well as from other states.

15. CPPEF and its member Planned Parenthood organizations are also members of Planned Parenthood Federation of America, Inc. ("PPFA").

III. PLANNED PARENTHOOD IN CALIFORNIA

16. The seven California Planned Parenthood Members independently operate 114 health centers across the State, providing over 1.3 million patient visits annually. Collectively, they are among California's largest providers of sexual and reproductive health care and sexual education.

17. The seven California Planned Parenthood Members' health center locations span from the northwest corner of the State in Eureka to the southeast corner in El Centro near the U.S.-Mexico border almost 900 miles away. These health centers are intentionally located in underserved areas, near public transportation to facilitate access for patients who rely on public transit, and in other locations where there are shortages of adequate health care resources to meet patient needs. Health centers can be found in the major metropolitan areas of Los Angeles, San Diego, San Jose, San Francisco, Oakland, and Sacramento, along California's more rural Central Coast, and throughout the State's Central Valley. There are also a number of health centers in other, more rural parts of the State, such as Antelope Valley, Victorville, Ukiah, and Redding. A true and correct copy of a map showing the location of the health centers throughout the State of California is attached as Exhibit A.

18. California Planned Parenthood Members' health centers offer a range of sexual and reproductive health care services, including the provision of birth control, including emergency contraception; testing and treatment of STIs; pregnancy testing and services; breast and cervical cancer screenings; gender-affirming care; and abortion. Some also provide primary care services. Others provide behavioral health and prenatal care services. All seven California Planned Parenthood Members provide health care services in person and via telehealth.

19. Last year, California's Planned Parenthood Members' health centers provided care to roughly 700,000 individual patients, including almost 100,000 telehealth visits. The primary

services provided during those visits included: 2.6 million tests for STIs; over 500,000 visits for contraception, including emergency contraception; almost 500,000 pregnancy tests; nearly 100,000 cancer screenings; and pre-exposure prophylaxis ("PrEP") and post-exposure prophylaxis ("PEP"), two HIV-related medications, to more than 6,000 patients.

20. The services we provide are critical to the health and well-being of our patients. Our work to screen and immunize against human papillomavirus ("HPV"), and treat pre-cancerous cervical lesions undoubtedly reduces the incidence of cervical cancer for our patients, but nonetheless, we do sometimes need to make the diagnosis. For example, last month, a PPPSGV physician diagnosed two patients with cervical cancer. The first patient presented for intrauterine device ("IUD") removal had been seen in a local emergency room due to abdominal pain, where they said they could not remove the IUD because strings were not seen and treated for a presumed pelvic infection. The patient had a large cervical mass pushing into her abdomen causing significant pain. She had sought care through multiple health providers without receiving the diagnosis. The second patient had been seen regularly by PPPSGV for cervical cell abnormalities. Monitoring closely, the PPPSGV provider was able to diagnose cancerous cells at an early stage, increasing the patient's likelihood of survival greatly. Both patients had Medi-Cal, and PPPSGV was able to connect them directly to cancer doctors once the diagnoses were made.

21. Planned Parenthood Members often diagnose patients with ectopic pregnancy, a life-threatening condition, and are often able to get them the emergency treatment they need. For example, recently, one member's health center identified an ectopic pregnancy on an ultrasound at the visit and immediately referred the patient, who was seven weeks pregnant, to Los Angeles General. She had a salpingostomy (fallopian tube-sparing surgery) before the tube ruptured.

22. As another example, two months ago, a member's health center saw a patient who

was six weeks pregnant. No pregnancy was seen in the uterus on the ultrasound. The Planned Parenthood provider drew human chorionic gonadotropin ("hCG") (a pregnancy hormone) levels, and the patient was referred the next day for evaluation at the emergency department. She was able to get Methotrexate treatment (an injection to treat ectopic pregnancy) rather than surgery due to the early diagnosis.

23. In addition, all seven California Planned Parenthood Members offer education and counseling on sexual and reproductive health, reaching nearly 100,000 Californians every year.

24. Planned Parenthood Members' health centers primarily serve patients who have low incomes and rely on Medi-Cal programs to access health care services. Approximately 90% of patients who come to Planned Parenthood Members' health centers in California have incomes that are below 200% of the federal poverty line ("FPL") ($31,300 for one person in 2025)[2] and over 80% are under the age of 35. Three out of four patients identify as people of color.

25. Patients come to Planned Parenthood Members' health centers because they know they can receive high-quality, patient-centered, confidential, compassionate, and nonjudgemental care regardless of their ability to pay. California's Planned Parenthood Members have longstanding, deeply rooted relationships in the communities they serve, and work to provide culturally-appropriate care to meet the needs of California's diverse population. For example, PPNorCal came into existence in 1929, and PPPSGV in 1933. PPCCC, PPPSW, PPLA, and PPOSBC have served their communities since the 1960's.

26. Many patients also choose to receive care at Planned Parenthood Members' health

[2] U.S. Dep't of Health & Hum. Servs., Off. of the Assistant Sec'y for Plan. & Evaluation, *2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)*, https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf (last visited July 5, 2025).

centers because they are often able to see a clinician, receive care and counseling (including relevant labs and other testing), and obtain medications or supplies at one location, without having to travel to a separate lab testing facility or pharmacy. This allows patients to receive sensitive medical services confidentially and efficiently, saving time, money, and resources that would be required to arrange for childcare or to take additional time off from work or school. At Planned Parenthood Members' health centers, patients can receive help with State coverage program enrollment, be tested for STIs and then receive results and treatment if necessary, receive birth control counseling, and obtain any needed services, referrals, and medications in one visit at one location. California's Planned Parenthood Members also operate several health centers that have extended hours, including weekend hours, and provide services to accommodate patients who have inflexible work schedules, childcare, or other unique scheduling challenges.

27. The seven California Planned Parenthood Members implement programs and policies to address the unique and diverse needs of the communities they serve, including survivors of trauma and assault, people with disabilities, people with physical, mental, or social challenges, migrant workers, and people who are unhoused.

28. For example, a patient with a history of significant trauma sought an IUD as a birth control method. The patient desired sedation for the insertion because of their past trauma and came to a PPOSBC health center after their regular primary care doctor refused any type of sedation. PPOSBC was able to see the patient the next day and make sure that the patient could receive the birth control method of their choice in a manner that addressed their circumstances—ensuring that the patient felt safe and supported during the medical procedure.

29. Planned Parenthood Members' health centers in the State serve many patients who speak languages other than English. Access to care with a trusted provider is crucial for these

patients, who are more likely to have lower incomes, poorer health, and experience discrimination in the health care system. All Planned Parenthood Members' health centers in California offer language access services to address the needs of California's diverse population, including multilingual staff in many of their locations to meet the specific needs of the patient population in their communities, and telephone or video access to translators in over 200 languages.

30. For example, at PPCCC, the member where I serve as the President and CEO, we have a health center that serves a large indigenous farmworker population from Mexico. Many in that community speak the indigenous language of their region. They face many challenges related to poverty and lack of access to health care. Recently, a patient came in for a pregnancy test who did not speak English or Spanish. Our interpreter working in that health center was able to speak to her in her indigenous language. During the visit, the patient reported that she had been sexually assaulted and was pregnant as a result. She was extremely scared and was not sure she would be able to come back for another visit. We were able to do rapid testing to determine whether she had acquired an STI, provided an abortion, and inserted an IUD. The patient told our clinicians that they had helped her more than anybody else, particularly since they were able to provide all these services during one visit.

IV. PLANNED PARENTHOOD'S PARTICIPATION IN THE CALIFORNIA MEDICAID PROGRAM

31. Medi-Cal covers almost 15 million Californians—over a third of the State's population. Most Medi-Cal enrollees are covered through a state contract with a managed care plan. For beneficiaries who access care through a managed care plan, sexual and reproductive health care services, including for family planning and abortion, are available both in- and out-of-network as sensitive services.[3]

[3] Medi-Cal Providers, *Client Eligibility* 19, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/

32. Of those covered by Medi-Cal, 36.6% are 20 years of age and younger.[4] 34.3% of Medi-Cal enrollees are a part of the ACA expansion adult population with incomes up to 138% of the FPL between the ages of 19–64.[5] The California Department of Health Care Services ("DHCS") manages the State's Medicaid Programs and is responsible for provider enrollment, claims processing, program design, and responding to the public.

33. The Medi-Cal program provides coverage for comprehensive sexual and reproductive health services, covering all health care services required by federal law as well as many federal optional benefits that are eligible for federal matching funds. The State also provides coverage using state-only funds for certain health care services that are not eligible for federal funds, which includes abortion, and for certain populations whose care is not eligible for federal matching funds.

34. The State administers Medi-Cal, subject to federal and state regulations, and cost of care under the program is shared between California and the federal government. The federal medical assistance percentage ("FMAP") is the percentage of costs paid by the federal government to state Medicaid programs, which varies by service type and the enrollee receiving the service. California's FMAP is 50% for most services and enrollees,[6] while certain services and enrollees, including family planning services, are eligible for an FMAP of up to 90%.[7] Current budget

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assets/907504BF-B611-4569-AA2F-AD19852DC99A/clientelig.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (last visited July 5, 2025).

[4] Cal. Dep't of Health Care Servs., *Medi-Cal Monthly Eligible Fast Facts* 9 (May 2025), https://www.dhcs.ca.gov/dataandstats/reports/Documents/Fast-Facts.pdf.

[5] *Id*. at 13.

[6] KFF, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ (last visited July 5, 2025); Social Security Amendments of 1965, Pub. L. No. 89-97 (1965).

[7] Social Security Amendments of 1972, Pub. L. No. 92-603 (1972), https://www.govinfo.gov/content/pkg/STATUTE-86/pdf/STATUTE-86-Pg1329.pdf.

estimates show that federal funds cover around 60% of the total Medi-Cal program expenditures.[8]

35. The Family PACT, or FPACT, Program is a comprehensive family planning services program, part of Medi-Cal, which is funded 77.5% by the federal government. FPACT provides contraceptive and family planning-related services, along with client-centered health education and counseling, at no cost to California's residents of reproductive age with low incomes. Operating since 1997, it is administered by the DHCS, Office of Family Planning (OFP), which is responsible for program policy, program monitoring, quality improvement, and program evaluation. The Family PACT Program is designed to assist individuals who have a medical necessity for family planning services, so that they can establish the timing, number, and spacing of their children, and maintain optimal reproductive health. Family PACT serves over 600,000 income-eligible people of childbearing age.[9]

36. Family PACT patients are California residents of reproductive age who have a family income at or below 200% of the FPL.[10] FPACT patients must have a medical necessity for family planning services and either have no other source of health care coverage for family planning or meet certain criteria for eligibility. Planned Parenthood Members' health centers provide approximately 70% of the health care services that are reimbursed by Family PACT in California.[11]

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[8] Cal. Dep't of Health Care Servs., *Medi-Cal May 2025 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26* (May 2025), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf.

[9] Cal. Dep't of Health Care Servs., *supra* note 1, at 11.

[10] Cal. Dep't of Health Care Servs., *Family Pact: An Overview*, https://familypact.org/wp-content/uploads/2024/04/Family-PACT-Program-Fact-Sheet.pdf (last visited July 5, 2025).

[11] Cal. Dep't of Health Care Servs., *Medi-Cal May 2023 Local Assistance Estimate for Fiscal Years 2022-23 and 2023-24* (May 2023), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2023_May_Estimate/MAY-2023-Medi-Cal-Local-Assistance-Estimate.pdf; Dep't of Health Care Access & Info., *2023 Primary Care Clinic Annual Utilization*

37. All seven of the Planned Parenthood Members offering health care services currently participate in the Medi-Cal program and are enrolled as Family PACT providers. Approximately 54% of the patients seen at Planned Parenthood Members' health centers in California are enrolled in Medi-Cal with an additional 26% enrolled in the Family PACT program. Combined, Medi-Cal and its related programs including Family PACT make up approximately 80% of Planned Parenthood's patient visits.

38. Planned Parenthood Members' health centers are reimbursed by the State of California for eligible patient care through a combination of state and federal funding. Planned Parenthood Members' health centers in California are the backbone of the Medi-Cal program's network of sexual and reproductive health care providers and collectively provide approximately $425 million of services to patients that are covered by Medi-Cal and its related programs annually.[12] Of that, around 77%, or $328 million, is paid using federal funds.[13]

39. Planned Parenthood Members' health centers also assist and support patients who are uninsured and/or need assistance navigating publicly-funded coverage options. Many people turn to Planned Parenthood Members' health centers for care because they do not have health care coverage and have few options to obtain care. Health center staff will often assist patients who may be between jobs, recently lost their job, or simply cannot afford health care, in order to help them navigate what coverage they may be eligible for and help them enroll in coverage.

40. For example, one recent PPPSGV patient discovered that their health care coverage had expired and they were due for their birth control shot the next day. PPPSGV was able to assist

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Data (November 2024), CA.gov (July 5, 2025), https://sandbox.data.ca.gov/dataset/primary-care-clinic
-annual-utilization-data/82f4dc4e-b1fb-4961-b362-6d05534f3781.

[12] Dep't of Health Care Access & Info., *supra* note 11.

[13] Cal. Dep't of Health Care Servs., *supra* note 8.

the patient by helping them enroll in Family PACT.

41. Another patient recently visited a PPNorCal's health center after losing their insurance. The patient needed help accessing prescription medication for their chronic medical conditions. A community health worker at PPNorCal was able to assist the patient with obtaining Medi-Cal coverage, and connect them with clinicians and specialists that accepted Medi-Cal. PPNorCal was able to help their patient navigate a complex health care system and gain access to critical care and services.

42. In another example, PPMM assisted a patient who was working as an agricultural worker, and who was uninsured, to enroll in the Family PACT program, and performed a preventive care visit where the clinician identified concerning findings. PPMM was able to order imaging and diagnostic testing that resulted in a cancer diagnosis. PPMM then facilitated a referral to an oncology provider and supported the patient in enrolling in additional public coverage programs to cover the costs of the treatment.

43. At PPCCC, a patient came to one of our health centers who was uninsured. She had a breast mass that she was worried about. We helped her get funding for the visit and ordered screening, which showed that she had Stage 1 breast cancer. We then helped her make an appointment with a local oncologist and did a warm hand-off, which is known to improve the chances of survival. The patient indicated she had tried to see another Ob-Gyn, but could not afford the visit.

V. EFFECT OF THE PP DEFUND ON PLANNED PARENTHOOD MEMBERS IN CALIFORNIA

44. It is my understanding that the seven separately incorporated Planned Parenthood Members in California that operate the 114 health centers throughout the State are "prohibited entit[ies]" under the PP Defund because they are all 501(c)(3) not-for-profit organizations and

essential community providers, which operate community clinics that primarily engage in family planning and reproductive health, provide abortion, and because each received more than $800,000 in total state and federal Medicaid funding in fiscal year 2023. The PP Defund is in effect. Because Planned Parenthood members in California are now prohibited from receiving federal Medicaid payments, they are unable to submit the vast majority of claims to Medi-Cal as of the time of President Trump's signature on July 4, 2025.

45. If California Planned Parenthood Members remain unable to seek reimbursement for the vast majority of services provided to the more than 25,000 patients their health centers serve every week, they will be forced to close health centers and reduce hours, staff, and services, and Californians will lose vital access to sexual and reproductive health care. Absent a temporary restraining order and preliminary injunction, the California Planned Parenthood Members will have to scale back the health services they offer almost immediately. The PP Defund will not only impact abortion access, but will be devastating for access to family planning and other sexual and reproductive health care, not just for Medi-Cal beneficiaries but for all patients who seek care at Planned Parenthood Members' health centers in California. The PP Defund also threatens access to Planned Parenthood Members' community-based educational services that reach almost 100,000 Californians a year.

46. Even short disruptions in revenue will have drastic impacts to funding because over 80% of Planned Parenthood Members' services in California are provided to Medi-Cal and Family PACT patients. Without reimbursement for those services, California's Planned Parenthood Members will lose approximately two-thirds of their revenue, and health centers will need to close, which is a time-consuming, administratively burdensome, and expensive process. Additionally, this process will likely include termination of leases or selling health center buildings that

Members own. Once a location is closed, it sometimes never reopens. Even if funding resumes and re-opening is possible, it is very difficult, time-consuming and expensive to reopen. New staff would have to be hired and trained, new locations would have to be found to lease, new systems for medical records and billing would have to be installed and implemented, and a multitude of new licenses would have to be obtained. Plus, each Member would need to extensively expand philanthropic fundraising to raise the costs of opening health centers: expenses for insurance, billing and medical record systems, leases and staff will be incurred long before any revenues exist from services provided that could be used to cover those costs. It also takes 6 months, and perhaps longer, to get the licenses and regulatory approvals from the various State agencies to open a health center, and all of that would have to occur before a clinic could open and begin to see patients.

47. Closures of Planned Parenthood health centers will reduce the number of family planning and abortion providers in the Medi-Cal program, leading to longer wait times and more barriers to care. Californians may need to travel significant distances to receive in-person care, which is especially problematic for rural and remote areas of the state where transportation is already a significant barrier to care. For many people who live in California's vast state, patients would have to drive multiple hours for over 200 miles to access the next closest reproductive health clinic. Forcing people to travel long distances to access care results in delays in time-sensitive care, or in care becoming inaccessible.

48. In addition to the impacts on the provision of health care, the PP Defund will have huge economic consequences on the employees who work for the California Planned Parenthood Members and the communities in which their health centers are located. The seven California Planned Parenthood Members employ over 3,000 Californians, including experienced clinicians, support staff, educators, and administrative staff. Planned Parenthood's California Members will

be forced to do large lay-offs, and would need to provide severance, health care coverage for the severance period, and career transition and outplacement services for any staff laid off. The extreme and sudden nature of the PP Defund will make it difficult to adequately prepare for staff transitions and cover the costs of these transition services.

VI. PROVISION OF FAMILY PLANNING AND FAMILY PLANNING-RELATED CARE IN CALIFORNIA

49. Publicly funded family planning clinics, including Planned Parenthood Member health centers, provide essential health care to patients with low incomes, including access to contraception and other family planning services.[14] In 2020, over 2.2 million California women aged 13–44 were in need of publicly funded family planning services.[15] It is critical that providers like Planned Parenthood Members' health centers be able to continue operating; people that have trouble accessing family planning services are more likely to experience an unplanned pregnancy, contract an STI, or suffer other health complications.[16]

50. In California, Planned Parenthood Members' health centers see approximately half of all patients served at a publicly funded clinic for family planning services. Planned Parenthood Members' health centers saw half of the 1.2 million contraceptive clients served by all safety-net family planning centers in 2020 across California.[17]

51. Screening and treatment of STIs is the most cost-effective strategy for reducing adverse reproductive health outcomes, such as pelvic inflammatory disease and infertility, and

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[14] Usha Ranji et al., *Financing Family Planning Services for Low-income Women: The Role of Public Programs*, KFF (Oct. 25, 2019), https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/.
[15] Blades et al., *supra* note 1.
[16] Inst. of Med. of the Nat'l Acads., *Overview of Family Planning in the United States*, *in* A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results (2009).
[17] Guttmacher Inst., *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood* (June 4, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

their associated costs.[18] For many patients, Planned Parenthood Members' health centers are the only health care provider and trusted source for information and services related to STI testing and treatment. Over the past five years, the California Planned Parenthood Members have partnered with state and local public health officials to address the STI epidemic by increasing testing and treatment rates within their communities. In the past year, Planned Parenthood Members' health centers in California have performed over 2.6 million STI tests. Many have implemented rapid testing, which expands testing capacity and enables STI testing and treatment on the same day.

52. In 2020, only 56% of federally qualified health center (FQHC) sites nationwide reported offering contraceptive care to at least 10 women per year.[19] If Planned Parenthood Members are forced to reduce services and hours and close health center locations as a result of the PP Defund, patients will need to identify other publicly funded providers, such as FQHCs, to provide their care. FQHCs, however, are already struggling to meet a rapidly increasing demand for services and will be unable to absorb the patients of Planned Parenthood's Members in California. The California Primary Care Association ("CPCA"), which represents the community clinics in California, has stated that these clinics do not have the capacity to take on the patient volume served by Planned Parenthood Members. CPCA states: "[e]liminating Planned Parenthood from our state's comprehensive network of care would put untenable stress on remaining health centers. We do not have the capacity for such an increase in care and building such capacity would require significant capital investment." A true and correct copy of the CPCA letter dated June 3, 2025, is attached as Exhibit B.

53. For example, PPPSGV has referral relationships with local clinics that have very

[18] *See, e.g.,* Andrea K. Kennedy et al., *Direct and Indirect Cost Savings from STI Testing, Treatment, and Counseling among Foster Youth*, 49 Sexually Transmitted Diseases 86 (2022).
[19] Guttmacher Inst., *supra* note 17.

limited capacity to provide family planning services. In fulfilling this role, PPPSGV's health centers play a critical part in the safety net infrastructure. In addition to providing health care services, PPPSGV has served as a pillar within its community by providing information, education, and outreach to combat disinformation and acted as a hub for vaccine distribution to the most vulnerable.

54. In another example, PPCCC is the only safety-net, comprehensive reproductive health care provider in the State's Santa Barbara, San Luis Obispo, and Ventura counties located in the central coast region of California. Local hospitals and clinics routinely refer patients to PPCCC, especially for abortion, gynecological cancer prevention, and gender-affirming hormone therapy. Currently, the FQHCs refer their patients to PPCCC because the clinics either do not offer the range of services PPCCC provides or because they have a much longer wait time.

55. In fact, Planned Parenthood Members' health centers are much more likely than other clinic types to provide patient-centered options for care, including offering the full range of reversible contraceptive methods, providing same-day care for IUD and implant insertions, on-site dispensing of oral contraceptives, and the provision of contraceptives using telehealth.[20] Compared to other clinic types, Planned Parenthood Members' health centers offer a wider range of contraceptive methods that help patients identify and obtain methods that work best for them.

56. For example, one patient sought care at PPLA after being told by a gynecologist that it would be 5 months before they could schedule an appointment for a contraceptive implant. PPLA was able to offer the patient a same-day appointment.

57. As another example, another patient described how PPPSW staff took the time to

[20] Alicia VandeVusse et al., *Publicly Supported Family Planning Clinics in 2022–2023: Trends in Service Delivery Practices and Protocols*, Guttmacher Inst. (Nov. 2024), https://www.guttmacher.org/report/publicly-supported-family-planning-clinics-2022-2023.

talk to them about all the birth control options so they could consider what would be the best for them. They were able to make a choice about their preferred birth control method feeling equipped with the information they needed to make that decision. As the patient stated, "I'm so grateful that I was able to access care at Planned Parenthood through Medi-Cal—to get tested, get my annual exams, access birth control, and the information I needed to decide what's best for my body."

***

58. In sum, it is my belief that the PP Defund will have a large and devastating impact on Planned Parenthood Members' health centers in California, widen disparities in health care, and threaten access to family planning and abortion services for Californians.

I declare under penalty of perjury that the foregoing is correct and that this declaration is executed on 6th day of July, 2025, in Santa Barbara, California.

Jenna Tosh

Jenna Tosh

7/6/2025

Date

Exhibit A

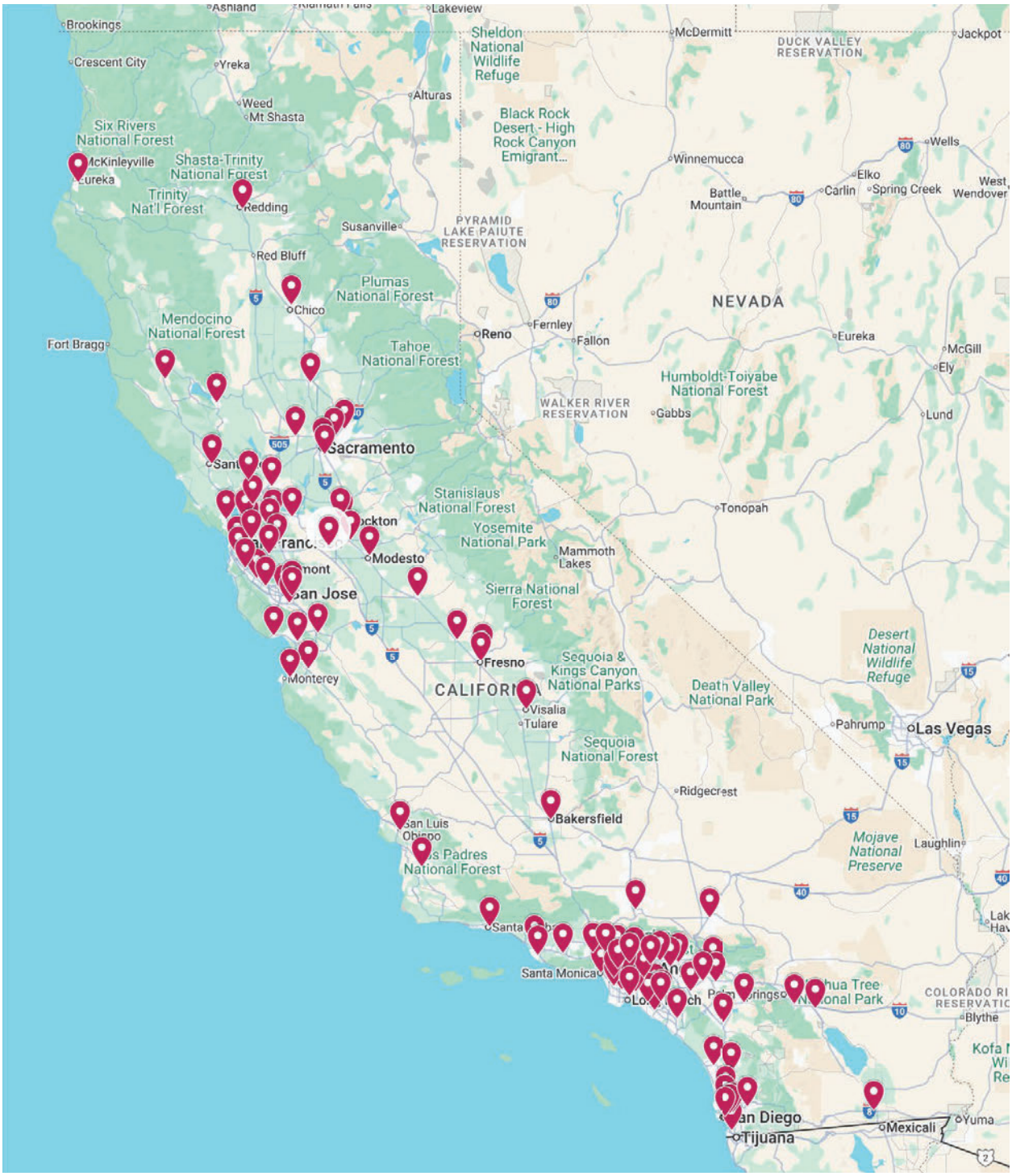

Brookings
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Weed
Mt Shasta
Six Rivers National Forest
McKinleyville
Eureka
Shasta-Trinity National Forest
Trinity Nat'l Forest
Redding
Alturas
Lakeview
Sheldon National Wildlife Refuge
McDermitt
DUCK VALLEY RESERVATION
Jackpot
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Wells
Elko
Carlin
Spring Creek
West Wendover
Battle Mountain
Susanville
PYRAMID LAKE PAIUTE RESERVATION
Red Bluff
Plumas National Forest
Chico
NEVADA
Mendocino National Forest
Fort Bragg
Reno
Fernley
Fallon
Eureka
McGill
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Tahoe National Forest
Humboldt-Toiyabe National Forest
WALKER RIVER RESERVATION
Gabbs
Lund
Sacramento
Stanislaus National Forest
Tonopah
Yosemite National Park
Mammoth Lakes
Modesto
San Jose
Monterey
Sierra National Forest
Fresno
Sequoia & Kings Canyon National Parks
Desert National Wildlife Refuge
Death Valley National Park
Visalia
Tulare
Pahrump
Las Vegas
Sequoia National Forest
Ridgecrest
Bakersfield
San Luis Obispo
Los Padres National Forest
Mojave National Preserve
Laughlin
Santa Monica
COLORADO RIVER RESERVATION
Blythe
San Diego
Tijuana
Mexicali
Yuma

Exhibit B

California Primary Care ASSOCIATION

June 3, 2025

The Honorable Alex Padilla
The Honorable Adam Schiff
United States Senate
331 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Padilla and Senator Schiff,

The California Primary Care Association is aware of provisions in the House-passed Budget Reconciliation Bill that is currently before the Senate that would prohibit federal funding from being used for services provided by Planned Parenthood. In California, this would mean that Medi-Cal patients would lose an important point of access for family planning services, shifting care to federally qualified health centers that will be unable to meet patient needs. This provision has no purpose other than putting a moratorium on Planned Parenthood as a health care provider for ten years and in fact, according to the Congressional Budget Office, will increase the deficit by $300 million.

As the state-wide representatives of community clinics and health centers in California, who annually serve over 7.7 million Medi-Cal patients, we believe this action would negatively impact the health of our community.

Planned Parenthood currently operates 115 health centers in California and serves almost a million patients through 1.3 million total visits annually. Eliminating Planned Parenthood from our state's comprehensive network of care would put untenable stress on remaining health centers. We do not have the capacity for such an increase in care and building such capacity would require significant capital investment.

Moreover, the effort to defund Planned Parenthood would eliminate a patient's ability to choose the provider with which they feel most comfortable. Many patients rely on Planned Parenthood because they know that it is a place where they can get high quality care that is confidential and without judgment. Their reputation as a leading provider of sexual and reproductive health care means that they are the provider of choice to almost a million Californians who seek out a variety of services that include wellness exams, birth control, sexually transmitted infection (STI) testing and treatment, cancer screenings, and other preventive care. In 2024 alone, the Planned Parenthood affiliate health centers in CA conducted over 2.5 million STI tests.

Planned Parenthood is a vital component of the health care system in California and for that reason, we are opposed to any provisions in the budget reconciliation bill that will diminish their capacity to provide care in our state.

Sincerely,

Francisco J. Silva, Esq.
President and CEO
California Primary Care Association

EXHIBIT 4

U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

July 14, 2020

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate

Medicaid: Primer on Financing Arrangements

Dear Mr. Chairman:

Medicaid—a joint, federal-state program that finances health care coverage for low-income and medically needy populations—covered an estimated 76 million individuals at an estimated cost of $668 billion in fiscal year 2019, about $420 billion of which was federal spending. The federal government and states share responsibility for financing Medicaid expenditures. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, generally matches each state's Medicaid expenditures for health care services according to a statutory formula.[1] These expenditures include payments for care provided to Medicaid beneficiaries, such as base payments and supplemental payments to providers. Unlike base payments, which include fee-for-service or capitated payments, supplemental payments are not specifically tied to care for individual enrollees, but may help offset any remaining costs of care for Medicaid enrollees.

Federal law requires that states finance at least 40 percent of their share of total Medicaid expenditures through state funds; within limits, however, they can use other funding sources as well. For example, states can finance their nonfederal share of Medicaid expenditures through funds transferred from local governments, known as intergovernmental transfers; or through local government expenditures, known as certified public expenditures. States can also finance the nonfederal share through taxes levied on providers. States can use these financing arrangements to finance any type of Medicaid expenditure. We found in past work that states rely heavily on local government expenditures and taxes on providers to finance supplemental payments, sometimes in ways that lowered the amount the state contributed to Medicaid expenditures while increasing payments to providers and shifting responsibility for a larger share of the payments to the federal government.[2]

You asked us to provide information describing Medicaid financing arrangements used by states. Enclosure 1 includes a primer on this topic, describing the most common types of financing arrangements used by states to fund their nonfederal shares of Medicaid

[1]The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. For fiscal year 2020, states' federal matching rates range from 50.00 percent to 76.98 percent. The federal government reimburses states for a portion of their expenditures based on each state's match rate.

[2]See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627 (Washington, D.C.: July 29, 2014).

expenditures. The primer provides examples of how these financing arrangements can shift the magnitude or share of these expenditures to local governments, providers, and the federal government.

To describe the financing arrangements, we reviewed related GAO reports and other research published since 2012 that examined the arrangements commonly used by states.[3] We also reviewed relevant federal laws, regulations, and guidance. Using that information, we produced illustrations of the financing arrangements and described their implications.

We conducted this performance audit from September 2019 to July 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Agency comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this correspondence. Other key contributors to this correspondence included Tom Conahan (Assistant Director), Jasleen Modi (Analyst-in-Charge), Drew Long, Kimberly Perrault, Vikki Porter, Ethiene Salgado-Rodriguez, and Emily Wilson.

Sincerely yours,



Carolyn L. Yocom
Director, Health Care

Enclosure(s) – 1

[3]We reviewed research by Medicaid and CHIP Payment and Access Commission, Congressional Research Services, and Kaiser Family Foundation.

Enclosure I: Medicaid: Primer on Financing Arrangements

Why this matters

This primer provides information on Medicaid financing, identifying and illustrating examples of the most common types of permissible arrangements states have used to fund their Medicaid programs. We have found that in some cases, by using certain types of payments and sources of spending, states can lower the amount they contribute to total Medicaid expenditures. We have also found that, in certain cases, states can increase the magnitude or share of federal Medicaid expenditures. Understanding these arrangements and their implications for federal spending, particularly when the payments may not be economical or efficient, is important to recognizing the risks these financing arrangements can pose to the Medicaid program.

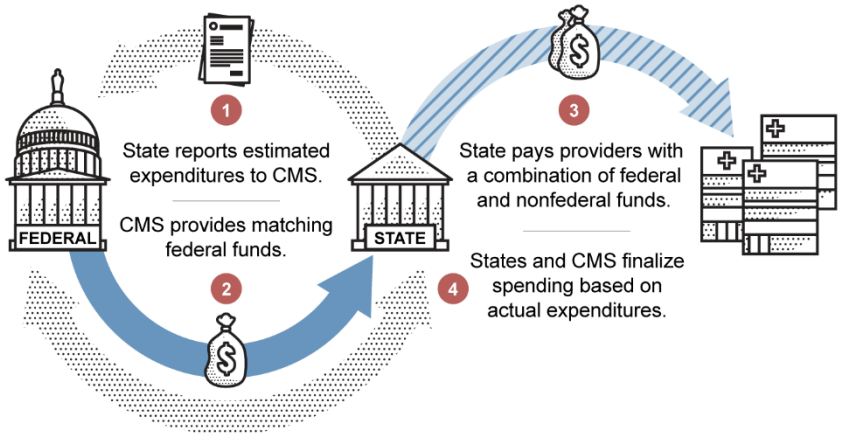
Background

The federal government generally matches each state's Medicaid expenditures for services according to a formula calculated annually. Under this formula, the federal government pays a percentage share of Medicaid expenditures; the remainder is referred to as the nonfederal share. For fiscal year 2020, states' federal matching rates range from 50.00 to 76.98 percent. [1]

States' Use of Federal Matching Funds. To receive federal matching funds, states estimate their quarterly Medicaid expenditures beforehand and report these estimates to the Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid. CMS provides federal matching funds based on states' estimates. States use these federal matching funds to make Medicaid payments to providers. (See fig. 1.)

[1]The formula is designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average. The range of federal matching rates for 2020 does not include the temporary additional 6.2 percentage point increase in federal matching provided under the Families First Coronavirus Response Act.

Figure 1: Federal Review and Matching of Estimated State Medicaid Expenditures



Source: GAO. | GAO-20-571R

Subsequently, states report actual expenditures to CMS, which reviews and reconciles states' actual expenditures and federal funds to ensure the federal government matches only actual state expenditures.

State Medicaid agencies make two primary types of payments—base payments and supplemental payments—and both can qualify for federal matching funds.

- **Base payments** are payments to providers or organizations for specific services provided to Medicaid enrollees through fee-for-service and managed care.[2]
- **Supplemental payments** are typically lump sum payments to providers that are not tied to care for individual enrollees, but may help offset remaining costs of care for Medicaid enrollees.

Under federal law, in order to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy and efficiency and sufficient to ensure access to and quality of care; and (3) must not exceed the Medicaid upper payment limit, which is a reasonable estimate of what Medicare would pay for comparable services.[3]

Federal law requires that states finance at least 40 percent of the nonfederal share of total Medicaid expenditures through state funds, which can include appropriations from state general funds and health care provider taxes levied by the state.[4] States can finance the remaining 60 percent of the

[2]Managed care organizations, which can vary in structure, are responsible for providing services to enrollees in return for a periodic payment per enrollee.

[3]Medicare is the federal health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. The upper payment limit is not applied to payments to individual providers; instead, it applies on an aggregate basis to all providers rendering specific services within an ownership class, such as state government-owned or -operated facilities that provide inpatient services.

[4]Providers can also donate funds, subject to federal requirements, to the state to finance Medicaid payments; however, donations are rarely used to finance the nonfederal share of Medicaid payments. We reported in 2014 that provider donations constituted less than 0.1 percent of the nonfederal share of Medicaid payments. See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data*

nonfederal share of Medicaid through funds transferred from local governments, known as intergovernmental transfers; or through local government expenditures, known as certified public expenditures. The limit on the percentage of the nonfederal share that may be financed by local governments is applied on the basis of total annual Medicaid program spending and not on individual payments or types of payments.

This primer illustrates the following financing arrangements:[5]

- State general funds
- State provider taxes
- Intergovernmental transfers
- Certified public expenditures.

Collection, GAO-14-627 (Washington, D.C.: July 29, 2014).

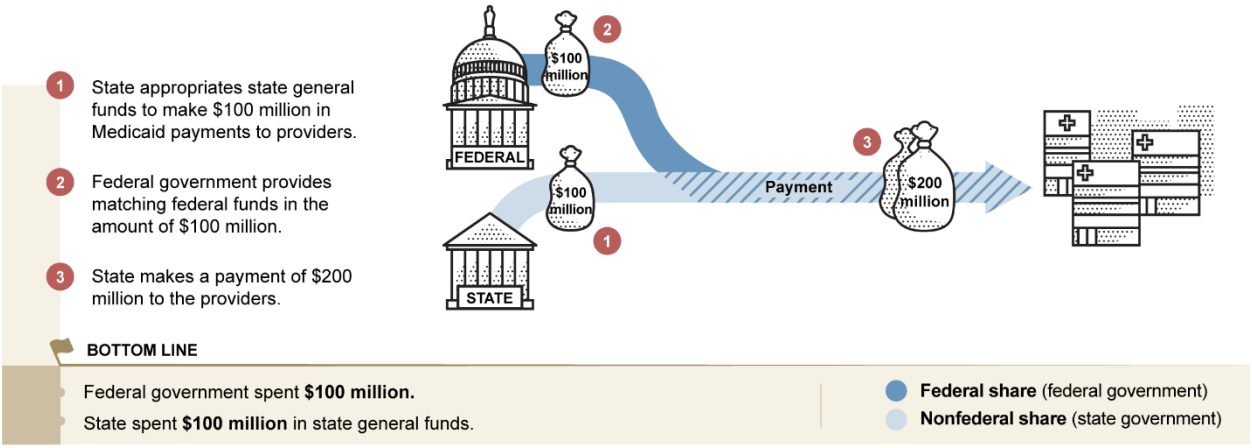
[5]In November 2019, CMS proposed regulations that, if finalized, could affect some of the arrangements we describe in this primer. See 84 Fed. Reg. 63,722 (Nov. 18, 2019).

State General Funds

States finance the nonfederal share of their Medicaid expenditures, in large part, through state general funds. State general funds can include intra-agency funds, whereby other state agencies receiving state appropriations—for example, state mental health agencies—can supply funds to finance the nonfederal share of the Medicaid services they provide. In 2014, we reported that state general funds accounted for 62.9 percent of the nonfederal share of Medicaid expenditures in 2012.[6]

In the following figure, the state and federal government are each responsible for a share of a $200 million Medicaid payment. In this arrangement, the state finances the nonfederal share using state general funds. The illustration assumes a 50 percent federal matching rate, in which case the federal share will consist of funds amounting to half of the total payment. In this scenario, providers receive a Medicaid payment that includes contributions from the federal government and state general funds. (See fig. 2.)

Figure 2: Example of a State Medicaid Payment Financed Using State General Funds and Federal Matching Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

Using this example, the state and federal government are responsible for an equal share of the net payment—the payment received by the provider minus any funds contributed by the provider. This arrangement does not shift costs to the federal government, as changes in state general fund spending would result in corresponding changes in federal spending per the federal match.

[6]See GAO-14-627.

State Provider Taxes

States can use funds raised through provider taxes to finance the nonfederal share of their Medicaid payments.[7] States may tax a wide range of health care services, and providers may be subject to more than one tax during a year.[8] Under federal requirements, taxes must be broad-based—i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state—and uniform (e.g., the tax is the same amount for all providers furnishing the services within the same category).[9] States may not hold providers harmless (—e.g., provide a direct or indirect guarantee that providers will receive all or a portion of their tax payments back). In a 2014 report, we found that provider taxes made up 10.4 percent of the nonfederal share of Medicaid payments in 2012.[10] In some cases, the nonfederal share of a particular payment may be paid entirely through the provider taxes, and the federal government matches payments made with these funds.

In the following figure, the state and federal government are each responsible for a share of a $200 million Medicaid payment to providers. In this arrangement, the state imposes taxes on all providers to finance the nonfederal share of the payment to some providers. The illustration also assumes a 50 percent federal matching rate, in which case the federal share will consist of funds amounting to half of the total payment. In this scenario, providers may receive a payment if they deliver Medicaid services or qualify for supplemental payments. (See fig. 3.)

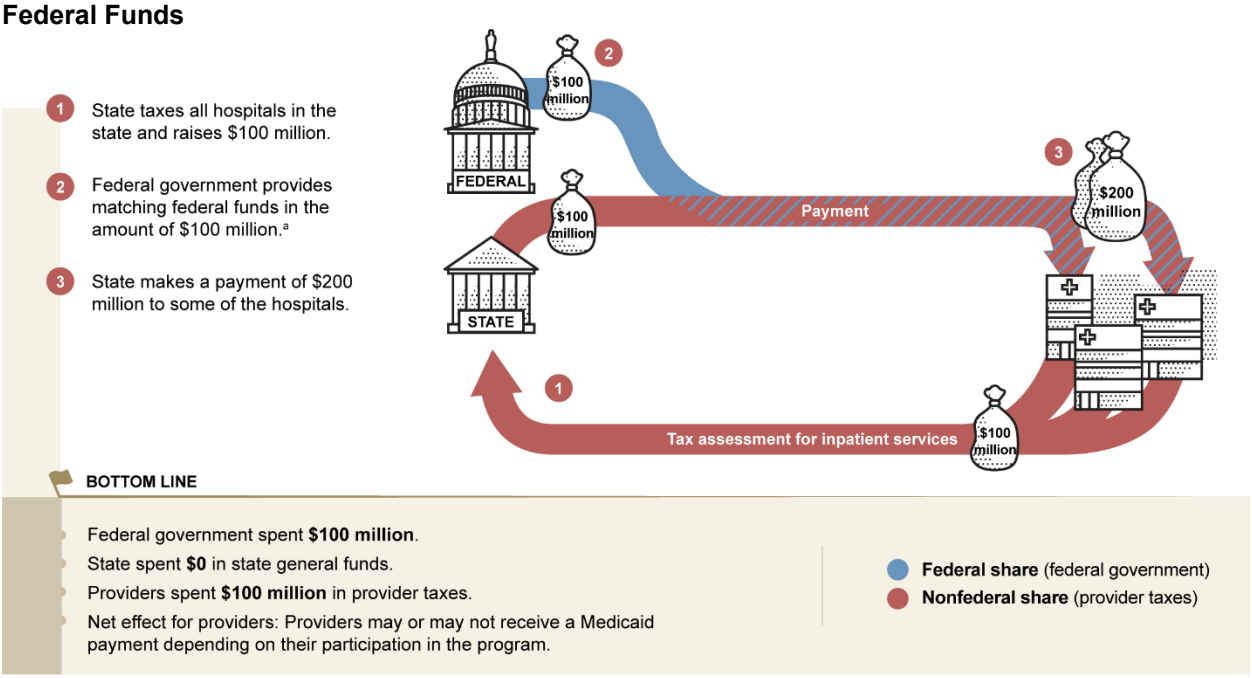
[7]State-imposed provider taxes constitute state funds for purposes of satisfying the requirement that states finance at least 40 percent of the nonfederal share of Medicaid expenditures with state funds. For the purposes of our report, we discuss provider taxes separately.

[8]Local governments may also impose health care provider taxes or receive provider donations that may be used for the nonfederal share if they are in compliance with federal requirements.

[9]States may seek CMS approval of a waiver of either the broad-based or uniformly imposed requirements. CMS may waive these requirements only if the net impact of the tax is generally redistributive and not directly correlated with Medicaid payments to the providers subject to the tax.

[10]See GAO-14-627.

Figure 3: Example of a State Medicaid Payment Financed Using State Provider Tax Revenue and Federal Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

The use of provider taxes to finance the nonfederal share of a state's Medicaid expenditures has financial implications for the providers, state, and the federal government.

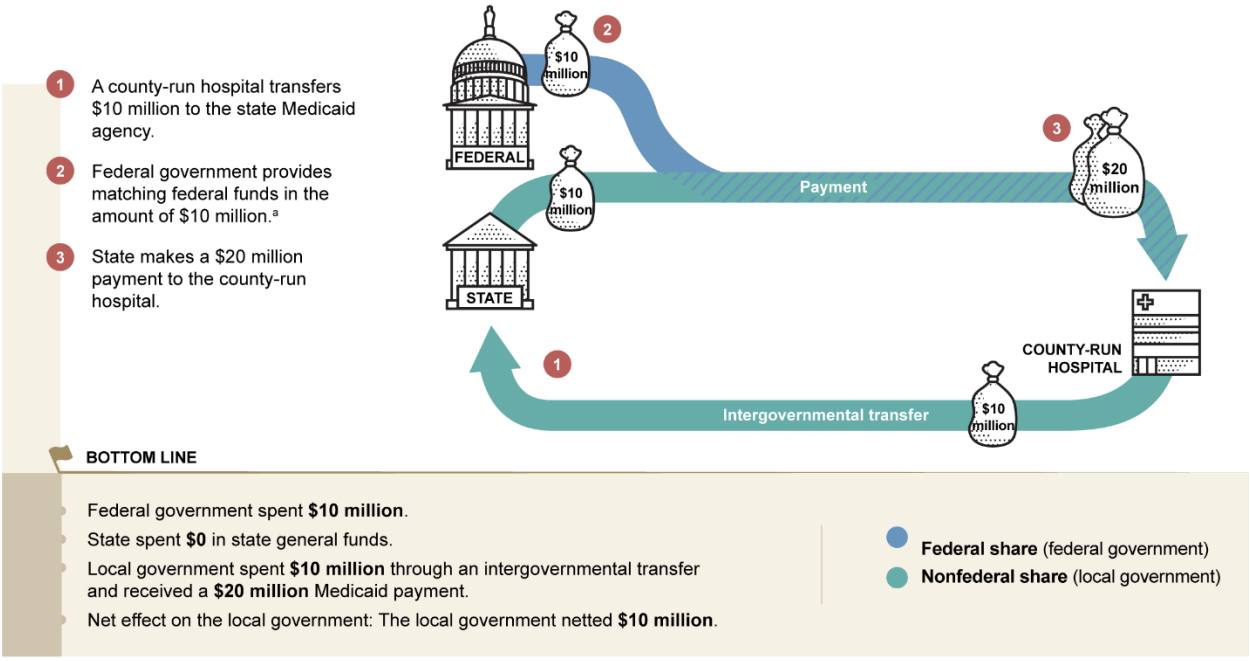
- The effects on the providers vary based on the extent to which they participate in the Medicaid program. For example, if provider taxes are used to finance a supplemental payment—which is not tied to care for individual enrollees—some providers could receive Medicaid payments that total more than the amount they were taxed, while others could be taxed and not receive any Medicaid payments.
- Additionally, a state can lower its own contribution to Medicaid spending if it imposes a provider tax to fund Medicaid payments previously funded by state general funds. In that situation, to the extent that the state replaces its contribution to Medicaid spending with provider tax revenues that return funds to some of the providers, the net payment to the providers is reduced and a greater share of the net payment to the providers would be financed by the federal government.

Intergovernmental Transfers

Intergovernmental transfers (IGTs) are transfers of funds from local governments, including providers owned or operated by local governments (e.g., county-run hospitals or nursing homes), to the state Medicaid agency to finance the nonfederal share of Medicaid payments.[11] In a 2014 report, we found that intergovernmental transfers made up 10.1 percent of the nonfederal share of Medicaid payments in 2012.[12] In some cases, a state's nonfederal share may be paid entirely through an IGT, and the federal government matches this transfer at the applicable matching rate.

In the following figure, the state and federal government are each responsible for a share of a $20 million Medicaid payment. In the example, the state uses an IGT to finance the nonfederal share of the payment. The illustration also assumes a 50 percent federal matching rate, in which case the federal share will consist of funds amounting to half of the total payment. In this scenario, the county-run hospital receives a Medicaid payment that includes contributions from the federal government and local government funds. (See fig. 4.)

Figure 4: Example of a State Medicaid Payment Financed by an Intergovernmental Transfer and Federal Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

[11]Under agency policy, CMS requires that IGTs occur before the state makes a Medicaid payment to the provider and that the amount of the transfer cannot be greater than the nonfederal share of the Medicaid payment amount. CMS took this action to curtail states' ability to claim federal matching funds on large Medicaid payments made to certain government providers that were then returned to the state in the form of IGTs. In addition to the state imposing taxes on providers, local governments may tax providers and revenue from the taxes are generally transferred to the state through an IGT.

[12]See GAO-14-627.

The use of IGTs to finance a state's nonfederal share of Medicaid expenditures has implications for local governments and the federal government. Using the above example, for example,

- The county-run hospital initially incurs costs in making an IGT, but subsequently receives the same amount from the state in the form of a Medicaid payment along with federal matching funds. In the example above, the county-run hospital receives $10 million more than it spent through the IGT, and the net Medicaid payment to the hospital is funded entirely by the federal government.
- IGTs can increase the magnitude of federal spending without a commensurate increase in state spending, because as the local government increases the nonfederal share, the federal government continues to match these increases. When IGTs, like other financing arrangements that can shift federal spending, are used to finance supplemental payments, they have the potential to increase federal spending without being clearly linked to care for Medicaid enrollees.

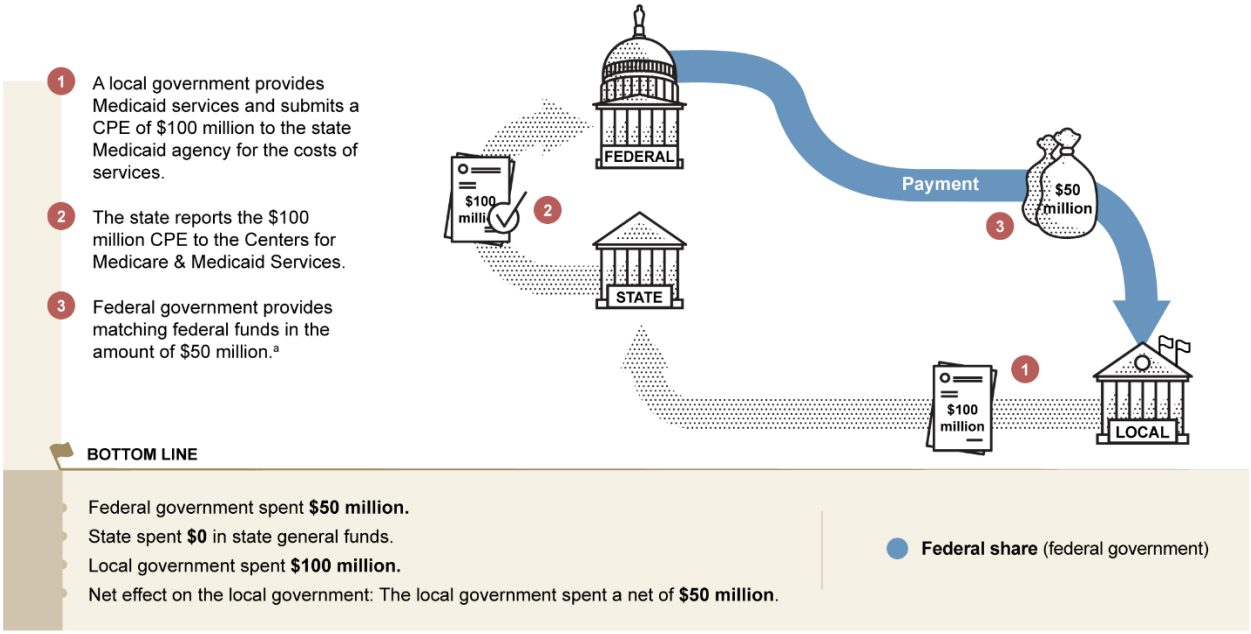
Certified Public Expenditures

Using certified public expenditures (CPE), a state may document Medicaid spending from local governments, hospitals, or other providers, and these entities can receive federal matching funds. In a 2014 report, we found that certified public expenditures made up 5.4 percent of the nonfederal share of Medicaid payments in 2012.[13]

CPEs do not involve the transfer of money to the state in order to finance the nonfederal share; rather, a local government certifies that government funds were used to pay for the cost of providing Medicaid services. The federal government matches the CPE under the federal matching rate for the state. The state has the flexibility to retain some or all of the matching federal funds.

In the following figure, the local government submits a $100 million CPE to the state Medicaid agency for the total cost of all Medicaid services provided, including those eligible for federal matching funds. In this figure, assuming a 50 percent federal matching rate, the federal government provides a payment amounting to half of the total cost of the certified Medicaid expenditures. In this scenario, the local government receives a Medicaid payment that includes only the federal share of Medicaid expenditures. (See fig. 5.)

Figure 5: Example of a State Medicaid Payment Financed Using Certified Public Expenditures and Federal Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For purposes of this figure, we have simplified the process by which the federal government matches state expenditures. The federal government provides matching federal funds to the state, which forwards all or part of the federal funds to the local government.

The use of CPEs to finance a state's nonfederal share of Medicaid expenditures can have

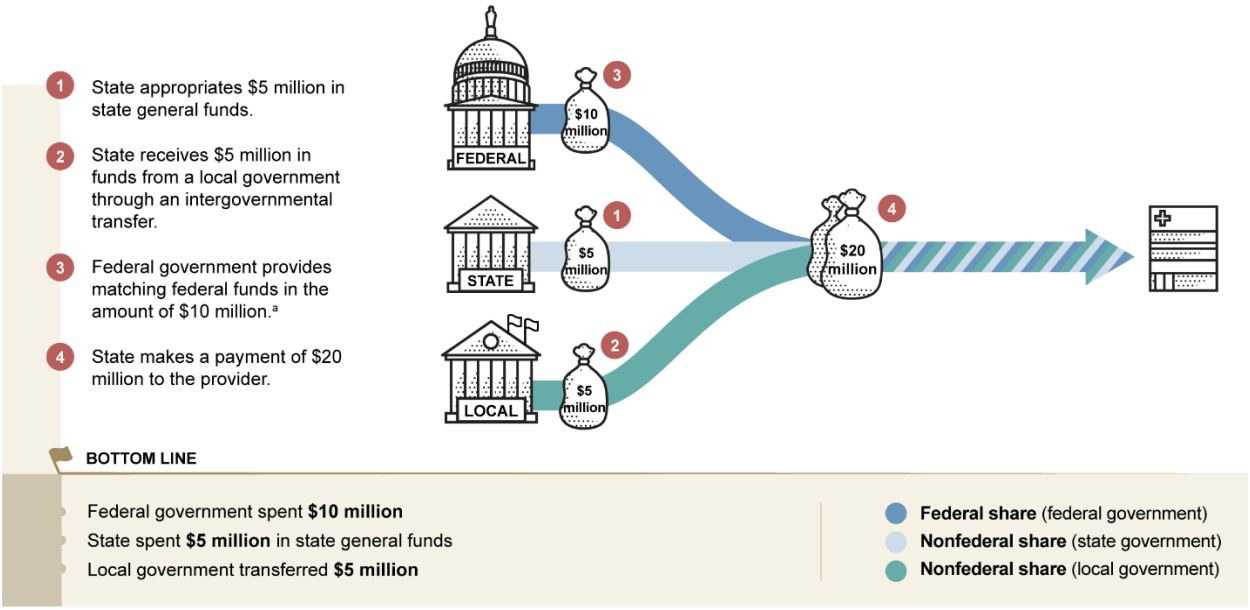
[13]See GAO-14-627.

implications for the local, state, and federal governments. Currently, a state has the flexibility to retain some or all of the matching federal funds instead of reimbursing the entity providing the CPE. If the state retains some or all of the federal matching funds, the local government receives a smaller Medicaid payment. Using the example above, if the state government were to retain a portion—$10 million—of the total Medicaid payment, then the total payment to the local government would be $40 million. Under these circumstances, the local government would have spent $100 million and received $40 million in federal matching funds instead of $50 million.

Oversight Risks

States may—and typically do—use a combination of different strategies and sources to finance a Medicaid payment. In the following figure, the state and federal government are each responsible for a share of a $20 million Medicaid payment. The state finances the nonfederal share using both state general funds and an IGT. The illustration assumes a 50 percent federal matching rate, in which case the federal share will consist of funds amounting to half of the total payment. In this scenario, the Medicaid payment includes contributions from the federal government, state general funds and local government funds. (See fig. 6.)

Figure 6: Example of a State Medicaid Payment Financed Using State General Funds, Intergovernmental Transfer, and Federal Matching Funds



Source: GAO. | GAO-20-571R

Note: The Centers for Medicare & Medicaid Services matches states' estimated expenditures and subsequently reconciles federal funding against states' actual expenditures. For the purposes of this figure, we have simplified the process by which the federal government matches state expenditures to show how the federal and nonfederal share contribute to a particular payment.

Our past work has found that states rely heavily on local government funds and provider taxes to finance supplemental payments, which states often direct to the public providers providing the IGT or to the class of providers paying the taxes. In doing this, states are able to shift to the federal government the responsibility for financing a greater net share of Medicaid payments.[14]

For example, as we reported in 2014, one state was able to significantly increase supplemental Medicaid payments with no commensurate increase in spending from state general funds.[15] To

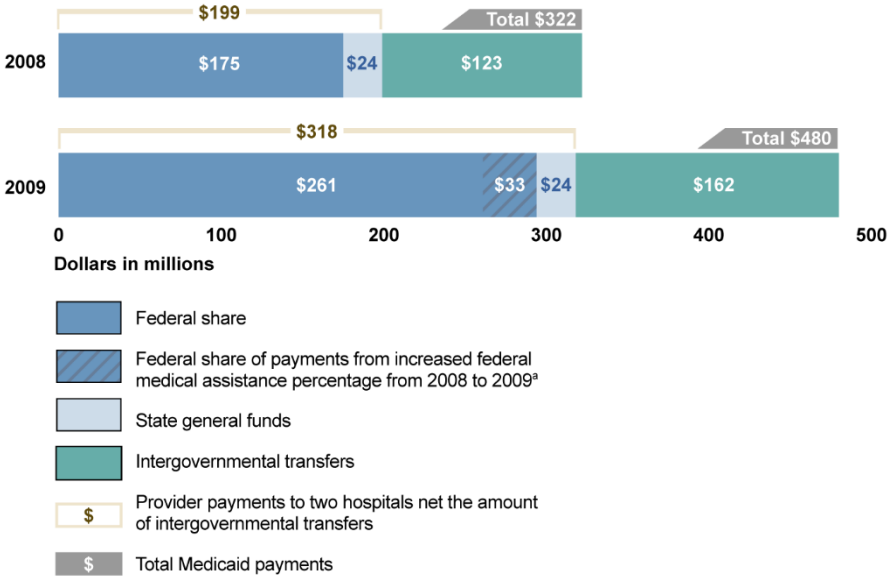
[14]In 2012, local government funds and provider taxes supplied 18 percent of the nonfederal share of regular Medicaid base payments, but over 70 percent of supplemental payments. See GAO-14-627.

[15]The state accomplished this by lowering its base Medicaid payment for inpatient hospital services in 2009. With the reduction in base payments, the state could make larger supplemental payments. See GAO-14-627.

finance the increased supplemental payments, the state relied on IGTs from the local government that owned and operated the two hospitals receiving the supplemental payments. In both 2008 and 2009—the year before and after the state increased supplemental payments—the state relied on IGTs from the local government to finance most of the nonfederal share, while the amount of Medicaid spending from state general funds—$24 million—did not change. Net provider payments increased from $199 million in 2008 to $318 million in 2009. As a result, this $119 million increase was effectively comprised entirely of federal funds, which increased from $175 million in 2008 to $294 million in 2009.[16]

By relying on IGTs to finance the increased supplemental payment, in this instance, the state increased the magnitude and share of federal spending for the Medicaid payment. (See fig. 7.)

Figure 7: Example of Change in Federal Spending as a Result of a State's Use of Intergovernmental Transfers to Finance Increased Supplemental Payments to Two Hospitals



Source: GAO. | GAO-14-627.

[a]During this time period, states received an increased federal matching rate under the American Recovery and Reinvestment Act of 2009, which accounted for $33 million in federal spending in year 2. See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*. GAO-14-627 (Washington, D.C.: July 29, 2014).

As we have described in past reports, the potential for effectively shifting Medicaid expenditures is facilitated by different financing arrangements and, in particular, can create incentives for states to

[16]See GAO-14-627. In this report we reviewed data from years 2008 through 2012 to determine the extent to which selected states relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid and extent to which states' reliance sources changed over time. The state received an increased federal matching rate under the American Recovery and Reinvestment Act of 2009, which accounted for $33 million of the $294 million in federal spending for supplemental payments to the two hospitals. Pub. L. No. 111-5, § 5001, 123 Stat. 115, 496 (Feb. 17, 2009).

maximize supplemental payments.[17] We have highlighted the importance of oversight to ensure that Medicaid supplemental payments are being made for Medicaid purposes in an economical and efficient fashion.[18] For example, our past work identified instances where supplemental payments have exceeded hospitals' costs, and we have raised questions about whether these payments are economical or efficient:

- As reported in November 2012, we found that the majority of states—39—had made supplemental payments to over 500 hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing care to Medicaid enrollees by $2.7 billion.[19]
- In some cases, payments greatly exceeded costs; for example, in 2012 we reported that one hospital received almost $320 million in supplemental payments and $331 million in regular Medicaid payments, which exceeded the $410 million in costs reported for the hospital for providing Medicaid services by about $241 million.[20]

In our prior work, we have also found that CMS oversight of supplemental payments is limited, in part, because the agency:

- does not collect sufficient information on supplemental payments to providers; consequently, the full extent of spending on supplemental payments remains unknown; and
- does not have a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient.

We have made several recommendations to CMS to strengthen its oversight of financing and supplemental payments.[21] In particular, we have recommended that CMS:

- improve data collection on the financing of supplemental payments, and
- develop policies and standards to assess whether payments are economical or efficient.

CMS disagreed with the first recommendation and agreed with the second. As of May 2020, these recommendations remained unimplemented. Without good data on financing and criteria for assessing whether the payments are economical and efficient, the federal government could be

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[17]See GAO-14-627; *CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: April 10, 2015*); and Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, GAO-15-239 (Washington, D.C.: April 13, 2015).

[18]Under federal law, to receive federal matching funds, payments generally (1) must be made for covered Medicaid items and services; (2) must be consistent with economy and efficiency, and sufficient to ensure access to and quality of care; and (3) must not exceed the Medicaid upper payment limit, which is a reasonable estimate of what Medicare would pay for comparable services. The upper payment limit is not applied to payments to individual providers; instead, it applies on an aggregate basis to all providers rendering specific services within an ownership class, such as state government-owned or -operated facilities that provide inpatient services.

[19]See GAO, *More Transparency of and Accountability for Supplemental Payments Are Needed.* GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

[20]See GAO-13-48

[21] See GAO-15-322, and *High Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas.* GAO-19-157SP (Washington, D.C.: Mar. 6, 2019). Since designating Medicaid as a high-risk area in 2003, we have made at least 55 recommendations related to the appropriate use of program dollars, 15 of which were open as of May 2020.

paying states hundreds of millions, or billions, of dollars more than what is appropriate.

In our prior work, we also identified a matter for congressional consideration to improve oversight of Medicaid expenditures related to supplemental payments. In particular, in 2012, we asked the Congress to consider broadening supplemental payment reporting and auditing requirements to improve transparency and strengthen oversight of their use and impact on the Medicaid program.[22] Supplemental payments are a significant and growing component of Medicaid spending, and improving oversight of supplemental payments is essential for ensuring the sustainability of the Medicaid program.

[22] GAO-13-48. As of February 2020, there has not been any related legislation enacted; however, CMS has taken some administrative actions, including releasing a proposed rule, that the agency says is intended to improve its oversight of supplemental payments.

Selected GAO Work

Medicaid States' Use and Distribution of Supplemental Payments to Hospitals. GAO-19-603. Washington, D.C.: July 19, 2019.

High Risk Series: Substantial Efforts needed to Achieve Greater Progress on High-Risk Areas. GAO-19-157SP. Washington, D.C.: March 6, 2019.

Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy. GAO-15-322. Washington, D.C.: April 10, 2015

Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. GAO-14-627. Washington, D.C.: July 29, 2014.

Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48. Washington, D.C.: November 26, 2012.

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EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MAINE

THE FAMILY PLANNING ASSOCIATION OF MAINE D/B/A MAINE FAMILY PLANNING; Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; CENTERS FOR MEDICARE & MEDICAID SERVICES and MEHMET OZ, in his official capacity as the Administrator of the Centers for Medicare & Medicaid Services, Defendants.	)	Case No. _____

DECLARATION OF EVELYN KIELTYKA IN SUPPORT OF PLAINTIFF'S MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

I, Evelyn Kieltyka, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. I am the Senior Vice President of Program Services for Plaintiff Maine Family Planning ("MFP"), where I have worked for nearly 31 years. In this position, I oversee MFP's programming, which includes clinical care at sites throughout the state, as well as educational, health, and social service programs. I also oversee our quality assurance program and manage our

budget for clinical services to ensure we are meeting revenue and expense targets. I submit this declaration in support of Plaintiff's motion for a temporary restraining order and/or preliminary injunction. It is based on my personal knowledge and experience, and my review of MFP's business records.

2. I am educated and trained as a family nurse practitioner, and I currently hold an active registered nurse license in Maine. I received a Master's of Science in Maternal-Child Health at the Harvard School of Public Health (now the Harvard T.H. Chan School of Public Health) and a Master's in Nursing at Simmons College in 1992. I earned my certificate as a Family Planning Nurse Practitioner at the College of Medicine and Dentistry of New Jersey in 1979. I received my Bachelor's of Science in Nursing degree at Sacred Heart University.

3. I have provided clinical care as a registered nurse and APRN (Advanced Practice Registered Nurse) throughout my career. In 2000, I was awarded the Nurse Practitioner of Excellence Award by the American Academy of Nurse Practitioners and the Maine Nurse Practitioner Association ("MNPA").

4. I am also a past President of the Board of Directors of MNPA, a position I held from 1995 to 1997 and 2015 to 2017. As President, I was responsible for overseeing advocacy and lobbying, member recruitment, and public relations and press work, as well as cultivating and maintaining MNPA's relationships with other medical professional associations.

5. I am familiar with section 71113 of the One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025) (the "Defunding Provision") and the devastating impact it will have on MFP. The Defunding Provision threatens our ability to continue caring for our patients, approximately half of whom are Medicaid recipients. The Defunding Provision will also gravely harm the thousands

of patients who depend on MFP for accessible, affordable, compassionate, and nonjudgmental care, particularly those from rural and underserved communities.

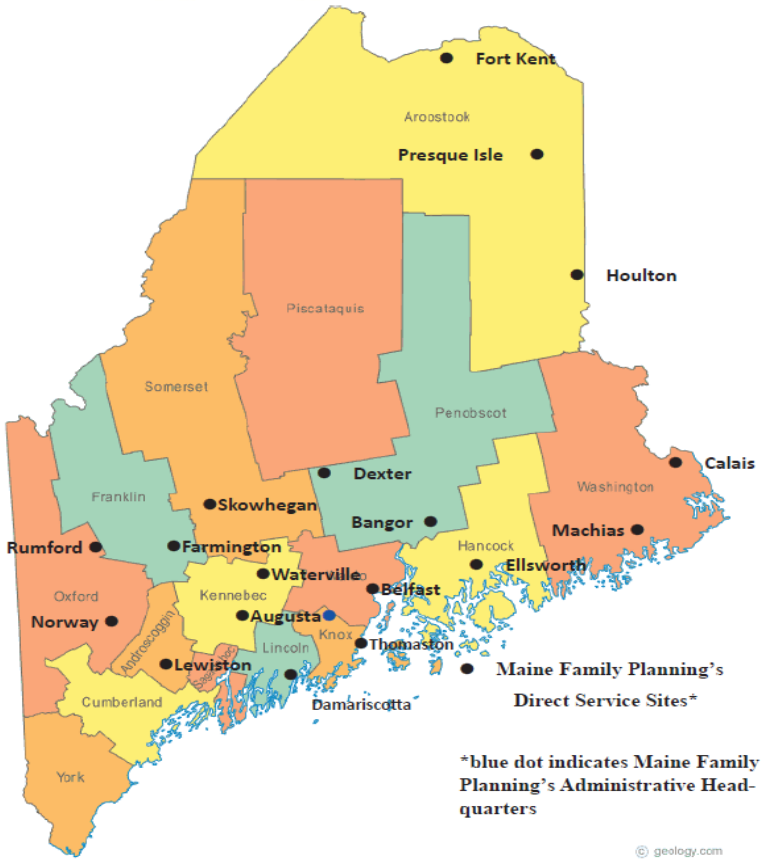
I. Maine Family Planning Provides Essential Health Care.

6. MFP is a 501(c)(3) non-profit corporation incorporated in Maine with its principal place of business in Augusta, Maine. MFP was founded on the promise of health care for all. MFP's mission is "to ensure that all people have access to high-quality, culturally relevant and affordable sexual and reproductive health care services, comprehensive sexual health education, and the right to control their sexual and reproductive lives."[1]

7. MFP offers a range of health care services, including annual gynecological exams; screening for cervical and breast cancer; family planning counseling; birth control/contraception services; preconception consultation; screening, diagnosis and treatment of urinary tract, vaginal, and sexually transmitted infections; biopsies for gynecological issues; hormone therapy; and miscarriage and abortion care.

8. Today, MFP operates eighteen family planning clinics, with at least one site in twelve of Maine's sixteen counties, and a mobile clinic. As pictured below, MFP's family planning clinics are located in Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Rumford, Skowhegan, Thomaston, and Waterville. MFP subcontracts with several other entities that in total provide access to sexual and reproductive health care in fifteen counties out of Maine's sixteen counties.

[1] Me. Family Plan., *2023-2024 Impact Report*, at 2 (2024), https://mainefamilyplanning.org/wp-content/uploads/MFP-2024-Annual-Report-v.4-single-pages-1.pdf.



9. Maine is one of the most rural states in the United States. According to Maine's Center for Disease Control & Prevention, 40 percent of the state's population live in rural areas.[2] Many patients live long distances from Maine's cities and find it difficult to access a health care provider. Moreover, due to Maine's challenging weather conditions, critical roads are often completely impassable during parts of the winter, particularly in rural Aroostook and Washington Counties.

10. Eleven of the counties where MFP operates clinics are more than 50 percent rural, as defined by the U.S. Census Bureau; eight of them are more than 80 percent rural.[3] Many of

[2] Me. Ctr. For Disease Control & Prevention, *Rural Health in Maine*, https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/rural-health.shtml (last visited July 11, 2025).

[3] U.S. Census Bureau, *County Rurality Level: 2010*, at 39, https://www2.census.gov/geo/pdfs/reference/ua/County_Rural_Lookup_v4.pdf (last visited July 11, 2025); *see also* U.S. Census Bureau, *County-level Urban and Rural Information for the 2020 Census, (Tab "2020_UA_COUNTY," Column "POPPCT_RUR," County Name Penobscot, Kennebec, Knox, Oxford, Somerset, Aroostook, Waldo, Lincoln,*

MFP's direct service clinics are located in regions of the state designated by the U.S. Health Resources and Services Administration as Medically Underserved Areas.[4] In many of these areas, reproductive health care has basically disappeared—for example, MFP is the sole provider of comprehensive family planning and reproductive health care services in Norway and Farmington in western Maine, as well as in Washington County in eastern Maine. Two MFP clinics are listed as an essential community provider in the family planning category on the HHS Rolling Draft Essential Community Provider (ECP) List for the Federally-facilitated Marketplace ("ECP List").[5]

11. Our family planning network subcontracts with forty-four additional sites, for a total of sixty-two family planning centers (sixty-three including the mobile clinic) located across the state. In recent years, our family planning network has served approximately 30,000 patients/year, providing services including STI/HIV tests, cervical cancer screenings, and placements of long-acting reversible contraception ("LARC"), such as IUDs or implants.[6] In calendar year 2024, the network served approximately 28,000 patients across the state, and MFP clinics specifically served 8,735 patients, including 645 abortion patients (7.38 percent of all patients), 633 primary care patients (7.25 percent of all patients), and 7,215 family planning patients (82.5 percent of all patients). Family planning patients had over 10,725 visits, including gynecological exams, pap smears, breast exams, STI testing, and birth control. Primary care

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Franklin, Hancock, Washington); https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww2.census.gov%2Fgeo%2Fdocs%2Freference%2Fua%2F2020_UA_COUNTY.xlsx&wdOrigin=BROWSELINK (last updated September, 2023).

[4] Health Res. & Servs. Admin., *MUA Find*, https://data.hrsa.gov/tools/shortage-area/mua-find (last visited July 14, 2025).

[5] *HHS Rolling Draft Essential Community Provider (ECP) List for the Federally-facilitated Marketplace*, Ctrs. for Medicare & Medicaid Servs., https://data.healthcare.gov/rolling-draft-list (last visited July 11, 2025) [hereinafter *ECP List*].

[6] Me. Fam. Plan., *Annual Report 2023*, at 4, https://mainefamilyplanning.org/wp-content/uploads/MFP2023AnnualReport.pdf (last visited July 14, 2025) (over 34,000 patients served by family planning network); Me. Fam. Plan., *2023-2024 Impact Report*, *supra* note 1, at 5 (over 31,000 patients served by family planning network).

patients had over 2,000 visits, including management of chronic conditions and menopause, physical exams, and geriatric health services.

12. Aside from MFP and some of the subgrantees in its family planning network (including Planned Parenthood of Northern New England ("PPNNE") and Greater Portland Health ("GPH")), to the best of my knowledge, family planning services in Maine are available only through private gynecologists, non-specialist practitioners, Federally Qualified Health Centers ("FQHCs"), MaineHealth Maine Medical Center, and an independent health center, Mabel Wadsworth Center ("Mabel's").

13. To the best of my knowledge, the only other publicly accessible health centers where a pregnant person can obtain abortion care in Maine aside from MFP are PPNNE clinics or Mabel's. To the best of my knowledge, PPNNE is also impacted by the Defunding Provision.

14. Mabel's is a 501(c)(3) organization located in Bangor,[7] one of Maine's most populated cities. People who live in rural areas of Maine would have to travel long distances to access care at Mabel's. Mabel's provides the "full spectrum of sexual and reproductive health care and primary care services," including wellness exams, birth control, vasectomies, cancer screenings, testing and treatment for STIs and vaginal infections, infertility consultation, pregnancy testing and options counseling, prenatal care, primary care, and mental health counseling.[8] Mabel's also provides medication and procedural abortion.[9] Nearly half of Mabel's patients rely on Medicaid.[10] To the best of my knowledge, Mabel's is not impacted by the Defunding Provision.[11]

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[7] Mabel Wadsworth Ctr., *Donate*, https://www.mabelwadsworth.org/donate/ (last visited July 14, 2025).
[8] Mabel Wadsworth Ctr., *Health Services*, https://www.mabelwadsworth.org/services/ (last visited July 14, 2025).
[9] *Id.*
[10] Remarks by Andrea Irwin, *Maine Community Leaders Urge Senators Collins and King to Oppose Kyle Duncan's Nomination*, Mabel Wadsworth Ctr. (Feb. 15, 2018), https://www.mabelwadsworth.org/2018/02/26/maine-community-leaders-urge-senators-collins-king-oppose-kyle-duncans-nomination/.
[11] *ECP List*, *supra* note 5.

15. GPH is a 501(c)(3) federally qualified health center that provides a range of family planning, women's health care, and maternal and prenatal health services, including contraception management and management of HIV/AIDS, Hepatitis C, and other infectious diseases.[12] GPH also provides primary care, including wellness exams, sick visits, and management of chronic conditions like diabetes and asthma; behavioral health care, including substance use disorder services; and dental care.[13] GPH does not provide abortions. GPH has locations in the Greater Portland metropolitan area, including a health center at 180 Park Avenue in Portland,[14] which appears on the ECP List as a family planning provider.[15] People who live in rural areas of Maine would have to travel long distances to access care at GPH. GPH accepts Medicaid, and in 2023 and 2024, approximately 51 percent of GPH's patients were on Medicaid.[16]

16. MaineHealth Maine Medical Center ("MMC") is part of MaineHealth, a 501(c)(3) integrated health care system that provides family planning and reproductive health care at some locations, including in Portland, such as routine gynecological exams; preventive screenings; infertility and family planning counseling; birth control services; pregnancy screening; diagnosis and treatment of urinary tract, vaginal, and sexually transmitted infections; biopsies for gynecological issues; and miscarriage care.[17] MMC provides a range of other medical and

[12] Greater Portland Health, *Services*, https://www.greaterportlandhealth.org/services (last visited July 14, 2025); Greater Portland Health, *Our Story*, https://www.greaterportlandhealth.org/about/our-story (last visited July 14, 2025); Greater Portland Health, *School Based Health Centers,* https://www.greaterportlandhealth.org/services/school-based-health-centers (last visited July 14, 2025).
[13] Greater Portland Health, *Services*, *supra* note 12.
[14] Greater Portland Health, *Hours & Locations,* https://www.greaterportlandhealth.org/locations (last visited July 14, 2025).
[15] *ECP List*, *supra* note 5.
[16] Greater Portland Health, *Payment and Insurance*, https://www.greaterportlandhealth.org/payment-and-insurance (last visited July 14, 2025); Greater Portland Health, *2023 Annual Report*, at 14, https://files.aptuitivcdn.com/eGVOpZw261-1791/docs/2023-Annual-Report-1.pdf (last visited July 14, 2025); Greater Portland Health, *2024 Annual Report*, at 14, https://files.aptuitivcdn.com/eGVOpZw261-1791/docs/2024-Annual-Report.pdf (last visited July 14, 2025).
[17] MaineHealth, *About MaineHealth*, https://www.mainehealth.org/about-mainehealth (last visited July 14, 2025); MaineHealth, *Obstetrics & Gynecology (OB/GYN)*, https://www.mainehealth.org/care-services/obstetrics-gynecology-obgyn (last visited July 14, 2025); MaineHealth, *Sexually Transmitted Diseases*,

behavioral health services, such as primary care, urgent and inpatient care, and other specialized care.[18] MMC provides abortions, including for lethal fetal conditions,[19] but generally only to existing or referred patients. MMC accepts Medicaid, and its Portland location appears on the ECP List.[20]

17. This shortage of family planning and reproductive health care providers has only been exacerbated by several hospitals in Maine closing their labor and delivery units and, as a result, OB/GYNs leaving the area and patients having to rely on their primary care providers for family planning and reproductive health services. However, my understanding is that some primary care providers tell their patients to come to MFP because they do not feel comfortable providing services they do not specialize in or routinely provide, or because they have caps on the number of Medicaid patients they accept into their practice.

18. After seeing the growing need for additional primary care providers, particularly given ongoing shortages of providers and long wait times, MFP decided to start offering primary care at our Ellsworth clinic in 2015 and at our Houlton and Presque Isle clinics in 2022. Those

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https://www.mainehealth.org/care-services/infectious-disease-care-travel-medicine/sexually-transmitted-disease-std (last visited July 14, 2025); MaineHealth, *Uterine Cancer/Endometrial Cancer*, https://www.mainehealth.org/mainehealth-cancer-care/cancer-conditions-services/uterine-cancer-endometrial-cancer (last visited July 14, 2025); MaineHealth, *Miscarriage Testing & Treatment*, https://www.mainehealth.org/care-services/prenatal-care-and-childbirth/miscarriage-testing-treatment (last visited July 14, 2025).

[18] MaineHealth, *Care & Services*, https://www.mainehealth.org/care-services (last visited July 14, 2025); MaineHealth, *Cervical Cancer*, https://www.mainehealth.org/mainehealth-cancer-care/cancer-conditions-services/cervical-cancer (last visited July 14, 2025); MaineHealth, *Vaginal Cancer*, https://www.mainehealth.org/mainehealth-cancer-care/cancer-conditions-services/vaginal-cancer (last visited July 14, 2025); MaineHealth, *Prenatal Testing/ Pregnancy Screening*, https://www.mainehealth.org/care-services/prenatal-care-and-childbirth/prenatal-testing-pregnancy-screening (last visited July 14, 2025); MaineHealth, *Obstetrics & Gynecology – MaineHealth Franklin Hospital*, https://www.mainehealth.org/mainehealth-franklin-hospital/care-services/obstetrics-gynecology-mainehealth-franklin-hospital (last visited July 14, 2025).

[19] Yves-Yvette Young et. al., *Expanding Access to Later Abortion Care in Maine*, Ibis Reprod. Health, Later Abortion Initiative, at 1 (Feb. 2021), https://www.ibisreproductivehealth.org/publications/expanding-access-later-abortion-care-maine-improving-state-clinic-referral-systems.

[20] MaineHealth, *Billing and Financial Services*, https://www.mainehealth.org/patients-visitors/billing-and-financial-services (last visited July 14, 2025); MaineHealth, *Health Insurance Coverage*, https://www.mainehealth.org/patients-visitors/billing-and-financial-services/mainehealth-access-care/health-insurance-coverage (last visited July 14, 2025); *ECP List*, *supra* note 5.

clinics offer a range of primary care services including wellness and preventive care; diagnosis and treatment of common acute and chronic conditions like strep throat, asthma, or diabetes; and geriatric health services. MFP also uses our referral network to ensure our patients can receive primary care outside of the areas served by those three clinics and access diagnostic screenings and services that we do not offer onsite.

19. For approximately 70 percent of our patients, we are the only health care provider they will see in a given year. Even if they are not seeing us for primary care, we will discuss their overall health and identify potential chronic illnesses.

20. Last year, MFP launched a mobile health care van that travels across the state to serve populations that have difficulty accessing health care, such as the unhoused, people with substance use disorder, and migrant farm workers, making stops at locations like safe injection sites and soup kitchens. These populations often have difficulty traveling to our brick-and-mortar clinics and often distrust or have experienced stigma and judgment by more traditional medical facilities. The mobile health care van provides urgent primary care, wound care, and family planning and reproductive health services including birth control, Pap smears, and STI testing. We also identify potential chronic illnesses that, without proper diagnosis and treatment, could lead to serious or even life-threatening illnesses. We are generally the sole health care provider these populations see in a given year, and many of these patients would otherwise not be able to access care.

21. MFP has won several awards for its provision of quality care, including the 2013 National Family Planning & Reproductive Health Association Dr. Allan Rosenfield Access Award for achievement in improving access to reproductive health care at the local level; the 2018 Dr. Wendy J. Wolf Health Leadership Award from the Maine Health Access Foundation, recognizing

MFP President/CEO George Hill and MFP's dedication to providing access to quality health care; the 2018 Pump Handle Award from the Maine Center for Disease Control and Prevention for important contributions to helping reduce the impact of infectious diseases in Maine; the 2021 Maine Association for Health, Physical Education, Recreation, and Dance Honor Award, recognizing MFP and its staff's efforts to provide evidence-based sexuality information for STI/HIV and pregnancy prevention to teachers in Maine; and the 2024 WIC Breastfeeding Award of Excellence for MFP WIC of Hancock and Washington Counties' prenatal education and breastfeeding peer counseling program.

II. Loss of Medicaid Funding Has Been Devastating to Maine Family Planning and Its Patients.

22. As of July 7, 2025, the first business day after the Defunding Provision went into effect, we are no longer accepting new patients enrolled in Medicaid who are seeking primary care. On average, we have about four new primary care patients who have Medicaid as either their primary or secondary insurance contact us every week. For existing patients with Medicaid, who come to us for family planning and primary care, we are continuing to see them for now. But we have determined that by September 30, 2025, we will start notifying all of our existing family planning and primary care patients that we will no longer be able to serve them past October 31, 2025. Overall, without Medicaid funding, several MFP clinics may be forced to limit or end their services.

23. MFP strives to make health care accessible to all patients, regardless of their income. MaineCare is the state of Maine's Medicaid program; it is the largest health insurance program in the state and is jointly funded by the federal and state governments. The federal government funds 62 percent of the insurance program, but in some cases, it can fund as high as

90 percent.[21] MFP started providing patient care in 1997 and has accepted Medicaid since 1998. All eighteen clinics, plus the mobile clinic, accept Medicaid today.

24. Medicaid is essential to MFP. About 20 to 25 percent of MFP's annual budget—roughly $1.9 million dollars—comes from Medicaid funding. Specifically, from July 1, 2022 to June 30, 2023, 22.7 percent of MFP's budget came from Medicaid (listed as "Program Fees").[22] In federal fiscal year 2023, October 1, 2022 to September 30, 2023, MFP received more than $800,000 from Medicaid reimbursements. However, because of the Defunding Provision's immediate effective date, we have stopped billing Medicaid for all services effective July 5, 2025.

25. The state of Maine covers the costs of abortion care for Medicaid patients using state funds. Outside of the narrow Hyde Amendment exceptions, we receive no federal funding for abortion care provided in Maine. MFP strictly ensures that our use of federal funds, including Medicaid funds, complies with abortion-related restrictions on these funds. In MFP's approximately fifty-year tenure as the Title X grantee for the state of Maine, MFP has never been found to have misappropriated funding or to have failed to distinguish between federal funding for non-abortion services and separate funding for abortion care.

26. The Defunding Provision has created a chaotic and uncertain financial future. To ensure that we (and the subgrantees in our family planning network) can continue to see patients without having to immediately close clinic sites or drastically cut services, MFP is currently relying on reserve funding. After careful consideration, MFP has concluded that it is unsustainable to deplete these reserves, and we can only continue providing care to all of our existing Medicaid family planning and primary care patients through October 2025, at the latest.

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[21] *Impact of Federal Medicaid Proposals on Maine*, Me. Dep't of Health & Human Servs. (May 2, 2025) https://www.maine.gov/dhhs/blog/impact-federal-medicaid-proposals-maine-2025-05-02.
[22] Me. Fam. Plan., *Annual Report 2023*, *supra* note 6 at 16.

27. We cannot abruptly discharge our Medicaid patients. Our practice is to provide at least 30 days' notice, explain the reason for the discharge and that we will continue providing them with emergency medical care during the 30-day notice period, and offer them resources to find alternative sources of medical care. Our patients rely on us for treatment of complex, chronic medical conditions; if we stopped seeing them, it could take them weeks or months to find and establish care with a new provider who takes Medicaid—if they are able to find one at all—given the burdens of longer travel, longer waits, and a statewide provider shortage. Without access to a Medicaid provider, many patients will be unable to afford care out of pocket.

28. Moreover, we have patients with recurring or follow-up appointments whose care may be interrupted by the Defunding Provision. For several of the procedures or treatments that we provide, follow-up appointments are recommended to confirm that the treatment worked and that the patient's condition has improved. For example, when patients test positive for chlamydia, our protocol is to follow-up in 12 weeks to ensure they are no longer infected; when patients have colposcopies (an examination of the cervix), our protocol is to follow-up in six months; and when patients have abnormal cervical cancer screenings, our protocol is to follow-up with them in three to six months. But now, we do not know whether patients that we see for these procedures will be able to return for follow-up appointments because we do not know whether we will be able to continue operating all of our clinic locations and offering these services. If we cannot see these patients or are not able to get them in for a follow-up appointment, I do not know if they could obtain care covered by Medicaid elsewhere. This has the potential to dramatically impact their health.

29. We have no choice but to begin notifying Medicaid patients by September 30 that we must discharge them. To do so, our staff will have to spend time—time that they could

otherwise use to serve patients—processing medical releases, preparing medical records, and finding alternate providers, as well as explaining to patients why we cannot continue to serve them. Moreover, once these patients are notified, it will be unlikely that they return to MFP, even if the Defunding Provision is blocked. Patients will be confused as to why we discharged them only to later learn that we can continue to serve them. Disruptions in care are detrimental to the patient-provider relationship.

30. Being forced to deny care to our existing patients and being unable to serve new patients is devastating. MFP clinics serve Maine counties with some of the highest rates of enrollment in Medicaid: for example, about 40 percent of the population in rural counties like Aroostook County, Washington County and Somerset County relies on Medicaid.[23] Between July 1, 2022 and June 30, 2023, 41 percent of our family planning network's patients had public insurance, 12 percent were uninsured, and 82 percent fell at or below 250 percent of the federal poverty level and, as a result, qualified for free or reduced services.[24] In calendar year 2024, 49.8 percent of patients who received care other than abortion at MFP were enrolled in Medicaid. Without access to Medicaid, most of these patients could not afford to see a health care provider.

31. MFP offers a broad range of health care to patients with Medicaid coverage or who are presumptively eligible under Maine's Limited Family Planning Benefit (which provides limited coverage for family planning services). For example, MFP provides these patients routine gynecologic exams, pregnancy testing, contraceptive services, cancer screenings, and STI testing.

32. For many Mainers, MFP is the only provider where they can practically obtain LARCs. All MFP clinics offer LARCs while, outside of MFP clinics, LARC availability is

[23] Letter from Janet T. Mills, Gov., State of Me., to Sen. Susan Collins et al. (June 25, 2025), https://mainemorningstar.com/wp-content/uploads/2025/06/6.25.25_Governor-Mills-Delegation-Letter.pdf.
[24] Me. Fam. Plan., *Annual Report 2023*, *supra* note 6.

sporadic and dependent on who is scheduled to work. This care is expensive and necessitates Medicaid funding. For contraceptive care, including LARCs, Medicaid reimburses providers not only for the visit but also for the cost of the contraceptive device. IUDs cost, on average, between $400 and $500. Since we have stopped billing Medicaid for covered services, we are now covering the cost of both the visit and the contraceptive devices themselves.

33. Many of our patients prefer to be seen at MFP rather than another Medicaid provider because we specialize in family planning and reproductive health care, and patients trust us to provide sensitive care like STI screening in a nonjudgmental and confidential manner. Likewise, because Maine's population is small—particularly in some of the less densely populated areas where MFP clinics are located—some patients prefer to keep their family planning- and reproductive health-related care at MFP separate from their primary care to avoid the chance of their acquaintances finding out about intimate and potentially stigmatizing health care decisions. Because MFP works hard to build strong, trusting relationships with our patients, many of our patients continue to come back to us for care.

34. If we can no longer accept Medicaid, MFP will have no choice but to turn away the patients who seek our services. Many of them will have nowhere else to turn, since MFP has clinics in many rural areas of the state where there are very few other health care providers, and none that specialize in family planning care. Indeed, most of the patients we see in the mobile health care facility are Medicaid-enrolled, and not being able to accept Medicaid threatens our ability to continue offering care to these populations due to the expense of maintaining the program.

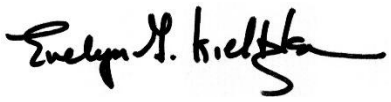
35. Even patients who may be able to access health care elsewhere will face significant delays from the already overstretched health care system in Maine. There is already a shortage of providers who accept Medicaid, and it will be difficult if not impossible for the thousands of

patients we see each year to find new practices willing to take on additional Medicaid recipients. Many of our patients will be forced to travel further distances and face longer wait times and higher costs to access alternate care. Many may be forced to forgo health care altogether. These additional burdens will fall on patients who, by definition, already face significant hurdles in accessing care in the first place.

36. Now that MFP has been labeled a "prohibited entity" under the Defunding Provision, I worry that our patients will be confused about whether MFP is precluded from receiving Medicaid funds because it is guilty of fraud or other serious criminal behavior. We will have to spend staff time and resources explaining that MFP is being excluded solely because we also provide abortion care. This may impact the trust and reputation that we worked hard to build.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this15th day of July 2025 at Augusta, Maine.



Evelyn Kieltyka

EXHIBIT 6

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Health and Economic Benefits of Breast Cancer Interventions

For Everyone
AUG. 14, 2025

AT A GLANCE

- 279,731 new cases of breast cancer were reported among women in 2022, and 42,213 women died of it in 2023.
- Breast cancer has the highest treatment cost of any cancer, accounting for 14% of costs ($29.8 billion) in 2020.
- Breast cancer screening can find cancers early when they are easier to treat, and reduces late-stage diagnoses, deaths, and treatment costs.



Breast cancer in the United States

Cancer is the second leading cause of death in the United States, and breast cancer is one of the most commonly diagnosed cancers in women. [1] The risk of breast cancer increases with age. About 83% of breast cancer diagnoses each year are among women aged 50 or older. [1]

Quick facts

- 279,731 new cases of breast cancer were reported among women in 2022, and 42,213 women died of it in 2023. [1]
- Death rates have been going down, but disparities persist. [1]
- The rate of new breast cancer cases is highest among non-Hispanic White women. The death rate is highest among non-Hispanic Black women. [1]

The high cost of breast cancer

The total annual medical cost for breast cancer in 2020 was $29.8 billion: [2]

- Breast cancer has the highest treatment cost of any cancer, accounting for 14% of costs in 2020—$26.2 billion for medical services and $3.5 billion for prescription drugs.
- If cancer diagnosis and treatment were divided into phases of care, then the initial phase would be the first year after a diagnosis, the end-of-life phase would be the year before death from cancer, and continuing care phase would be the time in between these two phases. The average per-patient costs for medical services were highest for the end-of-life phase ($76,100), followed by the initial care phase ($35,000) and continuing care phase ($3,500).
- The average per-patient costs for oral prescription drugs were highest for the end-of-life phase ($2,700), followed by the initial care phase ($1,100) and continuing care phase ($830).

Strategies that work

CDC is working to prevent cancer, detect it early, and improve the health of people with cancer, which can save lives and reduce health care costs.

To help find breast cancer early, the U.S. Preventive Services Task Force recommends that women aged 40 to 74 who are at average risk of breast cancer get a mammogram every 2 years. [3]

Benefits of using proven strategies

Breast cancer screening can:

- **REDUCE** deaths. Compared to no screening, screening every 2 years for women aged 50 to 74 reduces breast cancer deaths by 26%, or 7 deaths averted for every 1,000 women screened. [4]
- **DECREASE** the number of women diagnosed with late-stage cancer. Screening has contributed to a 29% reduction in the number of women diagnosed with breast cancer that has spread to other parts of the body. [5]
- **DETECT** cancer sooner when it is easier to treat. More than 99% of women diagnosed with breast cancer at the earliest stage live for 5 years or more, compared to about 33% of those diagnosed at the most advanced stage. [1]
- **REDUCE** health care spending. Breast cancers diagnosed at an early stage are much less expensive to treat than those diagnosed at a late stage. [6] [7]

What is CDC doing?

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) helps women with low incomes who are uninsured or underinsured get access to timely breast and cervical cancer screening and diagnostic services. Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which allows states to use Medicaid to cover treatment for women diagnosed with cancer through the NBCCEDP.

The NBCCEDP supports all 50 states, the District of Columbia, 5 U.S.-Affiliated Pacific Islands, 2 U.S. Territories, and 13 American Indian or Alaska Native tribes or tribal organizations.

NBCCEDP strategies include:

- Funding screening and diagnostic services for eligible women.
- Providing case management to help women navigate a complex health system.
- Supporting population-based approaches that increase high-quality breast and cervical cancer screening.

Since 1991, NBCCEDP-funded programs have:

- Served more than 6.5 million women.
- Provided more than 16.6 million breast and cervical cancer screening exams.
- Diagnosed 80,811 invasive breast cancers and 25,638 premalignant breast lesions.

Spotlight

More than 2.6 million U.S. women aged 40 to 64 were eligible for NBCCEDP breast cancer screening services during 2020 to 2021, based on income and lack of health insurance. The program served 13.5% of eligible women during this time.

SOURCES

CONTENT SOURCE:
National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

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2. National Cancer Institute. Financial burden of cancer care. Cancer Trends Progress Report. Reviewed March 2024. Accessed July 2024. https://progressreport.cancer.gov/after/economic_burden
3. U.S. Preventive Services Task Force. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2024;331(22):1918–1930. doi:10.1001/jama.2024.5534
4. Mandelblatt JS, Stout NK, Schechter CB, et al. Collaborative modeling of the benefits and harms associated with different US breast cancer screening strategies. *Ann Intern Med*. 2016;164(4):215–225.

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7. Subramanian S, Trogdon J, Ekwueme DU, Gardner JG, Whitmire JT, Rao C. Cost of breast cancer treatment in Medicaid: implications for state programs providing coverage for low-income women. *Med Care*. 2011;49(1):89–95.

EXHIBIT 7

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Health and Economic Benefits of Cervical Cancer Interventions

For Everyone
AUG. 15, 2025

AT A GLANCE

- In the United States 12,960 new cases of cervical cancer were reported in 2022, and 4,162 women died of it in 2023.
- Cervical cancer screening reduces cases, deaths, and health care spending.
- CDC's National Breast and Cervical Cancer Early Detection Program helps women with low incomes and little or no health insurance get this screening.



Cervical cancer in the United States

From 1999 to 2023, the death rates from cervical cancer have gone down.[1] This decline may be the result of many women getting regular Pap tests, which can find cervical precancer before it turns into cancer.[2] However, women with lower incomes and less education and women without health insurance coverage get screened less often.[3]

Quick facts

- 12,960 new cases of cervical cancer were reported in 2022, and 4,162 women died of this cancer in 2023.[1]
- The rate for new cervical cancer cases is highest for non-Hispanic American Indian/Alaska Native women and Hispanic women. The death rate is highest for non-Hispanic Native Hawaiian and Other Pacific Islander women.[1]

The high cost of cervical cancer

In 2020, the cost of cervical cancer care was $2.3 billion:[4]

- Cervical cancer treatment costs accounted for 1% of all cancer treatment costs.
- If cancer diagnosis and treatment were divided into phases of care, then the initial phase would be the first year after a diagnosis, the end-of-life phase would be the year before death from cancer, and the continuing care phase would be the time in between these two phases. The average per-patient costs for medical services were highest for the end-of-life phase ($97,000), followed by the initial care phase ($58,700) and continuing care phase ($4,000).
- The average per-patient costs for oral prescription drugs were $500 for the last year of life.

Strategies that work

CDC is working to prevent cancer, detect it early, and improve the health of people with cancer, which can save lives and reduce health care costs.

To help prevent cervical cancer or catch it early, the U.S. Preventive Services Task Force recommends screening for cervical cancer every 3 years with a Pap test alone in women aged 21 to 29. Women aged 30 to 65 should be screened every 3 years with a Pap test alone, every 5 years with high-risk human papillomavirus (HPV) testing alone, or every 5 years with both tests (co-testing).[2]

Screening reduces diagnoses and deaths from cervical cancer.[5] HPV vaccination can reduce new cervical cancer cases, but only about 63% of adolescents were up to date on the HPV vaccine in 2022.[6]

Benefits of using proven strategies

Cervical cancer screening can:

- **REDUCE** deaths. Cervical cancer is not a leading cause of cancer death in the United States.[1]
- **PREVENT** or detect cancer sooner when it is easier to treat. More than 90% of women diagnosed at the earliest stage of cervical cancer live for 5 years or more, compared to about 19% of those diagnosed at the most advanced stage.[1]
- **REDUCE** racial disparities. The 5-year survival rate for cervical cancer is about 65% for non-Hispanic Black women and 69% for non-Hispanic White women, who are more often diagnosed at an earlier stage.[1]
- **REDUCE** health care spending. Screening can identify cervical cancer at an early stage, when it is much less expensive to treat.[7]

What is CDC doing?

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) helps women with low incomes who are uninsured or underinsured get access to timely breast and cervical cancer screening and diagnostic services. Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which allows states to use Medicaid to cover treatment for women diagnosed with cancer through the NBCCEDP.

The NBCCEDP supports all 50 states, the District of Columbia, 5 U.S.-Affiliated Pacific Islands, 2 U.S Territories, and 13 American Indian or Alaska Native tribes or tribal organizations.

NBCCEDP strategies include:

- Funding screening and diagnostic services for eligible women.
- Providing case management to help women navigate a complex health system.
- Supporting population-based approaches that increase high-quality breast and cervical cancer screening.

Since 1991, NBCCEDP-funded programs have:

- Served more than 6.5 million women.
- Provided more than 16.6 million breast and cervical cancer screening exams.
- Diagnosed 5,333 invasive cervical cancers and 251,963 premalignant cervical lesions, of which 38% were high-grade.

Spotlight

More than 5.3 million U.S. women aged 21 to 64 were eligible for NBCCEDP cervical cancer screening services during 2019 to 2021, based on income and lack of health insurance. The program served 6.0% of eligible women during this time.

SOURCES

CONTENT SOURCE:
National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

REFERENCES

1. U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Updated June 2025. Accessed August 14, 2025. www.cdc.gov/cancer/dataviz
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

State of California, et al. ,

Plaintiffs,

v.

U.S. Department of Health and Human Services, et al.,

Defendants.

CA No.: 1:25-cv-12118

DECLARATION OF ERICA CONNOLLY IN SUPPORT OF PLAINTIFF STATES' MOTION FOR PRELIMINARY INJUNCTION

I, ERICA CONNOLLY, declare

1. I am a Deputy Attorney General in the Office of the Attorney General for the State of California and am a member in good standing with the State Bar of California. My pro hac vice application to appear in this Court has been approved. I represent the State of California, on behalf of California Attorney General Rob Bonta. I have personal knowledge of the following facts and could competently testify regarding their truth if called on to do so.

2. Attached to this declaration are true and correct copies of the following documents in support of the Plaintiff States' Notice of Motion and Motion for Preliminary Injunction:

a. Attached as Exhibit 1 is a true and correct copy of a letter from Donald J. Trump to "Pro-Life Leaders and Activists," dated September 3, 2020, and available at https://www.presidency.ucsb.edu/documents/trump-campaign-press-release-president-donald-j-trump-releases-letter-pro-life-leaders.

b. Attached as Exhibit 2 is a true and correct copy of a letter from Donald J. Trump to Pro-Life Leaders, dated September 2016, and available at https://sbaprolife.org/wp-content/uploads/2016/09/Trump-Letter-on-ProLife-Coalition.pdf.

c. Attached as Exhibit 3 is a true and correct copy of the transcript created by Youtube of the video titled *Speaker Johnson Joins The Story with Martha MacCallum*, dated December 4, 2024, and available at https://www.youtube.com/watch?v=VOM5wRs1WFc.

d. Attached as Exhibit 4 is a true and correct copy of a statement from Planned Parenthood Mar Monte, posted on Instagram on July 24, 2025, and available at https://www.instagram.com/p/DMgSedds0pq/?hl=en&img_index=1.

e. Attached as Exhibit 5 is the declaration of Megan L. Kavanaugh and accompanying exhibit.

f. Attached as Exhibit 6 is the declaration of Sarah Gilbert and accompanying exhibits.

g. Attached as Exhibit 7 is the declaration of Adela Flores-Brennan.

h. Attached as Exhibit 8 is the declaration of William Halsey.

i. Attached as Exhibit 9 is the declaration of Andrew Wilson.

j. Attached as Exhibit 10 is the declaration of Judy Mohr Peterson.

k. Attached as Exhibit 11 is the declaration of Laura Phelan

l. Attached as Exhibit 12 is the declaration of Sharon Boyle.

m. Attached as Exhibit 13 is the declaration of Michelle Probert.

n. Attached as Exhibit 14 is the declaration of Meghan Groen.

o. Attached as Exhibit 15 is the declaration of John Connolly.

p. Attached as Exhibit 16 is the declaration of Noya Woodrich.

q. Attached as Exhibit 17 is the declaration of Melanie Bush.

r. Attached as Exhibit 18 is the declaration of Sarah Adelman.

s. Attached as Exhibit 19 is the declaration of Alex Castillo Smith.

t. Attached as Exhibit 20 is the declaration of Johanne Morne.

u. Attached as Exhibit 21 is the declaration of Emma Sandoe.

v. Attached as Exhibit 22 is the declaration of Kristin Pono Sousa.

w. Attached as Exhibit 23 is the declaration of Charissa Fotinos.

x. Attached as Exhibit 24 is the declaration of Debra Standridge.

y. Attached as Exhibit 25 is the declaration of Sally A. Kozak.

z. Attached as Exhibit 26 is the declaration of Melisa Byrd.

I declare under penalty of perjury that the foregoing is true and correct and of my own personal knowledge.

Executed on September 24, 2025, in Sacramento, California.

/s/ Erica Connolly
Erica Connolly

SA2025303982

Exhibit 1

PRO-LIFE VOICES FOR TRUMP 2020

September 3, 2020

Dear Pro-Life Leaders and Activists:

In 2016, I ran as a pro-life candidate for president, and with your support, we won the White House. Since my inauguration, **I have proudly governed as the most pro-life president in our nation's history**. Together, we have accomplished so much for unborn children and their mothers during my first term in office by:

- **Transforming the federal judiciary** with the confirmations of Justices Neil Gorsuch and Brett Kavanaugh to the U.S. Supreme Court and over 200 lower-court judges
- **Fighting for the unborn around the globe** by enacting the Protecting Life in Global Health Assistance policy which prevents tax dollars from funding the international abortion industry, and combating efforts at the United Nations to make abortion an international right
- **Stopping taxpayer funding of the big abortion industry**, such as Planned Parenthood, through the Title X Protect Life Rule
- **Fighting for the conscience rights of the Little Sisters of the Poor** and for medical professionals such as nurses from being forced to participate in abortions
- **Ending taxpayer funding for new medical research using aborted baby body parts** at the National Institutes of Health
- **Becoming the first president ever to address the March for Life and the Susan B. Anthony List Campaign for Life Gala** in-person

As I seek re-election this November, I need your help in contrasting my bold pro-life leadership with Joe Biden's abortion extremism. The Democratic Party unequivocally supports abortion on-demand, up until the moment of birth, and even infanticide -- leaving babies to die after failed abortions. Joe Biden's embrace of this extreme position is most evidenced by his support for taxpayer funding of abortion on-demand. Forcing taxpayers to pay for abortions is an abhorrent position that must be defeated at the ballot box. Joe Biden has doubled down on these positions with his selection of abortion extremist Kamala Harris as his running mate.

With your help, I will win re-election, ensuring we have another four years to fight in the trenches for unborn children and their mothers. Together we will work to:

- **Continue our transformation of the federal judiciary**, filling the Supreme Court and lower courts with judges who will respect the Constitution and not legislate an abortion agenda from the bench
- **Overcome Democratic filibusters in Congress to finally pass and sign into law** the Pain-Capable Unborn Child Protection Act, the No Taxpayer Funding for Abortion Act, and the Born-Alive Abortion Survivors Protection Act
- **Fully defund the big abortion industry such as Planned Parenthood** of our tax dollars

I thank Marjorie Dannenfelser and Christina Bennett for co-chairing my Pro-Life Voices for Trump coalition. **I urge every pro-life American to join this effort** and do your part to defeat abortion extremism this November. Instead, we can score a major, historic victory for unborn children and their mothers.

President Donald J. Trump

Paid for by Donald J. Trump for President, Inc.

Exhibit 2

TRUMP
PENCE
MAKE AMERICA GREAT AGAIN!
2016

September 2016

Dear Pro-Life Leader:

I am writing to invite you to join my campaign's Pro-Life Coalition, which is being spearheaded by longtime leader Marjorie Dannenfelser.

As we head into the final stretch of the campaign, the help of leaders like you is essential to ensure that pro-life voters know where I stand, and also know where my opponent, Hillary Clinton, stands.

Hillary Clinton not only supports abortion on-demand for any reason, but she'd take it a step further: she wants to force the taxpayers to pay for abortions by repealing the bi-partisan Hyde Amendment. Hillary Clinton also supports abortion until an hour before birth. And she will only appoint Supreme Court justices who share this view.

She doesn't even try to hide her extremism. When asked on *Meet the Press* when unborn children have constitutional rights, Clinton bluntly responded, "The unborn person doesn't have constitutional rights." She is so committed to this view that she proclaimed in a speech that "religious beliefs… have to be changed" in order to advance her abortion agenda.

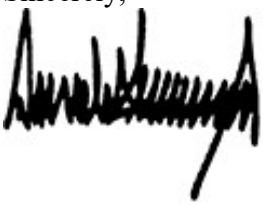
Hillary Clinton's unwavering commitment to advancing taxpayer-funded abortion on-demand stands in stark contrast to the commitments I've made to advance the rights of unborn children and their mothers when elected president.

I am committed to:

- Nominating pro-life justices to the U.S. Supreme Court.
- Signing into law the Pain-Capable Unborn Child Protection Act, which would end painful late-term abortions nationwide.
- Defunding Planned Parenthood as long as they continue to perform abortions, and re-allocating their funding to community health centers that provide comprehensive health care for women.
- Making the Hyde Amendment permanent law to protect taxpayers from having to pay for abortions.

Your help is crucial to make this contrast clear in the minds of pro-life voters, especially those in battleground states. Together we can form this vital coalition so that Mike Pence and I can be advocates for the unborn and their mothers every day we are in the White House.

Sincerely,



Donald J. Trump

Exhibit 3

Youtube Transcript

Speaker Johnson Joins The Story with Martha MacCallum – YouTube

https://www.youtube.com/watch?v=VOM5wRs1WFc

0:00

the Speaker of the House Mike Johnson

0:01

joins me now Mr speaker thank you very

0:03

much for joining us today uh just a

0:06

short distance from Capitol Hill over

0:07

here at the DC Studio do you have any

0:10

reaction to that um your thoughts on

0:12

Heth versus potentially DeSantis in the

0:15

defense role well I talked to Pete about

0:17

36 hours ago and he was feeling pretty

0:19

positive pretty good about it we were

0:20

talking about people that he might

0:22

select to help him in the Department of

0:23

Defense uh look we support the president

0:25

I mean he has made some really strong

0:27

nominations he needs people who will

0:29

come in and let's be frank shake up the

0:31

status quo and the Department of Defense

0:33

needs some reform we all know that and

0:35

Pete I think would do a good job at that

0:37

so I'm cheering for him so in order to

0:39

carry out the president's agenda you

0:41

have to first win the speaker vote on

0:43

January 3rd will you be asking Alise

0:45

stanic to stay in place through that

0:47

date to make sure that there are no

0:49

hitches in that yeah I think both she

0:51

and Mike Waltz will be in the chamber

0:53

they will leave after all of that

0:55

happens uh sometime in January so uh we

0:57

we'll have the sufficient votes and

0:59

we'll get this done and move forward we

1:00

have a lot to do we're going to have a

1:01

very aggressive first 100 days agenda

1:04

the election gave us a mandate gave

1:06

president Trump and the Republican Party

1:07

a mandate to fix everything so we got to

1:09

start on day one to do that yeah fixing

1:11

everything is a heavy lift uh and you

1:12

got a lot of cats to herd up there but

1:15

in terms of the Mandate you know you see

1:18

the Mandate in the White House you see a

1:19

strong mandate in the Senate yours is is

1:22

wobbly um one or two votes come January

1:25

Hakeem jeffre is the minority leader

1:27

says you don't have a mandate watch this

1:31

despite the claims of some of my

1:34

Republican colleagues who have spent a

1:36

lot of time over the last two weeks

1:37

talking about some big massive mandate

1:41

I'm looking for it this notion of some

1:43

mandate to make massive farri extreme

1:48

policy changes it doesn't exist what do

1:50

you say to that yeah I say we're going

1:52

to restore common sense and there's

1:53

clearly a mandate president Trump put a

1:56

big mandate out there and he delivered

1:57

the big vote we won the Senate with 53

1:59

votes

2:00

uh the house would have a larger

2:01

majority but redistricting and

2:03

gerrymandering in the blue States made

2:04

that almost impossible but we do have

2:06

the majority we know how to govern with

2:07

that small majority we've been doing it

2:09

for a year um we will fill those seats

2:11

there'll be three vacant when we start

2:12

so it'll go from 220 to 217 that is

2:14

Razor thin but it'll only be for a few

2:16

months and uh we're we're very confident

2:18

that we'll get uh qualified governing

2:20

conservatives uh put back in those seats

2:22

and we'll grow that margin as we go so

2:24

we're going to talk more about cutting

2:25

spending in the next segment but um in

2:28

terms of priorities for the first 100

2:30

days here is John th your counterpart in

2:32

the Senate talking about what he sees as

2:34

the priorities this morning on America's

2:36

Newsroom watch in order for us to be

2:38

successful here we have to be unified

2:40

coming out of the gate the key is

2:42

getting the things that he campaigned On

2:44

the Border energy dominance National

2:46

Security rebuilding our military uh

2:49

extending the Trump tax cuts those are

2:51

all things in the end that we have to

2:52

accomplish how we get there is what

2:54

we're

2:55

discussing so in terms of the first

2:58

thing on the agenda he said said border

3:00

first then he said defense spending when

3:02

you spoke at the stock exchange you put

3:05

extending the Trump tax cuts as number

3:07

one we've heard from Ron Johnson as well

3:10

uh extending the tax cuts we can handle

3:11

that a little bit down the road what

3:13

what is first for you these are all big

3:15

priorities we have to do them all early

3:17

in the in the Trump administration

3:19

because we'll have the largest tax

3:20

increase in US history all at once I

3:22

mean trillions of dollars by the end of

3:24

the year if we don't get the Trump tax

3:26

cuts extended so everybody that you've

3:28

just named knows that a big priority but

3:30

also border and also all these other

3:32

things energy policy uh we want to

3:35

maintain peace through strength again

3:36

restore that you and th and president

3:38

Trump say okay here we go this is number

3:40

one this is number two it's number three

3:42

and do you have that order yet yes look

3:44

we designed a Playbook let me use my

3:45

football metaphors okay we worked on a

3:47

playbook for about a year so we have the

3:49

menu of options in front of us um leader

3:51

th and I John and I were talking as

3:52

recently as within the last hour about

3:54

the priority of how we do it and what

3:56

sequence so the sequence is less

3:58

important than the idea that we actually

4:00

put those points on the board and we

4:01

will and everybody's excited I spent an

4:04

hour yesterday with all the Senate

4:05

Republicans in their uh conference when

4:07

they were getting together to talk about

4:08

the issues and we're we're very um I

4:10

think dialed in all of us on having a

4:12

bamal approach so we'll have the Senate

4:14

Republicans and the House Republicans

4:16

working as one team what a concept and

4:18

Unified Government with President Trump

4:20

and the White House will actually be

4:22

able to accomplish all this for the

4:23

American people and everybody's excited

4:25

to get going so what's number one on the

4:27

list well look you got to put border at

4:29

the top of the priority list we all

4:30

agree on that and the question is how

4:32

much of of that can we get in the early

4:35

right out of the gates and how much of

4:36

it needs to be a couple of months down

4:38

the road in terms of the sequence

4:39

remember the Senate is also going to be

4:41

very deeply involving confirmations of

4:43

all these uh cabinet appointees and

4:45

everybody else so it's clock management

4:46

using my game too I know Jordan has said

4:49

let's just do it right away um as an

4:51

opener well so we'll be doing the budget

4:53

reconciliation process is a big chunk of

4:55

the first 100 days and there are some

4:57

limits on what you can do with regard to

4:59

policy I love hr2 we're going to take as

5:01

much of that as we can and put it into

5:03

that process the reason we use budget

5:05

reconciliation is it only requires 51

5:08

votes in the Senate not the 60 vote

5:09

threshold so we'll get as much of that

5:10

done as we can in the early part and

5:13

then as the Congress uh goes further

5:15

we'll we'll do other pieces but we've

5:16

got a lot to do a big so what's your

5:18

estimate how many days before you can

5:20

pass hr2 and have a border Bill done

5:23

well I if if we all get on the same page

5:24

I think we could get that done very soon

5:26

I think first first maybe 15 days really

5:28

for the Border provisions we we'll

5:30

probably have two reconciliation

5:32

packages and what we're doing right now

5:33

is discussing what goes in which which

5:36

piece of that so it hasn't been totally

5:37

decided yet okay um we will be right

5:39

back with more from speaker Johnson as

5:41

he reveals the outlook for tomorrow's

5:44

arrival um these two gentlemen come to

5:47

Washington tomorrow VI ramaswami and

5:49

Elon Musk it should be very interesting

5:51

to watch the do duo in action as they

5:55

try to put their company skills and how

5:57

they you know cut grow the bottom line

6:00

by cutting spending they say $2 trillion

6:03

can come right out of this US government

6:05

waste we're going to talk about that

6:07

coming up

6:12

next so back with house Speaker Mike

6:14

Johnson tomorrow Elon Musk and V

6:17

ramaswami will be in Washington the

6:19

billionaire co-chairs of Doge will meet

6:22

with lawmakers as they plot a path

6:24

forward to slash spending in Washington

6:28

this has really never been done

6:29

certainly not in our lifetimes speaker

6:31

Johnson is back with me now um speaker

6:34

thanks again for for being here we're

6:35

$35 trillion in debt so the question is

6:39

how serious is this Congress about

6:43

actual reform can they cut spending by

6:45

$2 trillion even though Congress doesn't

6:47

have to sign off on all of that well

6:49

we're going to see look we're very

6:50

committed to this this is a core

6:52

principle for US government is too big

6:53

it does too many things and it does

6:55

almost nothing well and we need to scale

6:57

it back down we've always been Advocates

6:58

of limited government and individual

7:00

freedom and so here we have what I think

7:02

Martha is a generational opportunity to

7:04

make real transformational change uh to

7:07

the administrative State the Deep State

7:09

we want to take a blowtorch to the

7:10

regulatory State and I think what Elon

7:13

and V have in mind uh can help us in

7:15

that regard and so I invited them both

7:17

to come to the hill because we want to

7:18

get all everybody together that has that

7:19

same mindset we'll be inviting all the

7:21

Senate and House Republicans together to

7:23

a big sort of brainstorming session

7:24

because we need to do that early in the

7:26

process so we can formulate what the

7:27

actual plans are so it looks like you're

7:29

going to have uh Democrat support on

7:31

this this is Jared moscowitz this is

7:32

what he just said moments ago and we

7:34

know Rama Emanuel who wants to be the

7:36

head of the DNC also says Democrats get

7:39

involved with Doge

7:41

watch there's going to be other

7:43

Democrats I think that that join the

7:44

cckc Donald Trump has proven the way you

7:47

communicate now is not to leave a vacuum

7:48

you go everywhere where we disagree if

7:50

it's on social security or Medicare I'm

7:52

going to push back but if there's

7:53

agreements because hey we can find

7:55

hundreds of billions of dollars to save

7:56

the American people we should make that

7:59

a by hard is an issue okay so so tell me

8:02

some cuts that Congress does have

8:04

control over that you think Democrats

8:07

and Republicans can agree on well we've

8:09

got a long list of areas where we know

8:11

there are waste fraud and abuses and

8:12

oversight committee has been doing a lot

8:14

of aggressive work on that well in the

8:16

oversight Committee in the house we've

8:17

just created a new subcommittee that

8:19

will be laser focused on that finding

8:21

the places for the easy cuts and then

8:23

it's about scaling back the regulatory

8:25

State I mean we use the term

8:27

weaponization that's what's happened

8:28

over the last years that most of these

8:30

three-letter agencies that are supposed

8:32

to be serving the people are actually

8:34

working directly against them and their

8:36

interest we have whole industries that

8:38

have faced existential threats of their

8:39

very existence because they're literally

8:41

being smothered with red tape and so

8:43

it's a lot of methodical work that it

8:45

takes to go through and reduce and and

8:48

restore really the freedom speaker so

8:50

some people listen go okay we got a

8:51

subcommittee we got uh it's going to

8:53

take a while um understandably but you

8:57

know you look at the example in

8:58

Argentina um Malay there the president

9:01

has cut 10% of the workforce he has

9:03

shuttered 13 government agencies he's

9:05

doing things that nobody thought was

9:07

possible that economists up and down

9:09

said you know you can't do that you

9:12

can't do that and and he's doing it musk

9:14

wants to take government agencies from

9:16

428 to 99 can it be done we we certainly

9:20

hope so we want to be willing Partners

9:22

in that and we have a new uh a new

9:25

ability to do this now remember the

9:27

Supreme Court overturned the Chevron doc

9:29

right that's a gamechanging kind of

9:31

situation not in my lifetime we had the

9:33

opportunity to go in and really Take

9:35

Back Control from the administrative

9:36

state for a long time they've been

9:38

acting as judge jury and executioner on

9:40

the rules that they make on Industries

9:41

and small business owners and the rest

9:43

um so we we have the ingredients we have

9:45

the conditions right now to actually be

9:47

able to make really dramatic change and

9:49

we're going to go through and and have

9:50

those discussions those brainstorms to

9:52

see but you're going to have willing uh

9:53

Partners In the House and Senate among

9:55

the Republican you're also going to have

9:56

so many people who are pushing back oh

9:58

my donors my you know the lobbyists that

10:01

I promis things to they're not going to

10:02

go for that and I won't get reelected if

10:04

I let you cross that off on our list so

10:06

what are you going to do about well you

10:07

got to have a a president that's bold

10:09

enough to do it you know we have our own

10:11

version of the Argentinian leader right

10:13

with Donald Trump and um I've used the

10:15

blowtorch uh analogy rather than a

10:16

chainsaw but it's all the same we do

10:18

have to scale back the size and scope of

10:19

government it serves the people it

10:20

unleashes the free market again our

10:22

policy changes will be a part of that

10:24

but uh I think that if we can uh make

10:26

some dramatic changes in downsizing the

10:28

scale and scope of these things will go

10:30

a long way in two specific examples

10:32

Planned Parenthood and PBS are in go uh

10:35

Congressional control are you planning

10:36

to act both of those I would like to

10:38

that's for sure for both of those yeah

10:40

we got to build consensus to have the

10:41

votes to do that now some of this will

10:43

be done by executive order out of the

10:44

White House ABS he has a broad authority

10:46

to do a lot of that where Congress is

10:48

involved that's where it takes the the

10:49

hard work of legislating of getting

10:51

everybody on the same page so um

10:53

there'll be lots of ideas that come out

10:55

we don't want to put too many of it out

10:57

right now okay but this is part of that

10:59

preparing the Playbook to unleash and

11:01

unroll in January so well we know that

11:02

something like 70% of those polls said

11:05

they wanted significant change in the

11:08

American government system and um it all

11:11

falls on your shoulders yeah no pressure

11:13

right no pressure but that's what we

11:14

want too we doesn't you're right like

11:16

those two Supreme Court decisions are

11:18

things that don't need to go through

11:19

Congress so there there'll be baskets of

11:22

areas of responsibility and we look

11:24

forward to to watching it all thank you

11:26

speaker Mr Speaker good to have you with

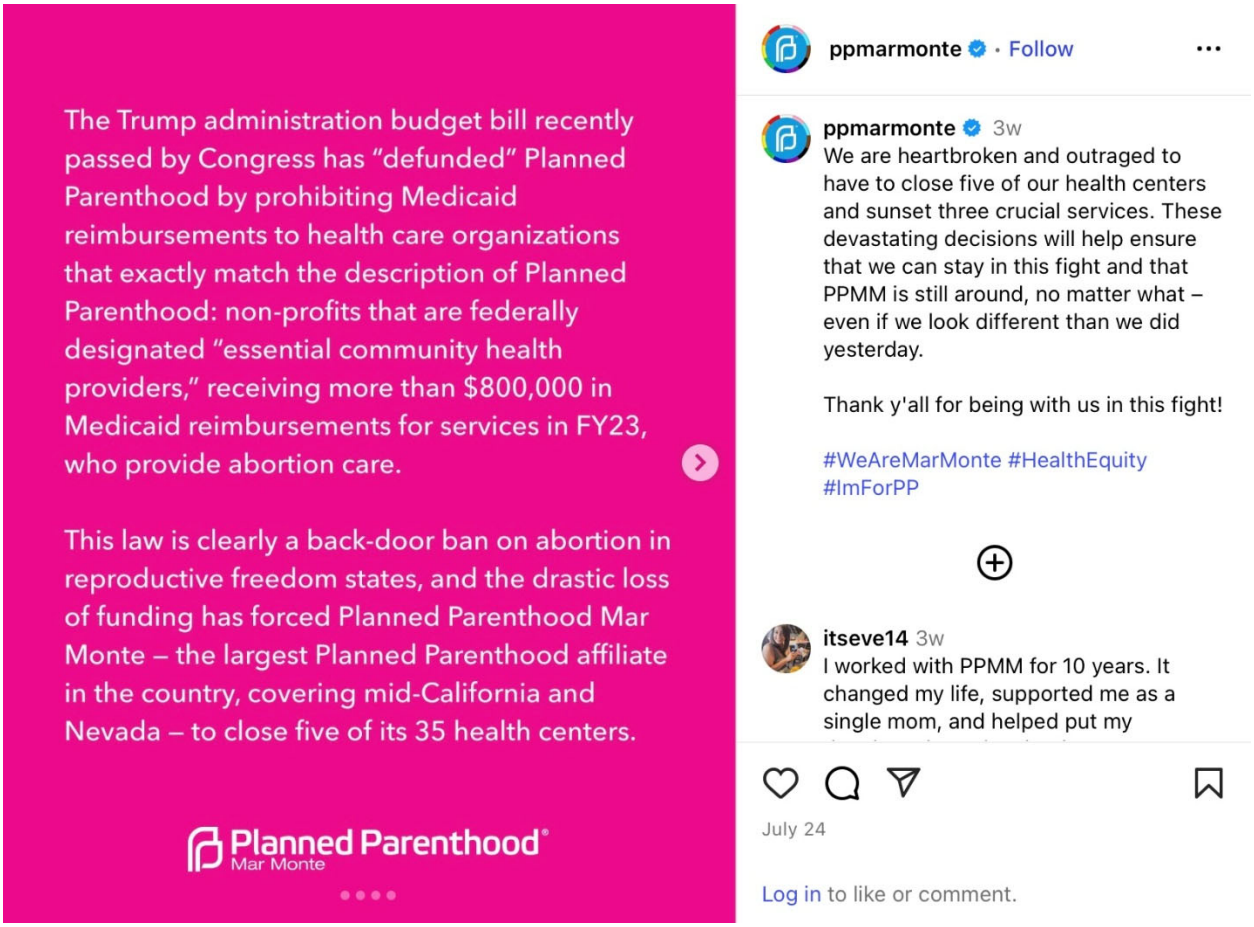
11:27

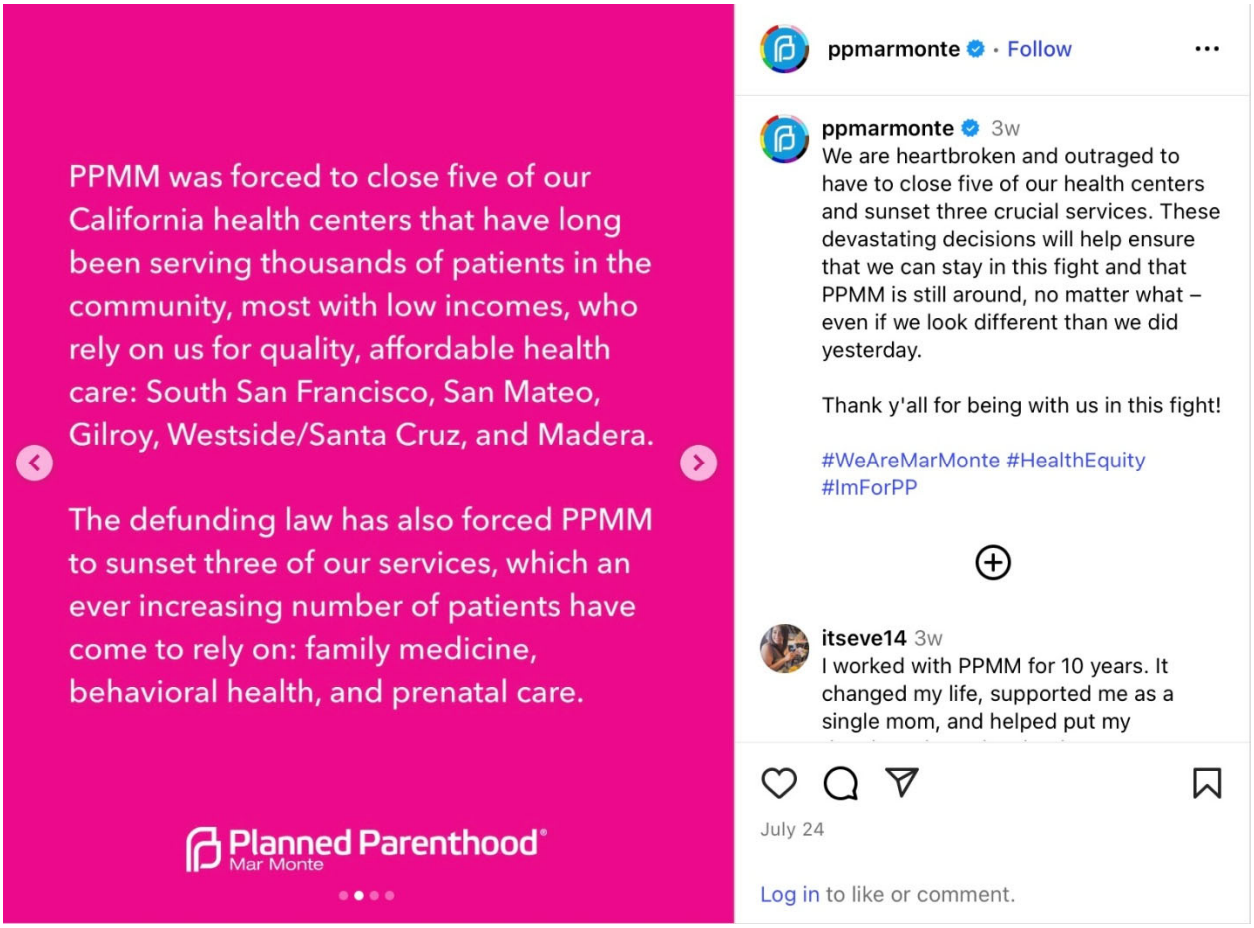
us great to be with you Mike Johnson

11:29

thank you very much

Exhibit 4


The Trump administration budget bill recently passed by Congress has "defunded" Planned Parenthood by prohibiting Medicaid reimbursements to health care organizations that exactly match the description of Planned Parenthood: non-profits that are federally designated "essential community health providers," receiving more than $800,000 in Medicaid reimbursements for services in FY23, who provide abortion care.
This law is clearly a back-door ban on abortion in reproductive freedom states, and the drastic loss of funding has forced Planned Parenthood Mar Monte – the largest Planned Parenthood affiliate in the country, covering mid-California and Nevada – to close five of its 35 health centers.
Planned Parenthood
Mar Monte
ppmarmonte · Follow
ppmarmonte 3w
We are heartbroken and outraged to have to close five of our health centers and sunset three crucial services. These devastating decisions will help ensure that we can stay in this fight and that PPMM is still around, no matter what – even if we look different than we did yesterday.
Thank y'all for being with us in this fight!
#WeAreMarMonte #HealthEquity #ImForPP
itseve14 3w
I worked with PPMM for 10 years. It changed my life, supported me as a single mom, and helped put my
July 24
Log in to like or comment.


PPMM was forced to close five of our California health centers that have long been serving thousands of patients in the community, most with low incomes, who rely on us for quality, affordable health care: South San Francisco, San Mateo, Gilroy, Westside/Santa Cruz, and Madera.
The defunding law has also forced PPMM to sunset three of our services, which an ever increasing number of patients have come to rely on: family medicine, behavioral health, and prenatal care.
Planned Parenthood
Mar Monte
ppmarmonte · Follow
ppmarmonte 3w
We are heartbroken and outraged to have to close five of our health centers and sunset three crucial services. These devastating decisions will help ensure that we can stay in this fight and that PPMM is still around, no matter what – even if we look different than we did yesterday.
Thank y'all for being with us in this fight!
#WeAreMarMonte #HealthEquity #ImForPP
itseve14 3w
I worked with PPMM for 10 years. It changed my life, supported me as a single mom, and helped put my
July 24
Log in to like or comment.


We are not backing down, but we must have the resources to continue this fight and to continue to provide care for the hundreds of thousands who rely on PPMM for care.
Our challenge to the Trump administration and the defund Planned Parenthood provision of the reconciliation bill may very well end up at the U.S. Supreme Court – which we know is adversarial toward Planned Parenthood.
Planned Parenthood
Mar Monte
ppmarmonte · Follow
ppmarmonte 3w
We are heartbroken and outraged to have to close five of our health centers and sunset three crucial services. These devastating decisions will help ensure that we can stay in this fight and that PPMM is still around, no matter what – even if we look different than we did yesterday.
Thank y'all for being with us in this fight!
#WeAreMarMonte #HealthEquity #ImForPP
itseve14 3w
I worked with PPMM for 10 years. It changed my life, supported me as a single mom, and helped put my
July 24
Log in to like or comment.

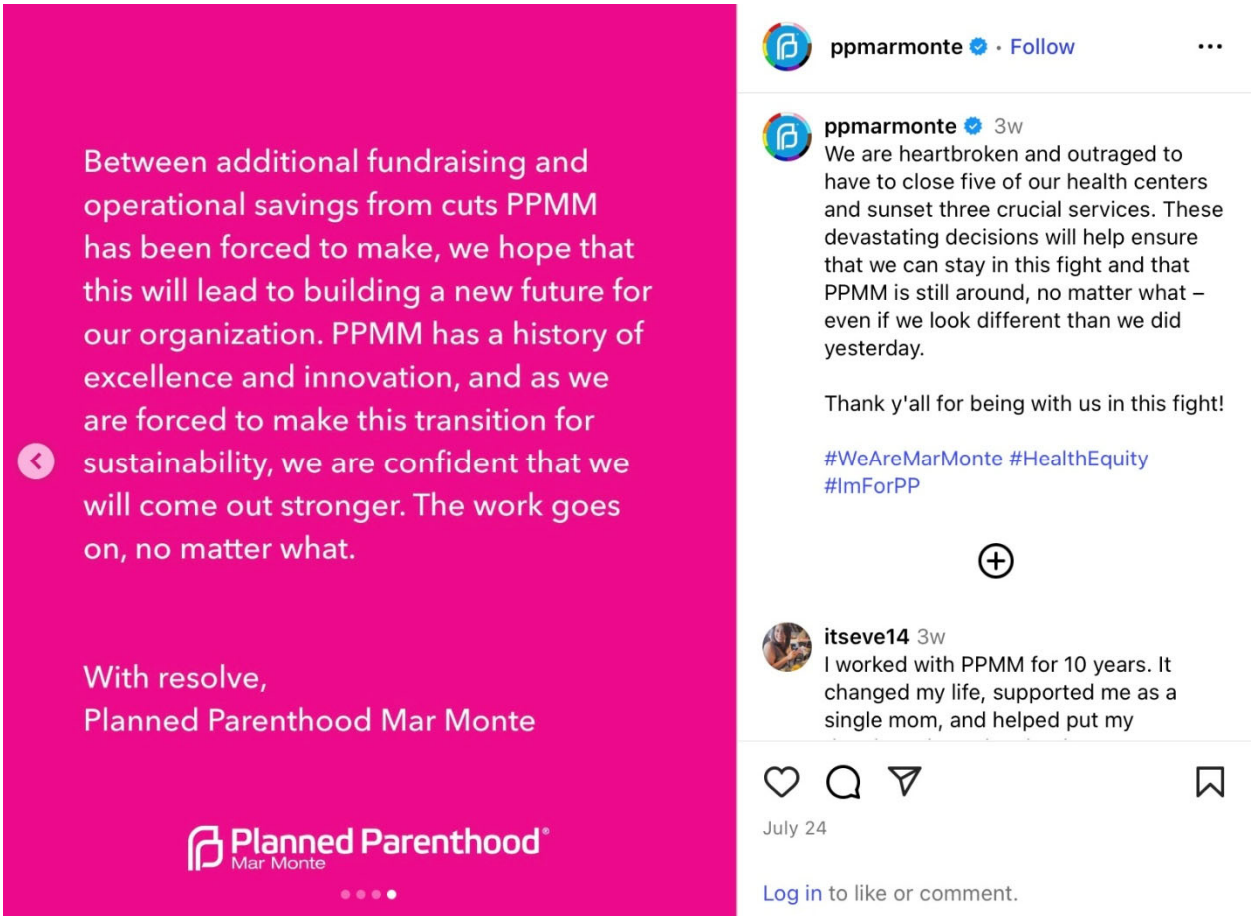

Between additional fundraising and operational savings from cuts PPMM has been forced to make, we hope that this will lead to building a new future for our organization. PPMM has a history of excellence and innovation, and as we are forced to make this transition for sustainability, we are confident that we will come out stronger. The work goes on, no matter what.
With resolve,
Planned Parenthood Mar Monte
Planned Parenthood Mar Monte
ppmarmonte · Follow
ppmarmonte 3w
We are heartbroken and outraged to have to close five of our health centers and sunset three crucial services. These devastating decisions will help ensure that we can stay in this fight and that PPMM is still around, no matter what – even if we look different than we did yesterday.
Thank y'all for being with us in this fight!
#WeAreMarMonte #HealthEquity #ImForPP
itseve14 3w
I worked with PPMM for 10 years. It changed my life, supported me as a single mom, and helped put my
July 24
Log in to like or comment.

Exhibit 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants,

Case No. 1:25-cv-12118-IT

DECLARATION OF MEGAN L. KAVANAUGH

I, Megan L. Kavanaugh, declare that if called as a witness, I would testify competently to the following:

1. I am a Principal Research Scientist at the Guttmacher Institute in New York City, New York. The Guttmacher Institute is a private, independent, nonprofit, nonpartisan entity that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. It produces a wide range of resources on topics pertaining to sexual and reproductive health and which are widely used and cited by researchers, policymakers, the media and advocates across the ideological spectrum. I have worked as a researcher at the Guttmacher Institute since 2008.
2. I am Adjunct Professor of Medicine in the Department of General Internal Medicine at the University of Pittsburgh School of Medicine in Pittsburgh, Pennsylvania. I have held this position since 2017.
3. I am affiliated faculty with the Center for Innovative Research on Gender Health Equity (CONVERGE) at the University of Pittsburgh, a center that convenes a multidisciplinary community of scholars who conduct and translate research focused on sexual and reproductive health, with particular attention to marginalized populations. I have been affiliated with CONVERGE since 2017.

4. I received a Doctor of Public Health (DrPH) degree and a Master of Public Health (MPH) degree, both in Behavioral and Community Health Sciences from the University of Pittsburgh Graduate School of Public Health.

5. A copy of my curriculum vitae is attached as Exhibit A.

6. My area of research expertise is monitoring sexual and reproductive healthcare delivery and demand in the United States, with attention to understanding inequities in access and barriers to this care. My most recent studies have tracked national- and state-level trends in contraceptive use, integrating a person-centered lens into understanding people's experiences and preferences related to contraception, and documenting barriers to sexual and reproductive health care and their consequences.

7. Of particular relevance, from 2017-2024, I served as Principal Investigator of the Reproductive Health Impact Study, a large multistate, multiyear research effort to understand the impact of federal and state policy changes on the publicly funded family planning network and on the patients served within this network.

8. I have served as a research grantee and/or consultant to a variety of federal government projects and agencies since 2010, including: grantee of the Office of Population Affairs (OPA) for Title X family planning research (2022-2025, 2014-2017, 2010-2012), consultant to the Centers for Disease Control and Prevention (CDC) regarding updating the family planning module of the Behavioral and Risk Factor Surveillance System (BRFSS) (2022), and expert panelist at the U.S. Department of Health and Human Services (DHHS)

Roundtable Series: Facilitating Reproductive Health Research post-Dobbs Decision (2023).

9. From 2004-2008, I received compensation from Planned Parenthood of Western Pennsylvania (PPWP) for employment as a part-time pregnancy options counselor.

10. I have been asked to provide my opinion on the impacts at multiple levels of Section 71113 of An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 ("Section 71113"), which I understand is intended to prohibit Planned Parenthood Federation of America ("PPFA") Member organizations from receiving federal funds through Medicaid.

11. In this declaration, I use shorthand to discuss PPFA Members' health centers, using the terms "Planned Parenthood," "Planned Parenthood health centers," and "Planned Parenthood clinics." For purposes of this declaration, unless otherwise indicated, those terms refer to the health centers owned and operated by PPFA Members, all of which include the words "Planned Parenthood" in their names.

12. In this declaration, I also use the term "publicly supported clinics" frequently. The Guttmacher Institute defines publicly supported clinics as sites that offer contraceptive services to the general public and use public funds (e.g., federal, state or local funding through programs such as Title X, Medicaid or the federally qualified health center (FQHC) program) to provide free or reduced-fee services to at least some patients. Sites must serve at least 10 contraceptive patients per year. These sites are operated by a diverse range of providers,

including public health departments, Planned Parenthood affiliates, hospitals, FQHCs and other independent organizations.

13. As further explained below, the implementation of Section 71113 of Public Law 119-21 prohibiting Planned Parenthood's ability to receive Medicaid funding, essentially removing government subsidies to support the delivery of healthcare at Planned Parenthood entities, or "defunding Planned Parenthood," will incur multiple harms across the Plaintiff States at the state, health system, and individual, including patient, levels.

14. I begin by providing an overview of why contraception is key to people leading full and healthy lives, and I then highlight how not all people have equitable access to contraception. I further explain the importance of the publicly supported sexual and reproductive health (SRH) care system in addressing inequities in access to contraception due to inability to pay, and the disproportionately large role that Medicaid plays in resourcing this system. I then situate Planned Parenthood's unique and critical role within the publicly supported SRH care system, in order to highlight the significant harms that would result from Planned Parenthood being removed from the system. I draw on evidence from two states (Iowa and Texas) to highlight case studies of what happened to these state-specific publicly supported SRH care systems when Planned Parenthood was effectively removed as an option for patients due to their carrying of Medicaid health insurance coverage.

I. Contraception is key to people living full and healthy lives

15. People use contraception for a variety of reasons, including to prevent pregnancy, to space and plan their pregnancies, to manage and treat medical conditions, and to prevent sexually transmitted infections. People also choose different contraceptive methods at different stages of their reproductive lives, and a variety of factors—like minimizing side effects, desiring a method that requires limited user oversight, and preferring to minimize provider interactions—influence which methods people prefer to use. Having access to the full range of contraceptive methods is therefore key for all people to live full, healthy lives. Beyond the immediate benefits for health and reproductive autonomy, a substantial body of evidence indicates that contraception helps people to realize social and economic life milestones—including improved economic outcomes related to educational attainment and financial security.[1]

16. Contraceptive use is ubiquitous in the United States; more than 99% of women aged 15–49 who have ever had sexual intercourse have used at least one contraceptive method during their lifetime.[2] This statistic holds across a variety of religious affiliations, urban-rural residence, education levels, and race and ethnicity.[3] About 65% of all women of reproductive age in the U.S. are currently using a contraceptive method. Among those not seeking pregnancy (i.e., women aged 15–49 who have had sexual intercourse in the

[1] ADAM SONFIELD ET AL., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 7-10, 14-17 (Guttmacher Inst., 2013), https://www.guttmacher.org/sites/default/files/pdfs/pubs/social-economic-benefits.pdf.
[2] KIMBERLY DANIELS & JOYCE C. ABMA, CONTRACEPTIVE METHODS WOMEN HAVE EVER USED: UNITED STATES, 2015-2019 4 (Ctrs. for Disease Control & Prevention Nat'l Ctr. for Health Stats., 2023), https://www.cdc.gov/nchs/data/nhsr/nhsr195.pdf.
[3] *Id.* at 8.

past three months, are not pregnant or trying to conceive, and are not sterile for noncontraceptive reasons), 89% are currently using a contraceptive method.[4]

17. Women and couples rely on a wide range of contraceptive methods to achieve their reproductive goals. In 2018, 21% of female contraceptive users relied on oral contraceptive pills and 13% on condoms as their single, most effective method. The remaining 2/3 of contraceptive users relied on other methods: female or male sterilization; hormonal or copper intrauterine devices (IUDs); hormonal methods including the injectable, the ring, the patch and the implant; and behavioral methods, such as withdrawal and fertility awareness methods.[5]

18. Many people use two or more methods at once: 18% of female contraceptive users did so the last time they had sex. For example, they may use condoms to prevent STIs and an IUD for the most reliable prevention of pregnancy. Or they may use multiple methods simultaneously—for instance, condoms, withdrawal and oral contraceptives—to provide extra pregnancy protection.[6]

19. Ensuring that people have access to a range of contraceptive methods so that they can select the method or methods that best meet their own needs and life circumstances is key to ensuring that users are satisfied with their selected methods. Individuals who are satisfied with their contraceptive methods are more likely to use them consistently and correctly.

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[4] *Fact Sheet: Contraceptive Use in the United States by Method*, GUTTMACHER INST. (May 2021), https://www.guttmacher.org/fact-sheet/contraceptive-method-use-united-states.
[5] *Id.*
[6] Megan L. Kavanaugh, Emma Pliskin & Jenna Jerman, *Use of Concurrent Multiple Methods of Contraception in the United States, 2008 to 2015*, 3 CONTRACEPTION: X 1, 3 (2021), https://www.sciencedirect.com/science/article/pii/S2590151621000071?via%3Dihub.

20. For example, a study by my Guttmacher colleagues found that 30% of neutral or dissatisfied users had a temporal gap in use, compared with 12% of completely satisfied users.[7] Similarly, 35% of satisfied oral contraceptive users had skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[8] In my recent research, we found that experiencing barriers to getting contraception is associated with decreased method satisfaction.[9]

II. People face a variety of barriers in accessing contraception, including cost and health insurance coverage

21. Accumulated research studies have documented that a number of factors hinder people's access to contraception, including availability of care, availability of over-the-counter options, travel distance to healthcare providers and availability of transportation, clinic hours of operation, health provider characteristics and approach, medical mistrust, and individual preferences and experiences.[10] One of the most central influences on access to care is cost and

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[7] JENNIFER J. FROST, JAQUELINE E. DARROCH & LISA REMEZ, IMPROVING CONTRACEPTIVE USE IN THE UNITED STATES 4 (Guttmacher Inst., 2008), https://www.guttmacher.org/sites/default/files/report_pdf/improvingcontraceptiveuse_0.pdf.

[8] *Id.* at 5.

[9] Megan L. Kavanaugh, Ellie Leong & Christina Geddes, *Differential Associations Between Access to Sexual and Reproductive Healthcare and Subsequent Contraceptive and Pregnancy Outcomes by Ethnicity Among Family Planning Patients in Arizona*, 12 WOMEN'S REPROD. HEALTH 199, 210-11 (2025), https://www.tandfonline.com/doi/full/10.1080/23293691.2024.2423719#d1e335.

[10] Kelsey Holt et al., *Beyond Same-day Long-acting Reversible Contraceptive Access: A Person-centered Framework for Advancing High-quality, Equitable Contraceptive Care*, 222 AM. J. OBSTETRICS & GYNECOLOGY S878, S878-S880 (2020), https://www.sciencedirect.com/science/article/pii/S0002937819327000; Rachel G. Logan et al., *"When Is Health Care Actually Going to Be Care?" The Lived Experience of Family Planning Care Among Young Black Women*, 31 QUALITATIVE HEALTH RSCH. 1169, 1169-1182 (2021), https://journals.sagepub.com/doi/10.1177/1049732321993094; Emily S. Mann, *The Power of Persuasion: Normative Accountability and Clinicians' Practices of Contraceptive Counseling*, 2 SSM – QUALITATIVE RSCH. HEALTH 1, 100049:7-8 (2022), https://www.sciencedirect.com/science/article/pii/S2667321522000117?via%3Dihub.

the role insurance plays in mediating service availability and affordability.[11] In 2024, one in five uninsured women reported having to stop using contraception because they could not afford it.[12] Research that I have led has documented that, as of 2015–2019, 23% of female contraceptive users and 39% of female nonusers of contraception living at 300% or less than the federal poverty level in the United States would prefer to use (another) contraceptive method if cost were not a consideration.[13] Cost, including affordability of methods and contraceptive-related health care, factors prominently in which methods individuals use[14] and why users may not be using their preferred method, a key predictor of continuous contraceptive use.[15]

22. Financial resources—income and health insurance coverage—also play a role in individuals' ability to realize their contraceptive preferences, with greater mismatches between preferred and used contraceptive methods among women

[11] Alicia VandeVusse et al., *Cost-related Barriers to Sexual and Reproductive Health Care: Results from a Longitudinal Qualitative Study in Arizona*, 4 SSM – QUALITATIVE RSCH. HEALTH 1, 6 (2023), https://www.sciencedirect.com/science/article/pii/S2667321523001440?via%3Dihub#bib44.
[12] Brittni Frederiksen, Karen Diep & Alina Salganicoff, *Contraceptive Experiences, Coverage, and Preferences: Findings from the 2024 KFF Women's Health Survey*, KFF (Nov. 2024), https://www.kff.org/womens-health-policy/issue-brief/contraceptive-experiences-coverage-and-preferences-findings-from-the-2024-kff-womens-health-survey/.
[13] Megan L. Kavanaugh, Emma Pliskin & Rubina Hussain, *Associations Between Unfulfilled Contraceptive Preferences Due to Cost and Low-income Patients' Access to and Experiences of Contraceptive Care in the United States, 2015–2019*, 4 CONTRACEPTION: X 1, 3-4 (2022), https://www.sciencedirect.com/science/article/pii/S2590151622000053?via%3Dihub.
[14] EMILY M. JOHNSTON, BRIGETTE COURTOT & GENEVIEVE M. KENNEY, ACCESS TO CONTRACEPTION IN 2016 AND WHAT IT MEANS TO WOMEN 5 (Urb. Inst., 2017), https://www.urban.org/sites/default/files/publication/87691/2001113-access-to-contraception-in-2016-and-what-it-means-to-women.pdf.
[15] Payal Chakraborty et al., *Use of Nonpreferred Contraceptive Methods Among Women in Ohio*, 103 CONTRACEPTION 328, 334 (2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00035-4/fulltext.

with lower socioeconomic statuses than among those with higher incomes.[16] In a 2024 national study, 15% of women who were not using their preferred method of contraception indicated that the primary reason was because they could not afford it.[17] Among women at risk of unintended pregnancy in the United States, nonusers of contraception are more likely to have lower incomes and be uninsured compared to users.[18]

23. Cost barriers restrict individuals' ability to fully realize their sexual and reproductive health and well-being, forcing individuals to "prioritize affordability over health, cost avoidance over prevention and insurance acceptance over quality of care."[19] Research that I conducted with Guttmacher colleagues highlights that individuals often postpone or forgo care when experiencing cost barriers.[20] Individuals are also more likely to switch care sites to access affordable care, even when it means visiting a less-preferred health care provider or facility.[21] Importantly, my research has documented that key strategies to address cost barriers to contraception and help individuals to realize their contraceptive preferences include health insurance coverage and person-centered contraceptive counseling.[22]

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[16] Joseph E. Potter et al., *Unmet Demand for Highly Effective Postpartum Contraception in Texas*, 90 CONTRACEPTION 488, 491 (2014), https://www.sciencedirect.com/science/article/pii/S0010782414005629; Katherine He et al., *Women's Contraceptive Preference-Use Mismatch*, 26 J. WOMEN'S HEALTH 692, 698-699 (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5512313/.
[17] Brittni Frederiksen, Karen Diep & Alina Salganicoff, *supra* note 12.
[18] Brittni Frederiksen & Katherine Ahrens, *Understanding the Extent of Contraceptive Non-use Among Women at Risk of Unintended Pregnancy*, *National Survey of Family Growth 2011–2017*, 2 CONTRACEPTION: X 1, 3 (2020), https://www.sciencedirect.com/science/article/pii/S2590151620300162?via%3Dihub.
[19] Alicia VandeVusse et al., *supra* note 11, at 6.
[20] *Id.*
[21] *Id.*
[22] Megan L. Kavanaugh, Emma Pliskin & Rubina Hussain, *supra* note 13, at 7.

24. Contraceptive users covered by health insurance who do not have co-payments associated with accessing contraception are more likely to use their contraceptive method consistently, avoiding periods of being unprotected due to cost barriers.[23]

III. The publicly supported SRH care system is therefore critical to addressing cost barriers and ensuring broad access to contraceptive and related SRH care

25. To address existing barriers to contraceptive access due to inability to pay, public dollars are allocated through federal, state, and local channels to the publicly supported SRH care system. Publicly supported clinics have long been a critical source of contraceptive and other SRH care for adolescents and low-income adults in the United States, providing access for vulnerable populations and promoting SRH equity.[24] Public support for this care comes primarily through Medicaid and the national Title X family planning program, which is the only federal grant program dedicated to providing subsidized contraceptive and related SRH services, with a focus on serving individuals who are disadvantaged in their access to health care. The publicly supported SRH care system includes a range of sites that receive public funding: federally qualified health centers (FQHCs), health departments, hospital outpatient clinics, Planned Parenthood sites, Indian Health Service sites, and

[23] Cassondra Marshall et al., *The Relationship Between Prescription Copayments and Contraceptive Adherence in a New-user Cohort*, 56 MED. CARE 577 582 (2018), https://pubmed.ncbi.nlm.nih.gov/29847539/; Lydia E. Pace, Stacie B. Dusetzina & Nancy L. Keating, *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and Nonadherence*, 35 HEALTH AFFS. 1616-1624 (2016), https://pubmed.ncbi.nlm.nih.gov/27605641/.

[24] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at US Clinics, 2015*, GUTTMACHER INST. (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

other community or independent clinics. Each year, this network provides contraceptive and other SRH care to millions of patients nationwide.[25]

26. Medicaid is a health insurance program for low-income people, jointly funded by federal and state governments. As such, Medicaid reimburses health care providers for covered services. Historically, Medicaid has accounted for the largest share of public dollars that go towards the delivery of contraceptive and related care.[26] Medicaid is critical to ensuring that people of reproductive age have access to health care, including sexual and reproductive health care. In 2023, 21.4% of women aged 15-49 were enrolled in Medicaid, and that proportion went up to 52.8% for women aged 15-49 with incomes below the poverty line.[27]

27. As of 2019, 39% of U.S. women aged 15-44 relied on Medicaid and other public insurance to cover their contraceptive care, and 33% of those obtaining care at publicly supported healthcare sites used their Medicaid and other public insurance to cover their care.[28]

[25] Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020*, GUTTMACHER INST. (May 2025), https://www.guttmacher.org/report/publicly-supported-FP-services-US-2020#.
[26] Kinsey Hasstedt, Adam Sonfield & Rachel Benson Gold, *Public Funding for Family Planning and Abortion Services, FY 1980–2015*, GUTTMACHER INST. (Apr. 2017), https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.
[27] Amy Friedrich-Karnik et al., *Increased Medicaid Coverage Helped Reduce the Uninsured Rate from 2019 to 2023, but Federal Policy Proposals Threaten Gains*, GUTTMACHER INST. (May 2025), https://www.guttmacher.org/2025/05/increased-medicaid-coverage-helped-reduce-uninsured-rate-2019-2023-federal-policy-proposals.
[28] Jennifer J. Frost, Jennifer Mueller & Zoe H. Pleasure, *Trends and Differentials in Receipt of Sexual and Reproductive Health Services in the United States: Services Received and Sources of Care, 2006–2019*, GUTTMACHER INST. (June 2021), https://www.guttmacher.org/report/sexual-reproductive-health-services-in-us-sources-care-2006-2019.

28. In addition to being a critical access point for SRH care, publicly supported healthcare facilities also often function as a usual source for medical care of any kind, not just SRH, indicating that these clinics often offer patients an entry point into the health care system. As of 2019, 65% of U.S. women aged 15-44 who visited a publicly funded clinic for one or more contraceptive or other related SRH care services in the prior year reported that the clinic was their usual source for medical care.[29] Non-Hispanic Black women and Hispanic women were more likely (74% and 69%, respectively) than non-Hispanic White women (59%) to report the clinic as their usual source of medical care.[30] Women with Medicaid coverage or those who were uninsured compared with privately insured women (71% and 70% vs. 53%) were more likely to report the clinic as their usual source of care.[31] Particularly for women of color and publicly insured or uninsured women, publicly supported clinics are critical to their ability to enter the health care system and get both the SRH care they need and broader medical care or referrals for such care.[32]

IV. Planned Parenthood is a crucial and widely used access point for individuals, especially those living with low incomes, to obtain high quality reproductive health care services across the United States

A. Planned Parenthood serves a substantial portion of Medicaid enrollees and publicly-supported family planning patients

[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*

29. In 2023, Planned Parenthood health centers served over two million patients, collectively delivering around 9.5 million services.[33] In 2022, 53% of Planned Parenthood patients relied on Medicaid and other government-funded health care programs to pay for their care. Planned Parenthood facilities comprise a relatively small proportion of the overall publicly supported SRH care system, but they serve an outsized number of patients who receive care from this system. In 2021, one in ten Medicaid enrollees received their family planning services at a Planned Parenthood clinic. And in some communities and for many women, Planned Parenthood is the sole source of publicly funded contraceptive care.[34]

30. In 2020, 9,388 publicly supported clinics provided subsidized family planning services nationally—5,429 (58%) were federally qualified health centers, 1,876 (20%) were health departments, 649 (7%) were hospital outpatient facilities, 600 (6%) were Planned Parenthood sites and 834 (9%) were other independent clinics.[35] Of the 4.7 million women who obtained contraceptive care from publicly supported clinics in 2020, 38% received services from federally qualified health centers, 33% from Planned Parenthood sites, 13% from health departments, 9% from hospital outpatient facilities and 7% from other independent clinics.[36]

[33] A FORCE FOR HOPE 6 (Planned Parenthood Fed'n Am., 2024), https://www.plannedparenthood.org/uploads/filer_public/ec/6d/ec6da0d6-98e5-4278-8d11-99a5cba8e615/2024-ppfa-annualreport-c3-digital.pdf.
[34] Frost, Jennifer J., and Kinsey Hasstedt. "Quantifying Planned Parenthood's critical role in meeting the need for publicly supported contraceptive care." *Health Affairs Forefront* (2015).
[35] Jennifer J. Frost et al., *supra* note 25.
[36] Jennifer J. Frost et al., *supra* note 25.

31. As highlighted in the table below, Planned Parenthood facilities serve between 5-72% of the Plaintiff States' publicly supported SRH patients; in eight of these states (California (49%), Connecticut (72%), Minnesota (66%), New Jersey (58%), Oregon (57%), Vermont (68%), Washington (59%), and Wisconsin (59%)), Planned Parenthoods service at least half of their states' overall patient counts. In seven of these Plaintiff states, at least 15% and up to 29% of female Medicaid enrollees who received SRH care did so at a Planned Parenthood clinic.[37]

Table: 2020 overall and state-level publicly supported clinic and patient numbers, highlighting share of care provided by Planned Parenthoods (PPs) across Plaintiff States[38]

	Total publicly supported clinics (2020)	Planned Parenthood clinics (2020)	**% Planned Parenthood as share of all publicly supported clinics**	Total patients served by publicly supported sites (2020)	Planned Parenthood patients served (2020)	**% Planned Parenthood patients served as share of all publicly supported patients**	% female Medicaid enrollees who went to Planned Parenthoods (2021)
All U.S states	9388	600	**6**	4740530	1585480	**33**	11
Plaintiff states							
CA	1366	121	**9**	1238800	603290	**49**	29
CO	181	18	**10**	92930	27180	**29**	12
CT	77	16	**21**	72120	52250	**72**	20
DE	55	3	**5**	14900	6220	**42**	5
DC	29	1	**3**	42920	2130	**5**	NA

[37] Brittni Frederiksen et al., *Recent Policy Proposals Could Weaken the Reproductive Health Safety Net as More People Become Uninsured*, KFF (July 28, 2025), https://www.kff.org/womens-health-policy/issue-brief/recent-policy-proposals-could-weaken-the-reproductive-health-safety-net-as-more-people-become-uninsured/.

[38] *Id.*; Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States, 2020: Tables and Appendix Tables*, GUTTMACHER INST. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf.

HI	49	2	**4**	13780	1860	**13**	1
IL	295	17	**6**	146910	29630	**20**	NA
MA	168	4	**2**	86830	12040	**14**	4
MD	117	9	**8**	69930	32860	**47**	4
ME	100	4	**4**	24730	6330	**26**	6
MI	229	16	**7**	72250	29460	**41**	4
MN	91	18	**20**	47620	31330	**66**	16
NC	240	9	**4**	102470	23240	**23**	2
NV	49	3	**6**	19360	6460	**33**	1
NJ	110	22	**20**	105640	61020	**58**	12
NM	169	4	**2**	32610	4560	**14**	5
NY	516	56	**11**	426210	109060	**26**	9
OR	156	12	**8**	66550	37800	**57**	16
PA	314	22	**7**	152570	36840	**24**	5
RI	33	1	**3**	26360	6860	**26**	4
VT	52	12	**23**	17170	11620	**68**	19
WA	239	33	**14**	134070	78860	**59**	21
WI	121	24	**20**	51,100	30,170	**59**	21

Notes: Total numbers of clinics and patients, overall and specific to Planned Parenthoods, come from: Jennifer J. Frost et al., Publicly Supported Family Planning Services in the United States, 2020: Tables and Appendix Tables, GUTTMACHER INST. (2025), https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-fp-services-us-2020-tables-and-appendix-tables.pdf. The bolded two columns are calculated based on data from these sources. % female Medicaid enrollees who went to Planned Parenthoods come from: Brittni Frederiksen et al., Recent Policy Proposals Could Weaken the Reproductive Health Safety Net as More People Become Uninsured, KFF (July 28, 2025), https://www.kff.org/womens-health-policy/issue-brief/recent-policy-proposals-could-weaken-the-reproductive-health-safety-net-as-more-people-become-uninsured/.

B. Planned Parenthood provides high-quality and comprehensive sexual and reproductive health services

32. In addition to serving a substantial proportion of publicly supported SRH patients, Planned Parenthoods are specialized SRH care facilities that provide high-quality, evidence-based SRH care. Thus, focusing exclusively on capacity—and ultimately whether or not patient caseload can be absorbed by other provider types based on volume alone—minimizes the overall impact on

patients, who could lose access to the specialized and patient-centered contraceptive care provided by Planned Parenthood clinics. Other providers that receive public support for family planning services do so as part of a range of other services (such as primary care and mental health care, for example) and therefore offer a different value to the communities they serve than do the dedicated SRH providers at Planned Parenthood affiliates.

33. For example, one objective of Healthy People 2030, an initiative of the Department of Health and Human Services that outlines public health objectives for the United States population, is to "increase the proportion of publicly funded family planning clinics that offer the full range of reversible contraception methods onsite."[39] Planned Parenthood clinics exemplify this practice.

34. Guttmacher's 2022-2023 Family Planning Clinic Survey Trends report highlights that Planned Parenthood health centers provide the broadest range of comprehensive contraceptive options among all of the publicly supported facility types.[40] Notably, Planned Parenthood clinics offer the widest contraceptive method mix, with nearly all (99%) offering 10 or more reversible methods. Availability of a wide range of methods is an important component of patient-centered care. In addition, my Guttmacher colleagues

[39] *Increase the Proportion of Publicly Funded Clinics that Offer the Full Range of Reversible Birth Control*, U.S. DEP'T HEALTH & HUM. SERVS. (N.D.), https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/increase-proportion-publicly-funded-clinics-offer-full-range-reversible-birth-control-fp-d01.

[40] Alicia VandeVusse et al., *Publicly Supported Family Planning Clinics in 2022–2023: Trends in Service Delivery Practices and Protocols*, GUTTMACHER INST. (Nov. 2024), https://www.guttmacher.org/report/publicly-supported-family-planning-clinics-2022-2023.

found that over 90% of Planned Parenthood clinics offered other important protocols for ensuring patient-centered care.[41] Using a patient-centered approach in contraceptive care and counseling is associated with higher patient satisfaction, which can lead to higher continuation of method use.[42]

35. Meeting the needs of family planning patients includes attending to how, when, and where contraception is prescribed and dispensed. The vast majority of Planned Parenthood clinics (92%) offer a supply of 12+ months of oral contraceptive pills—far more than other clinic types. (Overall, just over a third of all publicly supported clinics offer this extended supply). Dispensing 12-month supplies of contraception increases the likelihood of method continuation.[43] In the context of serving Medicaid enrollees and other communities facing barriers to care, prescription of 12 month supplies is particularly important, as the practice improves equity in SRH care; research has found that contraceptive users who discontinued use because they were unable to obtain their next supply on time were disproportionately Black and low income.[44] Planned Parenthood clinics are also more likely to dispense contraception on-site and to use Quick Start (a same day protocol), both of

[41] Jennifer Mueller et al., *Assessing the Provision of Person-Centered Contraceptive Care at Publicly Supported Clinics Providing Contraceptive Services in the United States*, 35 WOMEN'S HEALTH ISSUES 169, 172-74 (2025), https://www.sciencedirect.com/science/article/pii/S1049386725000507.
[42] Nathan Hale et al., *Contraceptive Counseling, Method Satisfaction, and Planned Method Continuation Among Women in the U.S. Southeast*, 132 CONTRACEPTION 1, 5 (2024), https://www.sciencedirect.com/science/article/pii/S0010782424000040.
[43] Diana G. Foster et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, 117 OBSTETRICS & GYNECOLOGY 566-572 (2011), https://pubmed.ncbi.nlm.nih.gov/21343759/.
[44] Sarah L. Day, Neena Qasba & Sarah Goff, *Twelve-month Contraception Dispensing Advances Access and Equity*, HEALTH AFFS. FOREFRONT (Apr. 2023), https://www.healthaffairs.org/content/forefront/twelve-month-contraception-dispensing-advances-access-and-equity.

which remove additional barriers for patients. Additionally, Planned Parenthood sites are most likely to offer advanced provision of emergency contraception—so that patients can keep the medication at home for future use, increasing the likelihood that users will be able to take the medication during the window when it is most effective, without additional obstacles to obtaining it.

36. Among publicly supported family planning clinics, Planned Parenthood has the highest availability of same-day IUD insertion and same-day implant insertion (available at 98% of Planned Parenthood clinics for both procedures, compared to 59% IUD and 69% implant for publicly supported clinics overall). Same-day initiation of long-acting reversible contraception (LARC), recommended by the American College of Obstetricians and Gynecology (ACOG), reduces barriers for patients, particularly related to cost and transportation associated with multiple visits;[45] these barriers can lead some patients to forgo contraception altogether.[46]

37. Data from my Guttmacher colleagues' work shows that Planned Parenthood clinics are more likely than other publicly supported family planning clinics to offer cervical cancer screenings, medication for HIV prevention, and HPV vaccination.[47] Planned Parenthood clinics are also more likely to offer

[45] ACCESS TO CONTRACEPTION: COMMITTEE OPINION NO. 615 4 (Am. Coll. Obstetricians & Gynecologists Comm. on Health Care for Underserved Women, 2015), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf?rev=326fce9f62fa42b983ea4b6c39325956&hash=CFD1BD28FCB0D17A23486A587A480A19.
[46] Rebecca McColl et al., *Same-day Long-acting Reversible Contraceptive Utilization After a Statewide Contraceptive Access Initiative*, 228 AM. J. OBSTETRICS & GYNECOLOGY 451.e4-451.e5, (2023), https://www.ajog.org/article/S0002-9378(22)02582-0/fulltext.
[47] Alicia VandeVusse et al., *supra* note 40.

extended office hours, which gives patients greater flexibility in scheduling appointments around work and family responsibilities.

38. Among patients seeking SRH care at a variety of publicly supported sites, those who received more recent contraceptive care at a Planned Parenthood reported almost two times higher odds of subsequently using their preferred contraceptive method compared to those who had not received recent contraceptive care.[48]

V. Given Planned Parenthood's critical role within the broader publicly supported landscape of care and evidence of the high-quality care available across Planned Parenthoods, removing them from this system will result in harms at multiple levels

39. The provision of reproductive health care is siloed and often stigmatized from other types of health care, and providers and facilities that serve low-income people must overcome barriers and cost restrictions to provide patients with necessary care. These obstacles lead to a gap between patients' need and access to contraceptive care, despite the vast number of patients served by Planned Parenthood and other publicly supported clinics. There were 69 million US women of reproductive age (13–44) in 2020, 19 million of whom were considered to have a likely need for publicly supported contraceptive services because they either had an income below 250% of the federal poverty level or were younger than 20.[49] And yet, only an estimated 7.2 million

[48] Megan L. Kavanaugh, Ellie Leong & Christina Geddes, *supra* note 9, at 210.
[49] Jennifer J. Frost et al., *supra* note 25.

women received publicly supported contraceptive services from all sources.[50] The majority of these women—an estimated 4.7 million contraceptive patients—were served at publicly funded clinics. These 2020 data capture a picture of a system under duress, both in the aftermath of regulation changes to the Title X federally funded system in the 2019 Title X Final Rule (colloquially known as the domestic gag rule for how it restricted the program) and during the onset of the COVID-19 pandemic.[51] The gap between the numbers of people who need care and who received care demonstrates both the critical importance of publicly supported services—and that the system is already unable to meet the needs of all who need it.

40. Policies like Section 71113 of Public Law 119-21 create additional hurdles that limit who providers can see or what types of insurance they can accept and ultimately threaten to permanently close facilities. These effects ripple through the entire health care ecosystem and across communities who rely on this care.

41. By excluding Planned Parenthood clinics from receiving federal Medicaid payments, Section 71113 of Public Law 119-21 threatens Planned Parenthood clinics' ability to meet the needs of people in their communities and, in many cases, threatens their ability to remain open. They may be forced to turn away patients with Medicaid insurance and, without Medicaid as a revenue source, many may be forced to shut down. All of this creates a crisis in access to

[50] *Id.*
[51] Amy Friedrich-Karnik & Rachel Easter, *Restricting Title X Results in Cascading Harms*, GUTTMACHER INST. (Aug. 2024), https://www.guttmacher.org/2024/08/restricting-title-x-results-cascading-harms.

health care for patients and places an enormous strain on the health care systems in communities across the country.

State- and systems-level impacts

42. It is unlikely that states would be able to fill the gap of federal Medicaid funding if Section 71113 of Public Law 119-21 is allowed to stand, in part because of how payments for Medicaid family planning are structured. The Federal Medicaid Assistance Program (FMAP) determines the state/federal split for services.[52] For family planning services and supplies, federal funding covers 90% with states paying the remaining 10%—a much higher federal match than most other Medicaid services.[53] Given this FMAP allocation, this restriction on federal funding creates a particularly dire situation for Medicaid enrollees' access to family planning services.

43. Anticipated impacts of Section 71113 of Public Law 119-21 at the healthcare systems level center around the extent to which other publicly supported healthcare facilities would be able to serve Planned Parenthood patients. However, given the outsized role that Planned Parenthood plays within the publicly supported SRH care system, it is unrealistic to expect other types of clinics to serve the millions of people who rely on them for care. I base this statement on a recent analysis from my Guttmacher colleagues that estimated the extent to which other facility types within this care system would need to

[52] Medicaid's Federal Medical Assistance Percentage (FMAP) (2025), https://www.congress.gov/crs-product/R43847.

[53] Brittni Frederiksen et al., *supra* note 37.

increase their contraceptive client caseload. Based on data from 2020, they estimated the following necessary capacity increases:

- Federally qualified health center (FQHC) sites offering contraceptive care would have to increase their capacity to provide these services by 56%, or an additional one million contraceptive clients per year.
- Health department sites offering contraceptive care would have to increase their capacity to provide these services by 28%, or an additional 168,000 contraceptive clients per year.
- Hospital sites offering contraceptive care would have to increase their capacity to provide these services by 53%, or an additional 344,000 contraceptive clients per year.
- Other sites offering contraceptive care, such as those operated by independent agencies, would have to increase their capacity to provide these services by 55%, or an additional 189,000 contraceptive clients per year.

44. FQHCs are an essential part of the nation's overall health care system, and they have been identified as the most likely facility type to "pick up the slack" if Planned Parenthoods were removed as a publicly supported option for patients. However, they are not structured to take on this dramatic increase in publicly supported patients for specialized SRH care, especially in the context of documented staffing shortages, funding pressures, and challenges navigating Medicaid enrollment changes.[54] Importantly, in seven Plaintiff

[54] Celli Horstman et al., *Community Health Centers' Progress and Challenges in Meeting* (continued…)

States (CT, MN, NJ, OR, VT, WA, and WI), FQHCs and other publicly supported clinics would need to increase their caseloads by more than 100% to provide care for patients currently served by Planned Parenthood.[55] In addition, FQHCs and other publicly supported clinics in two Plaintiff States (California and Maryland) would have to increase their caseloads by 80% or more.

Provider-level impacts

45. Our research at Guttmacher has shown that when healthcare facilities are forced to grapple with the loss of a major funding source, such as losing Title X funds or Medicaid reimbursement, many are forced to adapt fee models and reimbursement plans that create more financial obstacles for patients.[56] This can increase the burden on staff, as they have to counsel patients on their new, more limited options available to pay for care. As more patients are left uninsured, staff time may be further stretched through increased demands of attempting to find alternative sources of funding. In the context of family planning providers having to navigate these funding constraints and resulting compromised ability to provide person-centered care, some providers reported increased staff burnout, morale issues, and departures.[57] As one survey

Patients' Essential Primary Care Needs, COMMONWEALTH FUND (2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey.

[55] Press Release, Guttmacher Inst., Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood (May 13, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

[56] Alicia VandeVusse et al., *The Impact of Policy Changes from the Perspective of Providers of Family Planning Care in the US: Results from a Qualitative Study*, 30 SEXUAL & REPROD. HEALTH MATTERS 544, 549 (2022), doi:10.1080/26410397.2022.2089322.

[57] *Id.*

respondent explained: "Staff morale is often a challenge, as we see increased patient volumes and a higher percentage of patients without any [insurance] coverage or without stable coverage. Higher rates of upset patients, increased workload and a hostile political environment can make staff feel like they are frequently under attack just for doing what they believe in."[58] The combination of all of these obstacles can result in providers making care decisions that are not centered on a patient's needs and values but on financial and other constraints.[59]

Patient-level impacts

Impacts on access to contraception

46. Impacts of restrictions on SRH care at the systems- and provider-levels ultimately trickle down to impact the very people that these systems are set up to serve, resulting in decreased access to care and reproductive autonomy. Several studies that I led under the Reproductive Health Impact Study highlight how this ripple effect can occur and portend what may follow if Section 71113 of Public Law 119-21 stands. Broadly, when we analyzed longitudinal survey data from patients seeking SRH care prior to and after the implementation of the 2019 Title X Final Rule, which resulted in all Planned Parenthoods leaving the Title X network, we found that patients who obtained care prior to the Final Rule at a Title X–funded health care center that

[58] Alicia VandeVusse et al., *Publicly Funded Clinics Providing Contraceptive Services in Four US States: The Disruptions of the "Domestic Gag Rule" and COVID-19*, GUTTMACHER INST. (July 2023), https://www.guttmacher.org/report/clinics-providing-services-in-four-us-states-disruptions-of-gag-rule-and-covid-19.
[59] Alicia VandeVusse et al., *Contraceptive Care Post-Dobbs: A Qualitative Study of Clinic Staff Perspectives*, 7 SSM – QUALITATIVE RSCH. HEALTH 1, 5-6 (2025), https://www.sciencedirect.com/science/article/pii/S2667321525000101?via%3Dihub.

subsequently left the network were less likely to have received recent contraceptive care after the rule was implemented, compared with those who had initially accessed this care at a site that either stayed in the network or was never a part of it.[60] Further, we found that patients in the first group were less likely to have been using a provider-involved method, less likely to have been using a method that carries a cost and less likely to report being satisfied with their method after the rule went into effect. These data highlight how the removal of Planned Parenthoods as a key provider within the publicly supported network has impacts for individuals who rely on this care.

47. In addition, examining what happened to publicly supported SRH patients in Iowa following the removal of Planned Parenthood as a covered provider under the state Medicaid program also helps to foreshadow some of the impacts that we can expect will result from Section 71113 of Public Law 119-21. In 2017, the Iowa legislature voted to defund Planned Parenthood and reject federal Medicaid dollars for family planning, implementing instead a state-funded program that removed funding eligibility from health care sites that provided abortion care or referrals. According to media accounts highlighting Iowa Department of Health data, there was an 86% decline in patients served within the state family planning program after the policy went into effect.[61] We surveyed patients seeking sexual and reproductive health care

[60] Megan L. Kavanaugh, Ellie Leong & Madeleine Haas, *Measuring the Relationship Between the 2019 Title X Final Rule and Patients' Sexual and Reproductive Health Care Access and Behavior in Iowa Using a Difference-in-Difference Approach*, 21 SEXUALITY RSCH. & SOC. POL'Y 598, 609 (2024), https://link.springer.com/article/10.1007/s13178-023-00876-2.
[61] Michaela Ramm, *Iowa's Family Planning Service Use Plummets 85 Percent After Switch to New Program*, THE GAZETTE (Dec. 10, 2019), https://www.thegazette.com/health-care-

(continued…)

at publicly supported family planning clinics in Iowa soon after the policy went into effect and followed them for two years. We found:[62]

- The number of patients seeking care at clinics that were affected by the policy dropped dramatically in the two years following implementation of the rule (83% of respondents sought care before the policy went into effect and 15% did so at two years).
- The number of respondents who reported not receiving any recent sexual and reproductive health care increased from 25% at the six-month follow-up to 52% at the two-year point.
- The policy resulted in many patients shifting their contraceptive method: The number who used a method that cost money decreased from 76% to 57%, while the number who used no-cost methods increased from 15% to 28%."

48. We also conducted three rounds of in-depth interviews with some of these patients over eighteen months after the policy went into effect, and these interviews illustrated how pervasive cost-, access-, and quality-related barriers impeded patients' ongoing access to their preferred contraception.[63] Cost barriers such as high fees for visits and methods as well as restrictive or inadequate insurance coverage, and access barriers such as long appointment

medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

[62] Megan L. Kavanaugh et al., *A Prospective Cohort Study of Changes in Access to Contraceptive Care and Use Two Years after Iowa Medicaid Coverage Restrictions at Abortion-providing Facilities Went into Effect*, 41 POPULATION RSCH. & POL'Y REV. 2555, 2569 (2022), https://link.springer.com/article/10.1007/s11113-022-09740-4.

[63] Lori Frohwirth et al., *Access to Preferred Contraceptive Strategies in Iowa: A Longitudinal Qualitative Study of Effects of Shifts in Policy and Healthcare Contexts*, 33 J. HEALTH CARE FOR POOR & UNDERSERVED 1494, 1496-1513(2022), https://muse.jhu.edu/pub/1/article/862431/pdf.

> wait times were most common; these barriers were often experienced simultaneously, thus compounding one another. One respondent's story of navigating her SRH care and preferred contraception in the wake of the Iowa Medicaid policy restrictions illuminates the barriers and, ultimately, disrupted access to contraception and care:[64]

J was an uninsured OCP user who initially reported getting pills at a [Planned Parenthood] without any difficulty:

I thought that even if I was charged, I knew I would be charged a lot lower, because at [the site], they try to make them a little more affordable and a little more acceptable, but when I reported my income, they told me it was free. I was like, yay!

At Wave 2, J said staff at the site told her they would soon have to stop providing free pills onsite due to changes to their funding:

I knew that things have been covered on the media about the potential for defunding for [the site] and the birth control. I never knew that it had actually officially been passed that when I called, they told me that it had been passed and that people are just no longer eligible for the free birth control at all … So, that's no longer an option for me … our funds are quite tight.

She planned to get her pills through a pharmacy or a mail-order system instead of directly from the clinic:

Since all the funds have been cut, not all but most, but definitely for birth control, it's cheaper for me to go back to a regular pharmacy. I get at least a $10 discount going through the pharmacy instead of going through [the site].

[64] *Id.* at 1509.

At her last interview, she was delaying her annual SRH visit until she was sure that she could pay for it:

I asked about the coverage and if it was changed or what had changed, and they said yeah, all of our funding got cut and birth control is like this much. I asked if the appointment itself would end up costing me money and then she said, yes it would end up costing me money, and I canceled my appointment.

She did not know exactly when she might reschedule her visit, which was required to renew her prescription.

49. Taken together, the survey and interview findings indicate that the Iowa Medicaid restrictions on Planned Parenthood diminished access to high-quality, more affordable and more comprehensive sexual and reproductive health care and resulted in some patients shifting their contraceptive use to a method that they preferred less. These impacts on individuals' decision-making power run counter to the tenets of reproductive autonomy.

50. Texas provides another case study of how removing Planned Parenthoods from the publicly supported SRH care system impacts patients. In 2012 Texas legislators cut state funding for family planning services and passed legislation to exclude abortion-affiliated providers (primarily Planned Parenthoods) from participating in the state Medicaid program.[65] As a result, about a quarter of family planning clinics in Texas were forced to close, resulting in significantly

[65] Kari White et al., *Cutting Family Planning in Texas*, 367 NEJM 1179, 1179-1180(2012), https://doi.org/10.1056/NEJMp1207920.

fewer patients served.[66] In addition, patients were also forced to pay more for contraceptive services that had been reduced in cost or free under the program.[67] A 2016 New England Journal of Medicine (NEJM) study examining additional impacts of excluding Planned Parenthoods from the Texas Medicaid program attributed significant reductions in the use of long-acting and injectable contraceptive methods and, ultimately, increases in Medicaid-covered childbirths to the Medicaid restrictions.[68]

51. Patients who rate their interpersonal interactions with their sexual and reproductive health care provider more favorably are more likely to still be using their contraceptive method after six months and to use more effective methods.[69] As noted in Section V.B., Planned Parenthood clinics offer unique benefits in terms of not only volume of patients served, but also in the quality of specialized SRH care. In addition to not having capacity to take on previous Planned Parenthood patients, evidence indicates that FQHCs don't have the same breadth and depth of quality SRH care as specialized health centers like Planned Parenthoods,[70] indicating that patients would be harmed through both reduced access to care as well as reduced access to quality care.

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[66] Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851, 851 (2015), https://doi.org/10.2105/AJPH.2014.302515.

[67] Kristine Hopkins et al., *Women's Experiences Seeking Publicly Funded Family Planning Services in Texas*, 47 PERSPS. ON SEXUAL & REPROD. HEALTH 63, 65-66 (2015), https://doi.org/10.1363/47e2815.

[68] Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853, 858-59 (2016), https://www.nejm.org/doi/full/10.1056/nejmsa1511902.

[69] Christine Dehlendorf et al., *Association of the Quality of Interpersonal Care During Family Planning Counseling with Contraceptive Use*, 215 AM. J. OBSTETRICS & GYNECOLOGY 78.e1, 78.e4-78.e8 (2016), 10.1016/j.ajog.2016.01.173.

[70] Alicia VandeVusse et al., *supra* note 40 *Appendix Tables*, GUTTMACHER INST.,

(continued…)

52. Additional evidence from California helps to fill out the picture of how putting up cost barriers to people's access to contraception results in them shifting their use of methods. A survey among patients in California's publicly supported family planning network asked respondents what contraceptive methods they would use if paying out of pocket; respondents reported that their contraceptive use would shift from higher-efficacy to lower-efficacy methods. Specifically, respondents reported that the imposition of cost barriers would cause their use of lower-efficacy birth control to nearly double, from 25% to 46%, with use of medium- and high-efficacy methods decreasing.[71]

Impacts on access to broader SRH care

53. Many patients denied access to a Planned Parenthood clinic—either because they can't accept their Medicaid insurance or because the clinic is forced to shut down—would likely experience a serious gap in access to family planning services, which could result in untreated sexually transmitted infections (STIs) or cancers detected too late due to missed cancer screenings. Wellness visits at Planned Parenthood health centers typically include a regular physical exam (e.g., height, weight, and blood pressure), questions about a patient's medical history and family's medical history, vaccinations including for HPV, contraceptive counseling STD screening, cancer-related screenings such as pelvic exams, Pap tests, and breast examinations.[72] Evidence from California

https://www.guttmacher.org/sites/default/files/report_downloads/publicly-supported-family-planning-clinics-2022-2023-appendix_tables.pdf.

[71] ANTONIA BIGGS ET AL., FINDINGS FROM THE 2012 FAMILY PACT CLIENT EXIT INTERVIEWS 11 (Bixby Ctr. for Glob. Reprod. Health, 2014), https://familypact.org/wp-content/uploads/2019/10/Findings-from-the-2012-Family-PACT-Client-Exit-Interviews.pdf.

[72] *Wellness Visit*, PLANNED PARENTHOOD, https://familypact.org/wp-content/uploads/2019/10/Findings-from-the-2012-Family-PACT-Client-Exit-Interviews.pdf.

indicates that most patients getting care at publicly supported SRH facilities, approximately half of which in California are Planned Parenthoods, received key, preventive health screenings including for blood pressure, diabetes, alcohol, tobacco and drug use, and for experiences with interpersonal violence.[73]

54. Based on the most recent annual report from PPFA,[74] data on affiliate medical services provided across the network indicated the following annual services: 769,851 HIV tests, 4,330,310 STI tests, 173,397 Pap tests, and 40,247 HPV vaccinations, among other services. We at the Guttmacher Institute have developed a tool[75] to estimate the health benefits associated with the provision of publicly supported family planning. Using our "impact calculator" and the service data from PPFA's most recent annual report, the preventive services provided at Planned Parenthoods highlighted above avert, in a year, the following public health outcomes (approximated):

- 82,000 chlamydia infections
- 9,500 cases of pelvic inflammatory disease (PID)
- 820 ectopic pregnancies
- 1600 cases of infertility
- 130 HIV infections
- 200 cervical cancer cases

[73] ANTONIA BIGGS ET AL., *supra* note 71, at 9,19.
[74] A FORCE FOR HOPE, *supra* note 33, at 23.
[75] Frost, Jennifer J., et al. *Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program,* THE MILBANK QUARTERLY 92.4 696, 671 (2014), https://doi.org/10.1111/1468-0009.12080.

55. Without access to these services at Planned Parenthoods in the Plaintiff States due to Section 71113 of Public Law 119-21, we can reasonably expect that many of these public health outcomes would no longer be averted. Many of these negative health outcomes will likely be disproportionately experienced among patients from marginalized communities. For instance, the prevalence of STIs such as chlamydia, gonorrhea, and syphilis are influenced by geography and sociodemographic characteristics, with increased rates occurring among Hispanic and African American populations and individuals with lower incomes.[76]

56. Data from Iowa in the time period after the implementation of the Medicaid restrictions that excluded Planned Parenthood from the state Medicaid program (described above) help to provide an example of the broader SRH health impacts when this key provider is no longer available to patients for preventive care. According to media accounts highlighting Iowa Department of Health data from prior to after the restriction went into place, there was a spike in cases of gonorrhea, chlamydia, and syphilis in the year following the restriction. The 20,000 cases of the STIs represented an increase of more than 1,800 within a single year.[77]

57. There is no reason to believe that the effect of removing Planned Parenthood healthcare facilities from the federal Medicaid program on the Plaintiff States would be any less pronounced than the observed effects of excluding local

[76] JERUSHA BARTON ET AL., SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 69-75 (Ctrs. for Disease Control & Prevention, 2016), https://stacks.cdc.gov/view/cdc/41806.
[77] Michaela Ramm, *supra* note 66.

Planned Parenthood sites from programs in specific states, such as Iowa or Texas. Instead, it is reasonable to believe that many of the negative contraceptive and SRH outcomes documented in the state-specific research studies described above—including declines in the use of preferred and provider-involved methods, access to high-quality contraceptive care, and increases in STIs and reproductive cancers—will be replicated on a national scale if Section 71113 of Public Law 119-21 stands.

VI. Conclusion

58. For the reasons outlined above, Planned Parenthood healthcare facilities provide sexual and reproductive health services that cannot be readily replaced—in neither quality nor volume—by other existing providers. The implementation of Section 71113 of Public Law 119-21 will have immediate and long-lasting detrimental effects on the health and well-being of patients and their families in the Plaintiff States, as well as for the provider networks and states more broadly.

I declare under penalty of perjury that the foregoing is true and correct. EXECUTED on September 2025.



Megan L. Kavanaugh

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Exhibit A

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EDUCATION

Doctor of Public Health, Behavioral and Community Health Sciences, June 2008
University of Pittsburgh, Graduate School of Public Health, Pittsburgh, Pennsylvania
Dissertation: *Exploring the Context and Social Determinants of Unintended Pregnancy*
Advisor: Dr. Patricia Documét

Master's Certificate in Women's Studies, December 2005
University of Pittsburgh, Department of Women's Studies, Pittsburgh, Pennsylvania

Master of Public Health, Behavioral and Community Health Sciences, April 2005
University of Pittsburgh, Graduate School of Public Health, Pittsburgh, Pennsylvania
Thesis: *Emergency Contraceptive Services in Children's Hospital Emergency Departments*
Advisor: Dr. Martha A. Terry

Bachelor of Science, Agricultural and Biological Engineering, May 2001
Cornell University, College of Engineering, Dean's List, Ithaca, New York

PROFESSIONAL EXPERIENCE

Principal Research Scientist, Guttmacher Institute, New York, New York, August 2017 – Present
Play substantive lead on Institute's core area of domestic contraception. Contribute to overseeing and broadly providing input to research projects related to contraception, including idea generation, proposal development and institutional representation. Provide managerial supervision of senior and midlevel staff as well as broad mentorship to supervisees and other staff. Management and research duties as described for Senior Research Scientist below.

Adjunct Professor of Medicine, School of Medicine, Department of General Internal Medicine and Center for Innovative Research on Gender Health Equity (CONVERGE), University of Pittsburgh, Pittsburgh, Pennsylvania, February 2018 – Present
Lecture on topics related to mixed-methods research design and reproductive health to a variety of departments within the University of Pittsburgh. Present research at department seminars. Mentor and advise graduate students on topics related to expertise. Participate in regular meetings and initiatives to promote rigorous, policy-relevant research related to women's health through CONVERGE.

Senior Research Scientist, Guttmacher Institute, New York, New York, July 2010 – July 2017
Designed and managed research projects on sexual and reproductive health issues, specifically abortion, contraceptive use and unintended pregnancy, using quantitative and qualitative methods. Led quantitative analyses of large, national-level datasets and quantitative and qualitative analyses of smaller datasets from primary data collection. Oversaw junior research staff on research project tasks such as literature reviews, development of survey instruments and interview guides, sampling strategies and data collection. Wrote summaries of research to submit for publishing in peer-reviewed academic journals and developed research proposals to submit for grant funding. Disseminated findings of research to a broad audience of stakeholders.

Charlotte Ellertson Social Science Postdoctoral Fellow in Abortion and Reproductive Health, Guttmacher Institute, New York, New York, September 2008 – June 2010

Designed, conducted and managed research projects on providers' and patients' perspectives regarding the existence and value of contraceptive services in US abortion care settings. Developed study protocol, analyzed data and began drafting a manuscript from findings exploring the links between HIV stigma and abortion stigma around motherhood issues in Zambia and Nigeria. Assisted in project development, conceptual framing and analysis of colleagues' sexual and reproductive health research. Presented and submitted findings from fellowship and dissertation research projects to professional meetings and peer-reviewed journals. Participated in leadership/advocacy activities to develop skills for translating sexual and reproductive health research into practice.

Paraprofessional Counselor, Planned Parenthood of Western Pennsylvania/Women's Health Services, Pittsburgh, Pennsylvania, April 2004 – August 2008

Counseled patients regarding sexual health issues and pregnancy options. Assessed patients' medical histories and provided education on safe sexual health behaviors. Assisted physicians and supported patients during clinical procedures.

Research Assistant III, Center for Research on Health Care, University of Pittsburgh, Pittsburgh, Pennsylvania, January 2008 – September 2008

Designed and administered a quantitative survey instrument to measure prospective pregnancy intentions and assess interest in receiving IUDs during pregnancy testing services. Managed IRB submissions and revisions, data collection and data entry efforts of research team.

Graduate Student Researcher, Behavioral and Community Health, University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, May 2006 – September 2007

Analyzed data from an evaluation of child abuse prevention intervention program using SPSS. Facilitated focus groups of pediatric clinicians for evaluation of child abuse prevention intervention and drafted the first manuscript based on the focus group data. Supervised undergraduate students involved in literature reviews and data entry.

Sexual Health Educator, University of Pittsburgh Student Health Service, Pittsburgh, Pennsylvania, August 2004 – April 2006

Planned, implemented, and evaluated sexual health programs for university students. Coordinated planning and execution of health fairs and outreach events. Served as a resource for individual or group outreach programs related to sexual health.

Program Evaluator, The Program Center (TPC), University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pennsylvania, January 2004 – September 2004

Conducted participant observations at offender work-release facility. Developed in-depth interview guide and facilitated unstructured interviews with residents regarding program orientation. Analyzed qualitative data and presented completed evaluation to program supervisors.

Research Associate, Trophogen, Inc., Rockville, Maryland, October 2001 – June 2003

Designed and developed therapeutic analogs of TSH and gonadotropins. Performed immunoassays and bioassays of analogs to determine concentrations and activity. Investigated structure-function relationships of glycoprotein hormones and their receptors.

Computer Programming Teaching Assistant, Cornell University Department of Agricultural and Biological Engineering, Ithaca, New York, August 1999 – May 2001

Taught classes of 20+ students on developing algorithms and creating computer programs in Java. Worked with other teaching assistants to develop lectures and presentations for classes. Assisted in writing, revising, and grading homework sets and course exams.

Research Assistant, Cornell University Department of Environmental Health and Safety, Ithaca, New York, August 1997 – May 1999

Developed and implemented a mercury recycling program among all labs at the university. Lab research involved recycling of mercury and other hazardous wastes. Compiled and presented recommendations for universal implementation of program.

PUBLICATIONS

Peer-reviewed publications

Olson H, Haas M, Douglas-Hall A, **Kavanaugh ML**. How health insurance instability differentially impedes access to sexual and reproductive healthcare, by race/ethnicity and nativity. *Health Services Research* (in press).

Kavanaugh ML, Desai S, Borrero S, Gomez AM, Higgins J, Holt K, Malcolm N, O'Donnell J, VandeVusse A, Wade J, Zolna M, Frost J. Call to Action: Bringing sexual and reproductive health equity into how we quantify the impact of contraceptive access. *Contraception* (in press).

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Leong E, Geddes C, Weeks F, **Kavanaugh ML**. Contraceptive care and method use by sexual and gender minority individuals: insights from a longitudinal study of sexual and reproductive health care patients in Wisconsin. *Sexual and Reproductive Health Matters*. 2025; DOI:10.1080/26410397.2025.2544432.

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Yang T, Smith M, **Kavanaugh ML**, Ricks J, Gallo M. Prevalence of crisis pregnancy center attendance among women in four U.S. states. *PLOS ONE*. 2025; DOI:10.1371/journal.pone.0324228.

Olson H and **Kavanaugh ML**. Where do female contraceptive users get contraception, and does this differ by insurance coverage? A state-level examination. *Contraception*. 2025; DOI:10.1016/j.contraception.2025.110834.

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Kavanaugh ML, Leong E, Geddes C. Differential associations between access to sexual and reproductive healthcare and subsequent contraceptive and pregnancy outcomes by ethnicity among

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Kavanaugh ML, Haas M, Douglas-Hall A. Differential associations between experiences of contraceptive care and subsequent contraceptive access and preferences among family planning patients by racial identity: Evidence from Arizona, Iowa, and Wisconsin. *PLOS ONE*. 2024; DOI:10.1371/journal.pone.0312111.

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Gomez AM, Reed RD, Bennett AH, **Kavanaugh ML**. Integrating Sexual and Reproductive Health Equity into Public Health Goals and Metrics: Comparative Analysis of Healthy People 2030's Approach and a Person-Centered Approach to Contraceptive Access Using Population-Based Data. *JMIR Public Health and Surveillance*. 2024; DOI: 10.2196/58009.

Kavanaugh ML, Hussain R, Little A. Overall and method-specific contraceptive preferences among reproductive-aged contraceptive users in Arizona, Iowa, New Jersey, and Wisconsin. *Health Services Research*. 2024; DOI: 10.1111/1475-6773.14297.

Kavanaugh ML, Friedrich-Karnik A. Has the Fall of *Roe* Changed Contraceptive Access and Use? New Research from Four US States Offers Critical Insights. *Health Affairs Scholar*. 2024; DOI: 10.1093/haschl/qxae003.

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Moore AM, Keogh S, **Kavanaugh ML**, Mulambia C, Bankole A, Mutombo N. Bucking social norms: Examining anomalous fertility aspirations in the face of HIV in Lusaka, Zambia. *Social Science & Medicine*. 2014, 119:88-97.

Kavanaugh ML, Bessett D, Norris A, Littman LL. Connecting knowledge about abortion and sexual and reproductive health to belief about abortion restrictions: findings from an online survey. *Women's Health Issues.* 2013, 23(4): e239-e247.

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Reports, monographs and other publications

Friedrich-Karnik A and **Kavanaugh ML.** *The right is waging a quiet war on contraception*. Op-ed in The Hill; September 4, 2025.

Rodriguez M and **Kavanaugh ML.** *Navigating Reproductive Health Post-Dobbs: What We Know About Changes in Contraception*. Blog post for Academy Health; September 3, 2025.

Kavanaugh ML, Blades N, Friedrich-Karnik A, Frost J**.** *Trump Administration's Withholding of Funds Could Impact 30% of Title X Patients*. Guttmacher Policy Analysis; April 8, 2025.

Kavanaugh ML. *Is Birth Control Under Attack?* Op-Ed for Zocalo Public Square; September 9, 2024.

Olson H, Haas M, **Kavanaugh ML**. *State-Level Contraceptive Use and Preferences: Estimates from the US 2022 Behavioral Risk Factor Surveillance System*, New York: Guttmacher Institute, 2024. DOI: 10.1363/2024.300488.

Easter R, Friedrich-Karnik A, **Kavanaugh ML**. *Any Restrictions on Reproductive Health Care Harm Reproductive Autonomy: Evidence from Four States*, New York: Guttmacher Institute, 2024.

Kavanaugh ML. *Guttmacher Expert Testimony in Support of Approving Over-the-Counter Status for Opill Without an Age Restriction*, New York: Guttmacher Institute, 2023.

Douglas-Hall A, Li N, **Kavanaugh ML**. *State-Level Estimates of Contraceptive Use in the United States, 2019*, New York: Guttmacher Institute, 2020.

Douglas-Hall A, Kost K, **Kavanaugh ML**. *State-Level Estimates of Contraceptive Use in the United States, 2017*, New York: Guttmacher Institute, 2018.

Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013.

Sonfield A, Hasstedt K, **Kavanaugh ML**, Anderson RM. *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013.

Manuscripts under review and in preparation

Swan LET, Seymour J, Hung A, Higgins J, **Kavanaugh ML**. Understanding Reasons for Contraceptive and LARC Non-Use: Insights from the Reproductive Health Impact Study (under review).

VandeVusse A, Muller M, Douglas-Hall A, Sackiety S, **Kavanaugh ML**. Understanding patient perspectives on the quality of family planning care: a qualitative study (under review).

Olson H, Douglas-Hall A, Haas M, **Kavanaugh ML**. Investing in Reproductive Health: Contraceptive Use and Preference Fulfillment Among Low-Income Individuals Across State Policy Contexts (under review).

Zolna M, Mitchell L, **Kavanaugh ML**. Did *Dobbs* impact access to and use of preferred contraception and related outcomes?: Quasi-experimental evidence from three states in the U.S. (under review).

Smith M, Chakraborty P, Kim T, Peluso A, Steinberg J, **Kavanaugh ML**, Gallo M. State policy context and abortion support before Dobbs: Results from the Surveys of Women (under review).

Frost J, **Kavanaugh ML**, Gomez A, Douglas-Hall A. Moving Towards a Population Level Measure of Person-Centered Contraceptive Need in the United States (under review).

Mason RE, Caioli K, Pleasants E, Turner AN, Gallo MF, **Kavanaugh ML**, Smith MH. Changes in Emergency Contraception use pre- and post-*Dobbs* across seven states (in preparation).

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Pleasure ZH, Pleasants E, Danaux J, Hassan A, Scales D, **Kavanaugh ML**. A conceptual framework for understanding the comprehensive contraceptive health information ecosystem (in preparation).

GRANTS AND RESEARCH SUPPORT

Time-Sensitive Research to Assess the Effects of Reproductive Health Policy on the Health Outcomes of People with Chronic Diseases (INTREPID)
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Advisory Board Member *Funded: September 2023 – Present*
People with chronic and complex medical conditions are particularly vulnerable to adverse health consequences as a result of abortion policy. This study, Investigating Time- sensitive Reproductive Health Equity Post-Dobbs for Patients with ChronIc Disease (INTREPID), will evaluate the time-sensitive impact of evolving abortion policies on the health and well-being of patients, particularly those with chronic diseases that increase the risk of severe maternal morbidity and maternal mortality (e.g., cardiovascular disease, cancer, systemic lupus erythematosus); the clinical practice of physicians who care for people with chronic diseases; and downstream clinical outcomes at a population level. This project seeks to inform health policy that will optimize reproductive healthcare and clinical outcomes in the post-Dobbs era.

Evaluating indirect survey question methods on reproductive health behavior
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2023 – Present*
Supports a body of research to advance understanding on the characteristics, attitudes, and behaviors of those obtaining abortions in nine U.S. states by evaluating the validity of the Item Sum Technique (IST) to estimate mean numbers of abortions per woman of given sociodemographic characteristics and state of residence. This exploratory research will enable development and application of indirect survey questions on abortion in future state and national sample surveys of fertility and reproductive health. It will provide cross-state baseline information against which to gauge changes in abortion utilization in the near-term, especially critical given the increased restrictions on abortion access at the state level.

Generating Actionable Data to Ensure High-Quality, Equitable Sexual and Reproductive Health Care *Funded: September 2022 – Present*
Office of the Assistant Secretary for Health (OASH), Office of Population Affairs (OPA)
Role: Co-Principal investigator
Supports a comprehensive package of research to generate actionable data and ensure that high-quality, equitable sexual and reproductive health services are available to all people. Activities address individual-level, provider-level and systems-level questions of health equity to advance foundational resources to assess family planning care in the US. Information generated from this research will provide new insights and answers to four key research questions: Who needs SRH care? Where, for whom, and how is care provided and received? What care do people want? and What difference does access to care make?

Advancing Innovative Measurement of Pregnancy Preferences with Longitudinal Data
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Expert Advisory Panel Member *Funded: September 2022 – Present*
This proposal addresses critical scientific and measurement gaps using longitudinal data from population-based surveys, fielded to over 12,000 women, aged 18-44, across nine US states, which include the Desire to Avoid Pregnancy (DAP) scale. The DAP reconceptualizes "intentions" as "preferences" and captures the diversity of considerations and feelings women have about a potential future pregnancy. The insights gained and development of innovative extensions of the DAP instrument will facilitate the use of rigorous, meaningful measures in future research.

Development and validation of a novel, person-centered measure of post-conception pregnancy acceptability (the Post-CAP) *Funded: February 2021 – Present*
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Consultant
Supports work to develop a new, multidimensional measure of post-conception acceptability of pregnancy (the Post-CAP) to assess the relationship between existing pregnancies and health and social outcomes.

Advancing Measurement and Understanding of Contraceptive Failure in the United States
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2018 – Present*
Supports work to provide updated and enhanced measures of contraceptive failure by more fully incorporating theoretical perspectives on reproductive behavior. The project includes secondary analysis of qualitative interviews describing contraceptive strategies that resulted in contraceptive failures, updated estimates of method-specific contraceptive failure rates using Bayesian models to exploit richness of national-level data sources, and a national survey that draws on the findings from the first two components to identify factors contributing to changes over time in contraceptive failure rates.

Reproductive Health Impact Study *Funded: September 2017 – September 2024*
The William and Flora Hewlett Foundation
Anonymous Donor
Role: Principal investigator
Supported work to monitor the impact of policy changes affecting the publicly funded family planning safety net in the United States. The project tracked changes in reproductive health services and financing and employed longitudinal data collection (both quantitative and qualitative) to assess the impact of policy change on service providers and on the people who need the care provided by this health system in four states: Iowa, Arizona, New Jersey and Wisconsin.

An Evidence Base for Action: Tracking the State of the Nation's Reproductive Health
Anonymous Donor *Funded: October 2014 – September 2021*
Role: Co-investigator
Supported ongoing efforts to comprehensively track the state of the nation's reproductive health, including the Guttmacher Institute's flagship research efforts documenting levels of abortion, unintended pregnancy, and teen pregnancy (nationally and for each state), as well as tracking of reproductive health laws and policies at the state level. One specific component of this work was to monitor and track contraceptive use among American women and men using biannually collected data from the National Survey of Family Growth.

Advancing Measurement and Analysis of Sensitive Behaviors in the United States
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2016 – June 2021*
Advanced the measurement of abortion in the United States through a multi-faceted investigation of abortion underreporting in three national surveys, and through the design, testing and evaluation of a series of new approaches for improving reporting going forward.

Monitoring U.S. Family Planning Needs and Services *Funded: October 2019 – September 2020*
Anonymous Donor
Role: Co-investigator
Supported one year of work to reconceptualize and re-envision the Guttmacher research portfolio that tracks and documents contraceptive and sexual and reproductive health care in the United States. This work involved aligning the research portfolio with Guttmacher's Institutional values and identifying key evidence needed by policymakers, advocates, service providers, and litigators to develop and sustain policies and programs to protect care delivery within the publicly funded family planning health system.

Exploring Barriers to Post-Abortion Contraceptive Provision
Anonymous Donor *Funded: January 2017 – December 2017*
Role: Principal investigator
Supported work to examine and recommend strategies to overcome barriers to the provision of post-abortion contraception among abortion providers. Included under this grant was a policy analysis of provision obstacles and a qualitative study of independent abortion providers to document challenges to providing contraception within the abortion care context. Focus groups and in-depth interviews with clinic administrators were used to understand the complexities of providing post-abortion contraception.

Financial Viability and the Sustainability of Title X Centers *Funded: July 2014 – June 2017*
Office of Population Affairs, HHS
Role: Principal investigator
Supported data collection from publicly funded family planning clinics and their clients to document the gap between levels of third-party reimbursement and the cost to Title X-funded sites of delivering care, assess differences in the extent to which costs of providing care to clients were being recovered by Title X-funded systems and identify best practices in cost recovery, and identify women, or groups of women, who were seeking Title X-funded services but who were falling through gaps in the ACA's coverage expansions.

Contraceptive Use in the Health Care Reform Era *Funded: March 2015 – April 2016*
JPB Foundation
Role: Co-investigator

Supported efforts to track the impact of the Affordable Care Act (ACA) on contraceptive coverage, cost and method use, by carrying out a cross-sectional survey of women to obtain information on their source of insurance coverage, contraceptive method use and cost-sharing, and analysis of a Bayer Pharmaceuticals dataset looking at changes in what health plans were requiring women to pay out-of-pocket for IUDs.

Advancing Research on the Consequences of Unintended Childbearing
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator *Funded: September 2011– August 2015*
Supported work to improve the health and well-being of American families by identifying and clarifying the consequences of unintended childbearing, specifically focusing on the ways in which the intention status of a birth affects women's and men's behaviors during and after pregnancy, as well as the health and well-being of infants and children. A key piece of this research was conducting qualitative interviews with men and women who characterized their most recent birth as unintended in order to understand the consequences of these births from the perspective of those who had experienced them.

Return on Investment: A Fuller Assessment of the Benefits and Cost-Savings of America's Publicly Funded Family Planning Program *Funded: March 2012 – March 2015*
JPB Foundation
Role: Co-investigator
Supported quantitative work to build on the Guttmacher Institute's existing cost-benefit research by providing a more complete accounting of the returns on investment in family planning services, with the aim of bolstering the case for publicly-funded family planning programs. New quantifiable benefits that accrue from services received during family planning visits as well as updated estimates of the cost-savings associated with unplanned birth were identified.

HIV Status and Achieving Fertility Desires *Funded: May 2008 – May 2013*
Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Co-investigator
This project involved conducting in-depth quantitative and qualitative research to understand how individuals and couples in Nigeria and Zambia achieve their family size goals while avoiding or coping with HIV infection. The project provided a regional overview of the interrelationships between HIV status, fertility desires and sexual and reproductive behaviors and deepened understanding of relationships between HIV status and the actions women and men take to achieve their fertility aspirations and prevent or cope with HIV infection.

Meeting the contraceptive needs of adolescents and young adults: Program adequacy and the role of long acting reversible contraceptive methods *Funded: October 2010 – October 2012*
Office of Population Affairs, HHS
Role: Principal investigator
Supported quantitative and qualitative data collection from publicly funded family planning clinics and their clients to document contraceptive services for adolescents and young adults, the barriers to serving these populations and the need for these services. A specific focus of this project was on long-acting reversible contraceptive method services for this younger age group.

Who uses long-acting reversible contraceptive methods? *Funded: July 2010 – October 2011*
Society of Family Planning
Role: Principal Investigator
This one-year grant supported secondary data analysis of the 2006-2008 National Survey of Family Growth, which examined long-acting reversible contraceptive (LARC) method use and predictors of use.

Abortion patients' perspectives on receiving contraceptive services during abortion care
Society of Family Planning *Funded: October 2009 – October 2010*
Role: Principal Investigator
This one-year small grant supported a quantitative research study of US abortion patients' experiences with and attitudes towards receiving contraceptive services during abortion care.

Community attitudes towards motherhood and abortion for HIV-positive women
Charlotte Ellertson Social Science Postdoctoral Fellowship *Funded: March 2009 – August 2010*
Role: Principal Investigator
This two-year grant supported a project to assess community members' attitudes towards motherhood and abortion in the context of HIV in Nigeria and Zambia. The project supplemented a five-year ongoing NIH-funded research project that explores the relationship between HIV status and fertility desires among community members and clinical providers in these two countries.

Can abortion providers help women avoid subsequent unintended pregnancies and abortions?
Anonymous Donor *Funded: September 2008 – August 2010*
Role: Principal Investigator
This two-year grant supported mixed-methods research that documented contraceptive services in large, non-hospital US abortion care settings and identified barriers to the integration between contraceptive and abortion care.

Exploring the social determinants of unintended pregnancy *Funded: December 2007 – June 2008*
University of Pittsburgh Women's Studies
Student Research Fund Award
Role: Principal Investigator
This funding award supported the qualitative component of the PI's dissertation research, which encompassed in-depth interviews with low-income and African American women in Pittsburgh, PA regarding social and environmental factors that had an impact on their experiences of, and decisions about, unintended pregnancies.

Emergency contraceptive services in children's hospital emergency departments
Association of Reproductive Health Professionals
Gary Stewart Scholarship for Research *Funded: September 2006 – August 2007*
Role: Principal Investigator
This national scholarship is awarded to one public health graduate student who proposes a significant research project that addresses a pressing issue in the field of public health, especially as it may pertain to reproductive health. The award supported ongoing research regarding existing emergency contraceptive protocols and services in US children's hospital emergency departments.

Emergency contraceptive services in children's hospital emergency departments
University of Pittsburgh Women's Studies
Student Research Fund Award *Funded: December 2005 – June 2006*
Role: Principal Investigator
This funding award supported a quantitative research study of the existence and availability of emergency contraceptive services in US children's hospital emergency departments. Telephone surveys of children's hospital emergency department directors were used to collect the data.

PRESENTATIONS

Conference papers and oral presentations

Rocca C, Bullington BW, **Kavanaugh ML**, Stulberg D, Borrero S, Munoz I. Establishing evidence-based cut-points on the desire to avoid pregnancy measure. Oral presentation at the Society of Family Planning Annual Meeting, Pittsburgh, PA, October 2025 (scheduled).

Kavanaugh ML and VandeVusse A. Actionable, person-centered data to inform the landscape of contraceptive and related SRH care. Panel presentation at the National Reproductive Health Conference, virtual, August 8, 2025 (scheduled).

Olson H, Haas M, Douglas-Hall A, **Kavanaugh ML**. Investing in reproductive health: Contraceptive use and preference fulfillment among low-income individuals across state policy contexts. Oral presentation at the Population Association of America Annual Meeting, Washington, DC, April 13, 2025.

Gallo M, Johnston E, **Kavanaugh ML**, Smith M, Spencer N. Findings and the future of two state-representative surveys on reproductive health. Panel presentation at the Society of Family Planning Annual Meeting, Detroit, MI, October 2024.

VandeVusse A, Blades N, Mueller J, **Kavanaugh M**. How Policy Changes Impact Family Planning Providers and Patients: Key Findings from the Reproductive Health Impact Study. Panel presentation at the Title X National Grantee Conference, Baltimore, MD, July 12, 2023.

Kuhns T, Davis J, **Kavanaugh ML**, Gallo M. A multi-state analysis of crisis pregnancy center (CPC) attendance. Oral presentation at the Population Association of America 2023 annual meeting, New Orleans, LA, April 15, 2023.

Kavanaugh ML, Leong E, Haas M. Impact of the 2019 Title X Final Rule on patients' sexual and reproductive health care access and behavior in Iowa. Oral presentation during invited panel on Demography of Access to Contraception at the Population Association of America 2023 annual meeting. April 13, 2023.

Baker K, Beatty K, Gonzalez E, Rubin S, **Kavanaugh ML**. Conducting family planning services research with Federally Qualified Health Center (FQHC) partners. Panel presentation at the Society of Family Planning virtual annual meeting, October 10, 2020.

Khoury A, **Kavanaugh ML**, Gallo M, Boudreaux M, Hale N. Contraception use and experiences at the state level: Findings from the statewide survey of women. Panel presentation at the Society of Family Planning virtual annual meeting, October 9, 2020.

Bessett D, Bommaraju A, **Kavanaugh ML**, Hou M. Abortion Stigma: What can we learn from a comparison to miscarriage stigma? Oral presentation at the American Sociological Association 2016 annual meeting, Seattle, WA, August 20, 2016.

Kavanaugh ML, Kost K, Frohwirth L, Maddow-Zimet I. The Impact of an Unplanned Child: A Qualitative Study of the Consequences of Unintended Childbearing for Mothers and Fathers. Oral presentation at the Population Association of America 2015 annual meeting, San Diego, CA, May 1, 2015.

Bessett D, Gerdts C, Littman LL, **Kavanaugh ML,** Norris A. Does State-Level Context Matter for Individual's Knowledge about Abortion and Health? Oral presentation at the American Sociological Association 2014 annual meeting, San Francisco, CA, August 16, 2014.

Kavanaugh ML, Jerman J, Frohwirth L, Popkin R, Ethier K, Moskosky S. Provider practices and patient perspectives on LARC for young women. Oral presentation at the Office of Adolescent Health, Administration on Children, Youth and Families' and Centers for Disease Control and Prevention/Division of Reproductive Health's (OAH/ACYF/CDC) Third Annual Teenage Pregnancy Prevention Conference, National Harbor, MD, May 20, 2013.

Kavanaugh ML, Jerman J, Frohwirth L, Popkin R, Ethier K, Moskosky S. Contraceptive and LARC Services for Teens and Young Adults in Publicly Funded Facilities in the US. Oral presentation at the Population Association of America 2013 annual meeting, New Orleans, LA, April 11, 2013.

Finer LB, Jerman J, **Kavanaugh ML**. Changes in use of long-acting contraceptive methods in the U.S., 2007-2009. Oral presentation at the American Public Health Association annual meeting, San Francisco, CA, October 29, 2012.

Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Meeting the contraceptive needs of adolescents and young adults: Youth-friendly and long-acting reversible contraceptive Services in U.S. family planning facilities. Oral presentation at the "Reproductive Health Disparities among Youth: Improving Services and Ensuring Access" 2012 annual meeting, Chicago, IL, May 10, 2012.

Moore AM, **Kavanaugh ML**, Keogh SC, Mulambia C, Adewole I, Oladokun A, Mutombo N, Arulogun OS, Bewupe MM, Bankole A. Achieving fertility aspirations in high HIV settings: Using anomalous case analysis in Zambia. Oral presentation at the Population Association of America 2012 annual meeting, San Francisco, CA, May 3, 2012.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Oral presentation at the Union for African Population Studies meeting, Ouagadougou, Burkina Faso, December 5, 2011.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Oral presentation at the American Public Health Association meeting, Washington, DC, October 31, 2011.

Kavanaugh ML, Lindberg L, Frost J. Factors impacting partners' involvement in contraceptive services. Oral presentation at the Population Association of America 2011 annual meeting, Washington, DC, April 1, 2011.

Jones RK, **Kavanaugh ML**. Changes in U.S. abortion rates by subgroup, 2000 and 2008. Oral presentation at the Population Association of America 2011 annual meeting, Washington, DC, April 1, 2011.

Kavanaugh ML, Arulogun O, Adewole I, Dzekedzeke K, Oladokun A. Men's abortion attitudes in the context of HIV. Oral presentation at the UCLA Bixby Center on Population and Reproductive Health meeting "Men, Masculinities and Family Planning in Africa," Los Angeles, CA, October 15, 2010.

Moore A, **Kavanaugh ML,** Arulogun O, Dzekedzeke K, Oladokun A. HIV-Positive Women's Reports of Their and their Partners' Fertility Preferences: A Case Study of Zambia. Oral presentation at the UCLA Bixby Center on Population and Reproductive Health meeting "Men, Masculinities and Family Planning in Africa," Los Angeles, CA, October 15, 2010.

Kavanaugh ML, Jones RK, Finer LB. How Commonly Do U.S. Abortion Clinics Offer Contraceptive Services? Oral presentation at the National Abortion Federation 2010 annual meeting, Philadelphia, PA, April 26, 2010.

Kavanaugh ML, Gold MA. Emergency Contraception Services for Adolescents: a National Survey of Children's Hospital Emergency Department Directors. Oral presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2007 annual meeting, Minneapolis, MN, September 27, 2007.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Oral presentation at the Society of General Internal Medicine annual meeting, Toronto, ON, Canada, April 26, 2007.

Invited lectures

Kavanaugh ML. Actionable, person-centered data to inform the landscape of contraceptive and related SRH care in the United States: Recent updates to key SRH metrics that undergird federally funded family planning care. Presentation at the SPHERE Prato Meeting 2025: Grand challenges in the international landscape for women's sexual and reproductive health, Prato, Italy, July 2, 2025.

Kavanaugh ML. Contraception in the United States: Use, access, and recent shifts in this landscape. Mitch Creinin annual Family Planning Lectureship at UPMC Magee-Womens Hospital, Pittsburgh, PA, March 11, 2025.

Kavanaugh ML. Sexual and reproductive healthcare in the post-*Dobbs* context: Current landscape and threats. Presentation at the White House Convening on Contraceptive Access on the 59th Anniversary of *Griswold v. Connecticut*, Washington, DC, June 7, 2024.

Kavanaugh ML. Rethinking how we measure the "impact" of receiving sexual and reproductive healthcare: Ongoing updating of Guttmacher research portfolio documenting the landscape of publicly funded family planning in the United States. Presentation at the Psychosocial Workshop, Columbus, OH, April 16, 2024.

Kavanaugh ML. Reproductive Health Impact Study: How Public Policies Impact Family Planning Providers and Patients. Presentation at the U.S. Department of Health and Human Services (DHHS) Roundtable Series: Facilitating Reproductive Health Research post-Dobbs Decision, Washington, DC, November 6, 2023.

Kavanaugh ML. Generating actionable data to ensure high-quality, equitable sexual and reproductive health care: Updated surveillance of the publicly funded family planning program in the United States. Presentation at the Psychosocial Workshop, New Orleans, LA, April 12, 2023.

Kavanaugh ML. Reproductive Health Impact Study: What policy change in Wisconsin means for Wisconsinites' sexual and health. Presentation at the Wisconsin Department of Health Services, virtual, March 9, 2023.

Kavanaugh ML. Sexual and Reproductive Health Care Access and Service Delivery in Wisconsin: Latest Landscape and Projected Shifts. Presentation at the UW CORE Research Exchange, virtual, January 20, 2023.

Kavanaugh ML. Contraception in the United States: Use, access, and recent shifts in this landscape. Presentation to the American Public Health Association Contraception Task Force, virtual, September 21, 2022.

Kavanaugh ML. Where do reproductive-aged women want to get contraception? Presentation at the Psychosocial Workshop, Atlanta, GA (hybrid/virtual), April 5, 2022.

Kavanaugh ML. Reproductive Health Impact Study: What policy change in Wisconsin means for Wisconsinites' sexual and health. Presentation at the UW CORE Research Exchange, virtual, October 22, 2021.

Kavanaugh ML. Telehealth delivery of SRH care: What is the landscape and how has it shifted with COVID-19? Presentation at the Funders Convening for Contraceptive Access, virtual, October 16, 2020.

Kavanaugh ML. IUD Use in the United States: Trends and Characteristics. Presentation at the Sixth International Symposium on Intrauterine Devices and Systems for Women's Health, virtual, September 30, 2020.

Kavanaugh ML. Contraception in the United States: Use, access, and how COVID-19 has shifted this landscape. Presentation at the Contemporary Topics in OB-GYN Allegheny Health Network Virtual Conference, virtual, September 26, 2020.

Kavanaugh ML. Contraceptive access in the United States: Demand, source of care, and method use. Presentation at the CECA Technical Expert Panel meeting on Funding Strategies to Expand Contraceptive Access, Washington, DC, February 11, 2020.

Kavanaugh ML. Reproductive Health Impact Study: Update on state-level research in Iowa and Arizona. Presentation at the Psychosocial Workshop, Austin, TX, April 10, 2019.

Kavanaugh ML. Contraceptive Use and Unintended pregnancy in the United States: Measurement, Missteps and More Room for Improvement. Presentation at the University of Pittsburgh Health Services Research Seminar Series, Pittsburgh PA, March 7, 2019.

Kavanaugh ML. Family planning in the United States: What's at stake in the next four years? Presentation on the Society of Family Planning panel at the American Congress of Obstetricians and Gynecologists annual meeting, Sane Diego, CA, May 6, 2017.

Kavanaugh ML. Use of multiple methods in the United States. Presentation at the Psychosocial Workshop, Chicago, IL, April 25, 2017.

Kavanaugh ML. Contraceptive Use and Unintended pregnancy in the United States: Measurement, Missteps and More Room for Improvement. Presentation at the University of Cincinnati Department of Sociology Colloquium Lecture Series, Cincinnati, OH, September 30, 2016.

Kavanaugh ML. Trends in Unintended Pregnancy and LARC Use. Presentation at the Bridging the Divide: LARC Roundtable, Washington, DC, May 10, 2016.

Kavanaugh ML. Men's reactions to pregnancy intention terminology. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2016.

Kavanaugh ML. Women seeking information about abortion services run into the "abortion black hole": Findings from qualitative interviews with abortion patients. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2016.

Kavanaugh ML. Survey Methodology: the Whys and How tos. Presentation at the Junior Fellows Professional Development Workshop at the North American Forum on Family Planning annual meeting, Chicago, IL, November 13, 2015.

Kavanaugh ML. Unintended pregnancy and contraceptive use among adolescents and prevalence of sexual activity by age. Presentation at the Adolescents and Over-the-Counter Access to Oral Contraceptives Expert Meeting, Washington, DC, October 22, 2015.

Kavanaugh ML. Financial Viability and Sustainability of Title X Centers, 2014–2017. Presentation at the Office of Population Affairs Title X Grantee Meeting, Washington, DC, August 19, 2015.

Kavanaugh ML. Qualitative explorations of the consequences of unintended pregnancy and men's pregnancy intentions. Part of panel: Findings from a 5-year R01, "Advancing Research on the Consequences of Unintended Childbearing." Presentation at the Psychosocial Workshop, San Diego, CA, April 29, 2015.

Kavanaugh ML, Kost K, Frohwirth L, Maddow-Zimet I. Qualitative explorations of men's pregnancy intentions. Presentation at the Psychosocial Workshop, Boston, MA, April 30, 2014.

Kavanaugh ML, Bessett D, Littman LL, Norris A. Knowledge about abortion compared to knowledge about contraception, pregnancy and birth. Presentation at the Psychosocial Workshop, New Orleans, LA, April 9, 2013.

Kavanaugh ML. Contraceptive Use: What do we know? What do we not know? What do we do about it? Presentation at the RNDMU Region IV Title X workshop, Chapel Hill, NC, September 18, 2012.

Kavanaugh ML. Youth-Friendly Contraceptive Services, including Long-Acting Reversible Contraception Services, for Teens and Young Adults in the US. Webinar presentation to Planned Parenthood affiliates, organized by PPFA, June 15, 2012.

Kavanaugh ML. Long-acting reversible contraceptive (LARC) services for teens and young adults in US publicly funded family planning clinics. Presentation at the Psychosocial Workshop, San Francisco, CA, May 2, 2012.

Kavanaugh ML. LARC Services for Teens and Young Adults in Publicly Funded Clinics. Webinar presentation to Office of Population Affairs (OPA) Title X grantees, organized by OPA, February 22, 2012.

Kavanaugh ML. Utilization of Long-Acting Reversible Contraception (LARC) among Adolescents. Webinar presentation to CDC pregnancy prevention grantees, organized by Cicatelli Associates, Inc., November 10, 2011.

Kavanaugh ML, Williams SL, Schwarz EB. Emergency contraception use and counseling after changes in United States prescription status. Presentation at the EC Jamboree, New York, NY, October 4, 2011.

Kavanaugh ML. LARC Methods and Younger Patients: Research on Barriers and Opportunities for Title X. Presentation at the 2011 National Title X Grantee Meeting, Miami, FL, August 4, 2011.

Kavanaugh ML, Carlin LE, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2011.

Kavanaugh ML, Moore A, Akinyemi O, Arulogun O, Awolude O, Adewole I, Dzekedzeke K. Women's stigmatizing attitudes towards motherhood and abortion for HIV-positive pregnant women in Zambia and Nigeria. Presentation at the Psychosocial Workshop, Washington, DC, March 29, 2011.

Kavanaugh ML. Providing Contraception to Patients in the Abortion Care Setting: a Qualitative Exploration of Practices and Barriers. Presentation to the medical faculty, fellows, and residents in the Columbia University Division of Family Planning and Preventive Services, New York, NY, April 7, 2009.

Kavanaugh ML, Hershey N. Emergency Contraception Meets Historic Misconceptions. Presentation at the University of Pittsburgh Honor's College Friday Lecture Series, Pittsburgh, PA, February 2, 2007.

Gold MA, **Kavanaugh ML**. Emergency Contraception and Emergency Departments. Presentation to the medical faculty, fellows, and residents in the emergency department of the Children's Hospital of Pittsburgh, Pittsburgh, PA, June 28, 2006.

Kavanaugh ML. Emergency Misconceptions: Ongoing Research on Emergency Contraceptive Services in Children's Hospital Emergency Departments. Presentation to the University of Pittsburgh Women's Studies Seminar Series, Pittsburgh, PA, February 22, 2006.

Posters

Zolna M, Chiu D, Osias P, **Kavanaugh ML**. Updated national-level contraceptive use and preference estimates in the U.S. Poster presentation at the Society of Family Planning Annual Meeting, Pittsburgh, PA, October 2025 (scheduled).

Olson H and **Kavanaugh ML**. Contraceptive preferences and use at the state level: Findings from the 2022 Behavioral Risk Factor Surveillance System. Poster presentation at the Population Association of America annual meeting, Columbus, OH, April 19, 2024.

Neiman E, Bornstein M, Norris Turner A, **Kavanaugh ML,** Gallo M. Use of period tracking apps pre- and post-Dobbs. Poster presentation at the Midwest Nursing Research Society annual meeting, Minneapolis, MN, March 1, 2024.

Kavanaugh ML, Frost J. Reproductive Health Impact Study. Poster presentation at the Title X Grantee annual conference, virtual, July 14, 2021.

Douglas-Hall A, Finn S, **Kavanaugh ML**. Health insurance coverage and contraceptive use at the state level: Findings from the 2017 Behavioral Risk Factor Surveillance System. Poster presentation at the Population Association of America 2020 annual meeting, Washington, DC, April 22, 2020.

Kavanaugh ML, Jerman J. Use of concurrent multiple methods of contraception in the United States. Poster presentation at the North American Forum on Family Planning 2017 annual meeting, Atlanta, GA, October 15, 2017.

Kavanaugh ML, Jerman J, Finer L. Who uses long-acting reversible contraceptive methods in the United States, which methods do they use, and who stops using them? Poster presentation at the North American Forum on Family Planning 2015 annual meeting, Chicago, IL, November 17, 2015.

Norris A, Bessett D, Esber A, Littman L, **Kavanaugh ML.** Do the know-it-alls actually know? Comparing perceived and assessed knowledge of sexual and reproductive health among US adults. Poster presentation at the North American Forum on Family Planning 2015 annual meeting, Chicago, IL, November 17, 2015.

Littman L, Esber A, **Kavanaugh ML,** Bessett D, Norris A. Does the source matter? The association between individuals' trusted information source and reproductive health knowledge. Poster presentation at the North American Forum on Family Planning 2014 annual meeting, Miami, FL, October 12, 2014.

Bessett D, Norris A, Littman L, **Kavanaugh ML**. Knowledge about Abortion in 'Red,' 'Blue,' and 'Purple' States: Examining the relationship between state-level political contexts and individual knowledge about abortion. Poster presentation at the North American Forum on Family Planning 2013 annual meeting, Seattle, WA, October 7, 2013.

Kavanaugh ML, Bessett D, Littman L, Norris A. Knowledge about abortion compared to knowledge about contraception, pregnancy and birth. Poster presentation at the National Abortion Federation 2013 annual meeting, New York City, NY, April 29, 2013.

Kavanaugh ML, Frohwirth L, Jerman J, Popkin R, Ethier K, Moskosky S. Long-acting reversible contraception for adolescents and young adults: Service availability, provider attitudes and patient perspectives. Poster presentation at the Society for Adolescent Health and Medicine 2013 annual meeting, Atlanta, GA, March 15, 2013.

Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Long-acting Reversible Contraceptive Services for Teens and Young Adults in Publicly Funded Facilities in the United States. Poster presentation at the North American Forum on Family Planning 2012 annual meeting, San Francisco, CA, October 28, 2012.

Kavanaugh ML, Moore A, Akinyemi O, Adewole I, Dzekedzeke K, Awolude O, Arulogun O. Community attitudes toward childbearing and abortion among HIV-positive women in Nigeria and Zambia. Poster presentation at the XIX International AIDS Conference, Washington, DC, July 23, 2012.

Moore A, **Kavanaugh ML,** Arulogun O, Dzekedzeke K, Oladokun A. HIV-Positive Women's Reports of Their and their Partners' Fertility Preferences: A Case Study of Zambia. Poster presentation at the XIX International AIDS Conference, Washington, DC, July 23, 2012.

Kavanaugh ML, Jerman J, Hubacher D, Kost K, Finer LB. Characteristics of Women in the United States Who Use Long-Acting Reversible Contraceptive Methods. Poster presentation at the Population Association of America 2012 annual meeting, San Francisco, CA, May 3, 2012.

Jerman J and **Kavanaugh ML**. Women's characteristics associated with pill discontinuation due to dissatisfaction, by reason. Poster presentation at the American Public Health Association meeting, Washington, DC, October 31, 2011.

Kavanaugh ML, Jerman J, Hubacher D, Kost K, Finer LB**.** Who uses long-acting reversible contraceptive methods in the United States? Poster presentation at the North American Forum on Family Planning 2011 annual meeting, Washington, DC, October 23, 2011.

Williams SL, **Kavanaugh ML**, Parisi SM, Borrero S, Schwarz EB. Contraceptive use among obese women: results from the 2006-2008 National Survey of Family Growth. Poster presentation at the North American Forum on Family Planning 2011 annual meeting, Washington, DC, October 23, 2011.

Kavanaugh ML, Carlin E, Frohwirth L, Jones RK. Patients' attitudes and experiences related to receiving contraception during abortion care. Poster presentation at the National Abortion Federation 2011 annual meeting, Chicago, IL, April 11, 2011.

Zolna M, **Kavanaugh ML**, Lindberg L. Couples-based family planning services: Is there a need? Poster presentation at the American Public Health Association annual meeting, Denver, CO, November 8, 2010.

Kavanaugh ML, Terry MA, Documet PD. Life Stability and Unintended Pregnancy: How Social Context Shapes Women's Fertility Experiences. Poster presentation at the American Public Health Association annual meeting, Philadelphia, PA, November 9, 2009.

Kavanaugh ML, Jones RK, Finer LB. Providing Contraception to Patients in the Abortion Care Setting: Practices and Barriers. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2009 annual meeting, Los Angeles, CA, October 2, 2009.

Kavanaugh ML, Jones RK, Finer LB. Providing Contraception to Patients in the Abortion Care Setting: a Qualitative Exploration of Practices and Barriers. Poster presentation at the National Abortion Federation 2009 annual meeting, Portland, OR, April 29, 2009.

Kavanaugh ML, Schwarz EB. Prospective Assessment of Pregnancy Intentions Using a Single vs. Multi-item Measure. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2008 annual meeting, Washington, DC, September 19, 2008.

Schwarz EB, **Kavanaugh ML**, Horowitz T. While You're Here, Can I Interest You in an IUD? Interest in intrauterine contraception among women seeking pregnancy testing. Poster presentation at the Association of Reproductive Health Professionals and Society of Family Planning 2008 annual meeting, Washington, DC, September 19, 2008.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Poster presentation at the American Public Health Association annual meeting, Washington, DC, November 5, 2007.

Kavanaugh ML, Schwarz EB. Counseling About and Use of Emergency Contraception in the United States: Results from the National Survey of Family Growth. Poster presentation at the University of Pittsburgh Graduate School of Public Health Dean's Day, Pittsburgh, PA, March 16, 2007.

Terry MA, **Kavanaugh ML**, Beem P, Finch K, Goodman R. Improving African American Access to Epilepsy Resources. Poster presentation at the Pennsylvania Public Health Association, Pittsburgh, PA, October 24-26 2005.

PROFESSIONAL AFFILIATIONS

Fellow, Society of Family Planning, January 2013 – Present

- Secretary, Board of Directors, October 2019 – February 2024
  - Executive Committee, October 2019 – February 2024
  - Diversity, Equity and Inclusion (DEI) Committee Co-Chair, January 2019 – February 2024
  - Strategic Planning (VISION) Working Group Co-Chair, February 2021 – December 2022
  - Merger Working Group, May 2020 – March 2021
  - Governance Committee Chair, January 2018 – January 2021
  - Community Norms Working Group Chair, January 2019 – March 2020
  - At-large member, Board of Directors, November 2016 – October 2019
- SFP Traveling to abortion care, post-Dobbs RFP, Grant Review Committee, February 2024
- Member, Challenges in Future Abortion Research Learning Community, June – December 2022
- Research Abstract Selection Committee DEI Representative, 2022 Annual Meeting
- SFP Annual Awards Selection Committee Co-Chair, Spring 2022
- Research Abstract Selection Committee DEI Representative, 2021 Annual Meeting,
- SFP Annual Awards Selection Committee Co-Chair, Spring 2021
- Oral Abstract Judge Chair, 2020 Annual Meeting, October 2020
- Medication Abortion RFP#2 Grant Review Committee, August 2020
- Population Health Track Chair, 2019 Annual Meeting Session Working Group, May 2019
- Medication Abortion RFP#1 Grant Review Committee, August 2018
- Scientific Abstract Committee, May 2017
- Interdisciplinary Innovation (I2) Grant Review Committee, June 2016
- Trainee/Student Grant Review Committee, June 2014

Junior Fellow, Society of Family Planning, May 2007 – January 2013

- Junior Fellows Committee, March 2009 – January 2013
- Trainee/Student Grant Review Committee, June 2011

Member, Global Health Council, October 2008 – Present

Member, Population Association of America, September 2008 – Present

- Session organizer and chair, Contraceptive Use in Developed Countries, PAA annual meeting, April 2019
- Discussant, Patterns and Determinants of Contraceptive Use, PAA annual meeting, March 31, 2016
- Session organizer and chair, Contraceptive use, PAA annual meeting, May 2014
- Discussant, Determinants, Associations and Consequences of Abortion, PAA annual meeting, April 16, 2010

Member, American Public Health Association, August 2007 – Present

- Moderator, Panel on Abortion and Stigma, APHA annual meeting, November 8, 2010
- Co-chair, Abortion Task Force, Population, Reproductive and Sexual Health Section, November 2009

Member, Delta Omega Public Health Honor Society, April 2005 – Present

Member, Association of Reproductive Health Professionals, May 2006 – May 2018

Associate Faculty Member, Faculty 1000, March 2010 – January 2014

MEDIA (select interviews)

CNN. *Over-the-counter birth control pills have been available in the US for over a year. Here's who's using them.* August 18, 2025.

NBC News. *The morning-after pill is coming to a convenience store near you*. May 28, 2025.

Stateline. *More women are seeking sterilizations post-Dobbs, experts say.* October 2, 2024.

STAT. *Federal officials and physician groups express outrage over revelations of recent coercive sterilizations*. June 6, 2024.

Healthline. *After Dobbs, Study Finds Sharp Increase in Permanent Sterilizations in Young People*. April 12, 2024.

CNN. *Online orders begin for first over-the-counter birth control pill in the US*. March 18, 2024.

Des Moines Register. *Iowa women less likely to access birth control since Roe v. Wade overturned.* March 18, 2024.

Today, Explained (podcast). *Lip gloss, gum, and the Pill*. March 14, 2024.

Wisconsin Public Radio. *The economics of dogs, Over-the-counter birth control availability, Political age and gender gaps.* March 7, 2024.

Everyday Health. *Birth Control in America: A Brief History of Contraception*. October 18, 2023.

Thomson Reuters. *U.S. women struggle to find contraception as restrictions mount*. June 22, 2023.

The CUT. *The Great Morning-After-Pill Rebrand*. March 26, 2023.

Stateline. *New Research Shows State Restrictions Reduce Contraception Use*. September 22, 2022.

Montana Public Radio. *Abortion providers see greater interest in sterilization procedures*. July 22, 2022.

Bloomberg News. *Why Over-the-Counter Birth Control Has Taken So Long in the US*. July 13, 2022.

Tampa Bay Times. *Amid abortion battle, they chose permanent birth control. Here's why*. July 12, 2022.

San Francisco Chronicle. *The repeal of abortion rights sparked an online run on contraception. Bay area telehealth companies are trying to keep up*. July 5, 2022.

New York Post. *Making the cut: Younger men seek vasectomies in the wake of Roe v. Wade ruling*. July 1, 2022.

KFF Health News. *Post-'Roe,' People Are Seeking Permanent Sterilizations, and Some Are Being Turned Away*. June 25, 2022.

Medscape (podcast). *How Is US Policy Affecting Abortion, Pregnancy Rates?* September 6, 2018.

Smithsonian Magazine. *From Medical Pariah to Feminist Icon: The Story of the IUD*. June 15, 2017.

HuffPost. *Long-Term Birth Control Use Soars For American Women*. November 10, 2015.

NPR. *More Women Opt For IUD, Contraceptive Implant For Birth Control*. November 9, 2015.

Time. *More Women Are Getting the IUD and Implant for Birth Control*. October 8, 2015.

WBUR. *Coming To A Clinic Near You: The $50 IUD With A Fascinating Backstory*. October 2, 2015.

HONORS AND AWARDS

Power Player of the Month, Power to Decide, June 2024
Distinguished Alumni Award for Early Career Excellence, University of Pittsburgh Graduate School of Public Health, May 2015
Outstanding Student Award, Department of Behavioral and Community Health Sciences, April 2009
Wyeth New Leaders Fellowship, Association of Reproductive Health Professionals, September 2008
Delta Omega Poster Award, National Office, American Public Health Association, November 2007
Wyeth New Leaders Scholarship, Association of Reproductive Health Professionals, September 2007
Delta Omega Poster Award, Omicron chapter, University of Pittsburgh, March 2007
Dean's Day Doctoral Poster Prize, Graduate School of Public Health, March 2007
Gary Stewart Scholarship for Research, Association of Reproductive Health Professionals, September 2006
Jonas Salk Health Sciences Fellowship, Jewish Healthcare Foundation, September 2005-April 2006
Women's Studies Master's Paper Prize, University of Pittsburgh, June 2005
Delta Omega Public Health Honor Society, University of Pittsburgh, Inducted April 2005
Public Health Service Traineeship Scholarship, University of Pittsburgh, 2003-2004

SERVICE

Technical Expert Panel Member, Reproductive Health Experiences and Access (RHEA) Survey, December 2023 - Present
Steering Committee Member, Post-Roe Contraceptive Access Strategy, CECA, September 2023 - Present
Member, Power to Decide Research Advisory Group, March 2023 – Present
Trustee and Governance Committee member, St. Edmunds Academy Board of Trustees, Pittsburgh, PA, September 2022 – Present
Member, National Contraceptive Quality Measures Workgroup co-convened by PPFA and CECA, January 2022 – Present
Reviewer, *Adolescence Post-Dobbs: A Policy-Driven Research Agenda for Minor Adolescents and Abortion*, Youth Reproductive Equity, January 2024
Reviewer, Contraceptive agency metric development, Innovations for Choice and Autonomy (ICAN) project, July 2023
Expert stakeholder, Testimony provided during Open Public Hearing for FDA consideration of OPill OTC status, May 2023
Member, Setting a Post-Roe Contraceptive Access Strategy Summit convened by CECA, Fall 2022
Member, Contraceptive Access Metrics Working Group convened by CECA, March – August 2022
Member, Technical Expert Panel on Funding Strategies to Expand Contraceptive Access, CECA, January 2020 – August 2021
Research Advisory Board Member, Seeding New Ground pilot project of State Innovation Exchange (SiX), October 2019 – October 2020
Member, Guttmacher Institute Racial Equity Advisory Group, January 2018 – January 2021
Member, University of Pittsburgh Graduate School of Public Health Alumni Awards Committee, December 2015 – January 2020
Member, Power to Decide Reproductive Well-Being Shared Measurement Working Group, January 2019 – August 2020
Liaison, Planned Parenthood Federation of America's (PPFA's) National Medical Committee, January 2011 – February 2020
Alumni presenter, BCHS Alumni Stories Panel, Graduate School of Public Health, January 2018
Member, Guttmacher Institute Research Division Culture Team, September 2016 – March 2019
Member, IUD Data and Monitoring Work Group, IUD Task Force for New York City, January 2013 – September 2017
Participant, Training and Access Working Group (TAWG), March 2009 and October 2009

Stakeholder, ACLU Minors' Rights Project for Minor Victims of Sexual Assault, Pittsburgh, Pennsylvania, April 2007 – August 2008

Volunteer Alumni Interviewer, Cornell Alumni Admissions Ambassador Network, Pittsburgh, Pennsylvania, September 2004 – August 2008

Ad hoc reviewer

- Demography, January 2020 – Present
- International Journal of Health Policy and Management, September 2015 – Present
- Journal of Health Care for the Poor and Underserved, May 2013 – Present
- BMC Women's Health, April 2013 – Present
- Contraception, March 2013 – Present
- Human Reproduction, November 2012 – Present
- Social Problems, October 2012 – Present
- Journal of Immigrant and Minority Health, May 2012 – Present
- Journal of Women's Health, December 2011 – Present
- Women's Health Issues, December 2011 – Present
- Perspectives on Sexual and Reproductive Health, July 2011 – Present
- Social Science Research, June 2011 – Present
- Journal of General Internal Medicine, May 2011 – Present
- Journal of Adolescent Health, August 2010 – Present
- Pediatrics, June 2010 – Present
- Journal of Urban Health, August 2009 – Present
- Qualitative Health Research, August 2009 – Present
- American Journal of Public Health, February 2008 – Present

INTERNATIONAL FIELD RESEARCH

Concepts of Healing: Local Methods vs. Western Medicine, Cornell/Nepal Study Abroad Program, Kirtipur, Nepal, January 2000 – May 2000

Performed preliminary and background research on faith healers' rituals and health posts. Interviewed and observed traditional community healers and modern doctors. Collected data and wrote thesis on interactions between modern and traditional healing.

Exhibit 6

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

State of California, et al.,

Plaintiffs,

v.

U.S. Department of Health and Human Services, et al.,

Defendants.

CA No.: 1:25-cv-12118-TI

DECLARATION OF SARAH GILBERT IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Sarah Gilbert, declare as follows:

1. I am the Chief of the Office of Family Planning, at the Department of the Health Care Services (DHCS). I make this declaration from personal knowledge and the records of the Department that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As Chief of the Office of Family Planning, I am responsible for leading the Family Planning, Access, Care, and Treatment (Family PACT) Program, which provides family planning services for low-income individuals and families, as well as developing and implementing policies related to family planning and sexual and reproductive health services for Medi-Cal. I have held this position since April 7, 2025. I have a bachelor's degree in human biology with a focus on health policy and economics from Stanford University and a master's degree in nursing from Yale University. I am licensed as a Registered Nurse and Nurse Practitioner in the State of California and am board certified as an Adult Nurse Practitioner and Women's Health Nurse Practitioner. From January 2019 to March 2025, I served as the Senior Director of Clinical Practice at Planned Parenthood Northern California (PPNorCal) and oversaw the clinical care delivery across PPNorCal's 17 health centers, clinical training, and clinical initiatives.

3. Federal Medicaid funding comprises a significant percentage of California's budget. It is one of the largest sources of federal revenue for California. California has two relevant Medicaid programs that impact reproductive health in California: Medi-Cal and the Family PACT Program.

The Medi-Cal Program

4. DHCS is the single state agency responsible for administering Medi-Cal. Medi-Cal provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Medi-Cal's coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care. DHCS' mission is to improve the overall health and well-being of all Californians. In 2014, California opted in to Affordable Care Act Medicaid coverage, which expanded the eligible population. As of February 2025, approximately 14.8 million Californians were covered under Medi-Cal.

5. Any person who meets eligibility requirements is entitled to coverage under Medi-Cal. Covered services generally include doctor visits, hospital care, prescription drugs, mental health treatment, dental and vision services, and long-term care, as well as the provision of transportation to medical appointments and extensive benefits for children and people with disabilities, all at low or no cost. The services that Medi-Cal covers and receives federal funding to provide, also include family planning and reproductive health care services such as contraceptive counseling and methods (including birth control pills, intrauterine devices (IUDs), birth control implants, and sterilization), cervical cancer screening, pregnancy testing, as well as testing and treatment for sexually transmitted infections.

6. Most family planning services billed to Medicaid are eligible for a 90% federal match rate, meaning that for those medical exams, procedures, or other services for those covered by Medi-Cal, the federal government pays 90% and the state pays the remainder. Some reproductive health care services are not eligible for the 90% match rate, such as sexually transmitted infection treatment. Those services are eligible for a federal match rate of 50%.

7. Care under Medi-Cal is provided through a combination of managed care and fee-for-service delivery systems, with the majority of members receiving care through managed care plans. Enrollees select or are assigned to a health plan that coordinates care through a network of providers. Providers participate in Medi-Cal by contracting with Medi-Cal managed care plans and enrolling with DHCS as applicable, or, to only provide care to members enrolled in the fee-for-service delivery system, enrolling with DHCS. In general, members access care by seeing providers within their managed care plan's network, or, for members enrolled in the fee-for-service delivery system, by seeing any enrolled fee-for-service provider. For family planning services, members of managed care plans may also receive care from out of plan or out of network providers in accordance with Welfare and Institutions Code Section 14132.07.

8. Federal funds are not used to pay for abortion care under Medi-Cal.

Family Planning, Access, Care, and Treatment Program

9. Since 1997, California has operated a Medicaid family planning program called the Family PACT Program, which covers family planning services for residents in need of such services with incomes under 200% of the Federal Poverty Level (FPL), who have the ability to become pregnant or cause a pregnancy, and who lack other health care coverage who are not insured and not eligible for coverage under Medi-Cal.

10. The Family PACT Program is a comprehensive family planning services program that provides three main categories of services: family planning services (initiation and management of all FDA-approved methods of contraception, including but not limited to birth control pills, long-acting reversible contraception, emergency contraception and male/female sterilization), clinical and preventive reproductive health services (such as testing and treatment for STIs, HIV testing, breast and cervical cancer screening, and periodic physical exams), and

reproductive health education and counseling to empower individuals to make informed decisions about their reproductive health and family planning needs.

11. The Family PACT Program is one of the largest Medicaid family planning expansion programs in the country, with 600,000 enrolled individuals and 355,000 individuals served in fiscal year (FY) 2022-23 (most recent year of data available). The Family PACT Program serves a significant percentage of women in need of publicly-funded family planning services, with 10% of the estimated 2.78 million women in need (i.e., women of child-bearing age) served through the Family PACT Program in FY 2022-23. Family PACT helps avert undesired pregnancies and thereby saves millions of dollars of public expenses annually.

12. The federal match rate for family planning services and STI testing covered under the Family PACT Program is 90%. This means that for these services, federal funds cover 90% of the cost and state funds cover 10% of the cost. The federal match rate for STI treatment and related services is 50%.

13. The Family PACT Program is a fee-for-service program that directly reimburses participating providers for all covered family planning services rendered to enrolled clients. Family PACT providers bill for each individual service (e.g., consultation, contraceptive method) provided to a Family PACT client. Medi-Cal providers can elect to be Family PACT providers if they are in good standing and are able to provide comprehensive family planning and reproductive health services.

14. Abortion care is not covered under the Family PACT Program. Federal funds do not pay for abortion care under the Program.

Abortion Availability and Care

15. The right to choose whether, how, and when to terminate or keep a pregnancy in California is protected in both state constitutional provisions and state law. Cal. Const. art. I, § 1.1 (added by Proposition 1, Gen. Elec. (Nov. 8, 2022); Cal. Health & Safety Code §§ 123460–123468 (enacted by Reproductive Privacy Act, Stats. 2002, ch. 385)). The State of California considers the right to choose a fundamental human right to be essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

16. The State of California funds 100% of the cost of abortion care for participants of Medi-Cal. Abortion care is billed and paid separately from other covered and federally-funded health care services.

Planned Parenthood Entities

17. There are seven separately incorporated Planned Parenthood affiliates in California operating 109 health centers as of September 23, 2025. I am informed and believe that five health centers closed on July 24, 2025, following the July 21, 2025, preliminary injunction issued in *PPFA et al. v. Kennedy*. The remaining 109 health centers are located in urban, suburban, and rural locations across the state—spanning from the northern California counties of Humboldt and Shasta down to the U.S.-Mexico border and from the Pacific coast to the Central Valley.

18. Planned Parenthood provides high-quality comprehensive reproductive healthcare and family planning services in California, including: contraception; STI testing and treatment; HIV testing and prevention; wellness and preventative care, including breast exams and cervical cancer screening; vaccines; sexual and reproductive health care, including gynecologic care;

menopause treatment; pregnancy testing, planning, and counseling; and abortion care. For many people, family planning and sexual and reproductive health care is the primary health care they regularly receive.

19. In 2024, Planned Parenthood health centers in California served Medi-Cal members and Family PACT clients through more than 1,297,800 visits. Planned Parenthood health centers provide more than two-thirds of all services delivered by the Family PACT Program by expenditure, equaling approximately $104 million. Medi-Cal payments to Planned Parenthood health centers in California for visits during the 12-month period from March 2024 through February 2025 totaled approximately $460 million.

20. Planned Parenthood health centers in California provide high-quality evidence-based care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout California as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from federal Medicaid reimbursement for the care they provide.

Implementation of Defund Provision

21. DHCS typically issues official guidance to Medi-Cal and Family PACT providers through Provider Bulletins and All Plan Letters (APLs). On July 3, 2025, in response to the U.S. Congress signing H.R.1, DHCS issued a Provider Bulletin and APL advising providers who meet the definition of Prohibited Entity to hold claims with dates of service on or after date of enactment, with the exception of claims for abortion services, which are already paid with state-only funds. Upon enactment of H.R.1 and in response to subsequent legal actions, DHCS issued amended Provider Bulletins on July 8, 11, and 31, 2025, and on September 17, 2025, and

amended APLs on July 11 and 31, 2025, and on September 17, 2025. Attached hereto as Exhibit A and B are true and correct copies of the September 17, 2025, Provider Bulletin and APL.

22. DHCS has conducted extensive work to try to understand if any non-Planned Parenthood providers may meet the definition of Prohibited Entity in California as of October 1, 2025. However, DHCS does not have a mechanism for tracking Medicaid payments made by other states to Medi-Cal providers, including any "affiliates, subsidiaries, successors, or clinics". As a result, if a provider received less than $800,000 in Medi-Cal payments but also received payments from other state Medicaid programs, DHCS would be unable to independently determine whether the provider's total Medicaid reimbursements in Federal FY 2023 exceeded the threshold established in H.R. 1.

23. DHCS has and continues to field questions from confused and concerned providers and community stakeholders regarding the impact of the defund provision. Despite the lack of clarity regarding the full scope of affected providers, or even who makes the final determination as to which providers are considered Prohibited Entities, DHCS has developed and implemented system edits and technical safeguards in the claims processing systems to support compliance with H.R. 1.

Impact of Defund Provision

24. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on California and its residents would be profound. I am concerned that Planned Parenthood has already had to close five health centers in California (South San Francisco, San Mateo, Gilroy, Westside/Santa Cruz, and Madera) and may need to close more. If that occurs, that will compound the impact on California's health system and residents.

25. I received a letter from the California Primary Care Association (CPCA), which represents the community clinics and health centers in California. The letter stated that "[e]liminating Planned Parenthood from our state's comprehensive network of care puts untenable stress on remaining health centers." CPCA does not believe that California has sufficient Medicaid provider capacity to absorb the patients that Planned Parenthood will no longer be compensated for treating under H.R.1. Furthermore, that it would require significant capital investment to build up such capacity. Based on my knowledge and experience working with CPCA, they are a reliable and recognized voice for California's community health centers and I believe their assessment to be correct and concerning. A true and correct copy of the CPCA letter dated July 16, 2025, is attached as Exhibit C.

26. The impact of Planned Parenthood closures is particularly consequential in rural and underserved areas where access to health care is already limited. Planned Parenthood health centers—some of which also provide primary care, behavioral health, and telehealth services—are especially vital in rural and underserved areas. Seventy percent (70.5%) of Planned Parenthood health centers in California are located within Health Professional Shortage Area (HPSA) counties, meaning regions that are experiencing a shortage of healthcare providers both geographically and that serve Medicaid eligible populations. Six Planned Parenthood health centers are in HPSA-designated "rural" or "partially rural" counties. These health centers serve an expansive catchment area extending north to the Oregon border and east to Nevada. The Merced Planned Parenthood health center in the Central Valley reported that 68% of the patients they served in 2024 had incomes below 100% of the Federal Poverty Level.

27. With the continued closure of Planned Parenthood health centers, it is inevitable that some proportion of patients will be unable to find another provider for reproductive

healthcare and family planning services. As a result, many Californians may experience irreparable harm from delayed or foregone care—including birth control, cancer screenings, and STI testing and treatment—leading to undesired pregnancies, increased health risks, undetected cancer, untreated infections, and overall poorer health outcomes.

28. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in California for non-abortion, family planning services as they have done for decades, or the State of California would need to pay the former federal share of that healthcare.

29. The exclusion of Planned Parenthood health centers from federal Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of California, but it will also have a significant impact on California's entire health care system and the state budget. Excluding Planned Parenthood from federal Medicaid reimbursement will undermine access to preventive care that both improves individual and public health and reduces overall healthcare costs. Without access to timely services—such as birth control and emergency contraception to prevent undesired pregnancies; STI testing and treatment to prevent complications like antibiotic resistant STIs or congenital infections; breast and cervical cancer screening; early identification of life threatening conditions such as ectopic pregnancies—more patients may experience avoidable health crises, increasing reliance on costly emergency and hospital care and straining California's healthcare infrastructure and state budget.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 23, 2025.

Signed by:
CDCBD5D24CB441E...

Saran Gilbert, NP
Chief, Office of Family Planning
California Department of Health Care Services

EXHIBIT A

Published September 17, 2025

The Department of Health Care Services (DHCS) is providing this additional, important update to Medi-Cal and Family Planning, Access, Care, and Treatment Program (Family PACT) providers that may be impacted by H.R. 1. Please note that this update supersedes DHCS' prior News Articles published on July 3, 2025, July 8, 2025, July 11, 2025, and July 31, 2025.

Background

On July 3, 2025, the United States Congress passed H.R. 1, which includes Section 71113, Federal Payments to Prohibited Entities. H.R. 1 was enacted on July 4, 2025 (Public Law No: 119-21). Section 71113 is excerpted here:

> *"No Federal funds that are considered direct spending and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act, including any payments made directly to the prohibited entity or under a contract or other arrangement between a State and a covered organization."*

"Prohibited Entity" is defined as follows:

> *"The term "prohibited entity" means an entity, including its affiliates, subsidiaries, successors, and clinics–*
> *(A) that, as of the first day of the first quarter beginning after the date of enactment of this Act–*
> *(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;*
> *(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related*

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> *medical care; and*
> *(iii) provides for abortions, other than an abortion–*
> *(I) if the pregnancy is the result of an act of rape or incest; or*
> *(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and*
> *(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000."*

On July 7, 2025, Planned Parenthood Federation of America (Planned Parenthood) filed a complaint in Massachusetts federal court, asserting that the provisions in Section 71113 are unconstitutional and their clear purpose is to prevent Planned Parenthood from receiving Medicaid reimbursements. The Federal District Court Judge in Massachusetts issued a temporary restraining order (TRO) blocking immediate implementation of Section 71113 in H.R. 1 to Planned Parenthood and its members.

On July 21 and July 28, 2025, the Federal District Court issued two separate Preliminary Injunctions (PIs) that modified the TRO.

On September 11, 2025, the First Circuit Court of Appeals issued an order staying (putting a hold on) both PIs issued on July 21 and 28, 2025, respectively. DHCS is amending this notification in response.

Eligibility, Enrollment & Service Delivery

All Medi-Cal and Family PACT Providers, including those who meet the definition of "Prohibited Entity" as noted above, may continue to:

- Perform Presumptive Eligibility for Pregnant People (PE4PP) determinations and Family PACT enrollment;
- Accept eligible Medi-Cal members, PE4PP members, and Family PACT clients; and
- Render services per existing obligations and standards, which includes the prohibition against balance billing or charging Medi-Cal members for services.

Claim Submission

- Medi-Cal and Family PACT providers that determine in good faith they **do not meet** the definition of "Prohibited Entity" should continue to submit claims in accordance with published Medi-Cal and Family PACT policy. These claims are not impacted by H.R. 1.
- Medi-Cal and Family PACT providers that **meet** the definition of "Prohibited Entity" should take the following actions:
    - Providers should continue to submit claims in accordance with published Medi-Cal and Family PACT policy for services rendered with dates of services (DOS) on or before July 3, 2025. These claims are not impacted by H.R. 1.
    - Providers **that obtained relief** under the July 21 or the July 28, 2025, PIs should **submit claims for all services rendered with DOS July 4, 2025, through September 10, 2025,** after which the PIs were stayed (put on hold).
        - Providers that meet the definition of "Prohibited Entity" but **did not obtain relief** under either the July 21 or the July 28, 2025, PIs should hold claims (i.e., do not submit claims) for all non-abortion services rendered with DOS on or after July 4, 2025.
    - Providers should **hold claims (i.e., do not submit claims) for all services rendered with DOS on or after September 11, 2025, with the exception of abortion claims, which should continue to be submitted.**

DOS on or after July 4, 2025, in accordance with existing Medi-Cal policies:

- Abortions (abort)
- Presumptive Eligibility for Pregnant People (presum)
- Presumptive Eligibility for Pregnant People: Billing Codes (presum bill)

Claim submission instructions for Providers that meet the definition of "Prohibited Entity":

DOS	Abortion Services	Non-Abortion Services
On or before July 3, 2025	**Submit claims**	**Submit claims**
July 4, 2025 through September 10, 2025	**Submit claims**	*Providers that obtained relief under the 7/11/25 or 7/28/25 PIs:* **Submit claims** *Providers that did not obtain relief under the 7/11/25 or 7/28/25 PIs:* **Do not submit claims**
On or after September 11, 2025	**Submit claims**	**Do not submit claims**

Next Steps

DHCS recognizes that this situation is rapidly evolving and will implement all necessary policy and system updates to comply with H.R. 1 and any applicable court orders. DHCS will continue to communicate any additional information to Prohibited Entities as applicable through its regular communication channels and updated policy guidance.

DHCS is committed to maintaining access to essential family planning and reproductive health services for all Medi-Cal members and Family PACT clients while complying with all applicable federal requirements. DHCS appreciates your ongoing partnership and commitment to ensuring Medi-Cal members and Family PACT clients have access to these important covered services.

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For questions regarding this Provider Bulletin, contact DHCS' Office of Family Planning via email at OFPStakeholder@dhcs.ca.gov.

This article was published on September 17, 2025

Categories

Policy

Communities

CAH GM OB FPACT

EXHIBIT B

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: *September 17*, 2025

ALL PLAN LETTER 25-011 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: H.R. 1 – FEDERAL PAYMENTS TO PROHIBITED ENTITIES

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program (Family PACT) Providers who may be impacted by H.R. 1, enacted on July 4, 2025 (Public Law No: 119-21). This APL also provides guidance pertaining to a Temporary Restraining Order (TRO) blocking immediate implementation of Section 71113 in H.R. 1, *subsequent Preliminary Injunctions (PIs), and recent Order to Stay the PIs*.

Revised text is found in italics.

BACKGROUND:

On July 3, 2025, the United States Congress passed H.R. 1[1], which includes Section 71113, Federal Payments to Prohibited Entities. H.R. 1 was enacted on July 4, 2025 (Public Law No: 119-21). Section 71113 is excerpted here:

“No Federal funds that are considered direct spending and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 1-year period beginning on the date of the enactment of this Act, including any payments made directly to the prohibited entity or under a contract or other arrangement between a State and a covered organization.”

“Prohibited Entity” is defined as follows:

“The term ‘‘prohibited entity’’ means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the first day of the first quarter beginning after the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

[1]H.R.1 can be accessed at: https://www.congress.gov/bill/119th-congress/house-bill/1/text

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(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or (II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $800,000."

On July 7, 2025, Planned Parenthood Federation of America (Planned Parenthood) filed a complaint in Massachusetts federal court, asserting that the provisions in over H.R. 1, Section 71113 are unconstitutional, and its clear purpose is to prevent Planned Parenthood from receiving Medicaid reimbursements. The Federal District Court Judge in Massachusetts issued a TRO blocking immediate implementation of Section 71113 in H.R. 1 to Planned Parenthood and its members.

On July 21 and July 28, 2025, the Federal District Court issued two separate PIs that modified the TRO. On September 11, 2025, the First Circuit Court of Appeals issued an order staying (putting on hold) both PIs. The Department of Health Care Services (DHCS) is revising this APL in response.

POLICY:

Payments and Claims/Encounter Processing

MCPs should continue to cover services and process claims or Encounters for Medi-Cal and Family PACT Providers who *determine in good faith they* **do not meet** the definition of Prohibited Entity as these claims or Encounters are not impacted by H.R. 1.

*MCPs must continue to cover services and process and pay claims or Encounters for Medi-Cal and Family PACT Providers who **meet** the definition of Prohibited Entity based on the following Provider claims/Encounter submission allowances and prohibitions:*

- Medi-Cal and Family PACT Providers who **meet** the definition of "Prohibited Entity" should take the following actions:
    - Providers should *continue to* submit claims or Encounters in accordance with published Medi-Cal and Family PACT policy for services rendered

with *dates of service* (DOS) on or before July 3, 2025. These claims or Encounters are not impacted by H.R. 1.

- Providers who **obtained relief** under *either* the July *21 or the* 28 PI*s* should submit claims or Encounters for all services rendered with DOS on or after July 4, 2025 *through September 10, 2025, after which the PIs were stayed (put on hold)*.
    - Providers who **did not obtain relief** under *either* the July *21 or* 28 PI*s* should hold claims or Encounters for all services, except abortion services (please see further information below), rendered with DOS on or after July 4, 2025.
    - *Providers should hold (i.e., not submit) claims or Encounters for all services rendered with DOS on or after September 11, 2025, with the exception of abortion claims or Encounters, which should continue to be submitted for DOS on or after July 4, 2025, in accordance with existing Medi-Cal policies.*

Claim/Encounter submission instructions for Providers who meet the definition of "Prohibited Entity":		
DOS	***Abortion Services***	***Non-Abortion Services***
On or before July 3, 2025	***Submit claims***	***Submit claims***
July 4, 2025 through September 10, 2025	***Submit claims***	*Providers* ***who obtained*** *relief under either the July 21 or July 28, 2025 PIs:* ***Submit claims*** *Providers* ***who did not*** *obtain relief under either the July 21 or the July 28, 2025 PIs:* ***Do not submit claims***
On or after September 11, 2025	***Submit claims***	***Do not submit claims***

MCPs may, at their discretion, continue to make payments and process claims or Encounters for Medi-Cal and Family PACT Providers who **meet** the definition of "Prohibited Entity" *that fall outside of the Provider claim/Encounter submission allowances mentioned above*. Such services, and associated costs, will not be considered in capitation rates paid by DHCS to MCPs under the Primary Contract. Additional information will be forthcoming regarding whether such services, and associated costs, will receive consideration in capitation rates paid by DHCS to MCPs under the State-Only Contract.

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Exception for Abortion Services

All Providers, including Medi-Cal and Family PACT Providers who **meet** the definition of "Prohibited Entity" may continue to submit claims or Encounters **exclusively** for procedural and medication abortion using the following procedure codes as well as all directly related, ancillary services that are provided as part of the procedural or medication abortion claim or Encounter in accordance with existing Medi-Cal policy as outlined in the "Abortions" section of the Medi-Cal Provider Manual[2] since these services are already covered and reimbursed by DHCS with entirely State General Funds:

- 59840, 59841, 59850-59852, 59855-59857, S0190, S0191, and S0199.

To ensure appropriate adjudication and compliance with federal requirements, Medi-Cal and Family PACT Providers who **meet** the definition of "Prohibited Entity" should submit claims or Encounters for abortion services using the procedural codes above **on a separate claim or Encounter**. This claim or Encounter must **not** include any other services that are not directly related to the abortion service.

Subcontractors, Downstream Subcontractors, and Network Providers Compliance

MCPs are responsible for ensuring that these requirements, including the effective dates, are communicated to applicable Subcontractors, Downstream Subcontractors, and Network Providers.

Next Steps

DHCS recognizes that this situation is rapidly evolving and will implement necessary policy and system updates to comply with H.R. 1 and any applicable court orders. Now that H.R. 1 has been enacted, DHCS will continue to communicate any additional information to Prohibited Entities as applicable through its regular communication channels and updated policy guidance.

DHCS is committed to maintaining access to essential family planning and reproductive health services for all Medi-Cal members and Family PACT clients while complying with all applicable federal requirements. DHCS appreciates your ongoing partnership and commitment to ensuring Medi-Cal members and Family PACT clients have access to these important covered services.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager. For questions regarding the related Provider

[2] Medi-Cal Provider Manuals can be accessed at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual

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Bulletin, please contact DHCS' Office of Family Planning via email at: OFPStakeholder@dhcs.ca.gov.

Sincerely,

Bambi Cisneros

Acting Division Chief, Managed Care Quality and Monitoring Division

Assistant Deputy Director, Health Care Delivery Systems

EXHIBIT C

California Primary Care ASSOCIATION

July 16, 2025

Sarah Gilbert
Chief, Office of Family Planning
California Department of Health Care Services
P.O. Box 997413, MS Code 8400
Sacramento, CA 95899-7413

Sent via email to: Sarah.Gilbert@dhcs.ca.gov

Dear Chief Gilbert,

We are writing today to express concern about the recent passage of H.R.1 and the impending negative impacts on patient access to family planning services, reproductive services, and related medical care due to Section 71113, Federal Payments to Prohibited Entities.

As the statewide representative of community clinics and health centers in California, who annually serve over 7.7 million Medi-Cal patients, we believe that excluding Planned Parenthood and other prohibited essential community provider entities from federal funding would negatively impact the health of our communities.

In California, this would mean that Medi-Cal patients would lose an important point of access for family planning services, shifting care to federally qualified health centers (FQHCs) that are unable to meet the increase in patient demand. Planned Parenthood currently operates 114 health centers in California and serves nearly one million patients through 1.3 million total visits annually. Eliminating Planned Parenthood from our state's comprehensive network of care puts untenable stress on remaining health centers. According to data recently released by the Guttmacher Institute, FQHCs would need to increase their capacity to offer contraceptive care by 56% to compensate for the loss of these services at Planned Parenthood clinics. We do not have the capacity for such an increase in care and building it would require significant capital investment.

Moreover, this policy, which effectively defunds Planned Parenthood, would limit patients' choice of providers for sensitive medical services. Many patients rely on Planned Parenthood because they know that it is a place where they can get high quality care that is confidential and without judgment. Their reputation as a leading provider of sexual and reproductive health makes them the provider of choice for nearly a million Californians who seek out a variety of services including wellness exams, birth control, sexually transmitted infection testing and treatment, cancer screenings, and other preventive care.

Planned Parenthood is a vital component of the health care system in California, and for that reason, we are extremely concerned about the inclusion of this provision in the recently passed budget reconciliation bill and the ramifications it will have on provider capacity and patient access to family planning and reproductive health services in our state.

Sincerely,

California Primary Care ASSOCIATION



Allie Budenz, MPA
Vice President of Health Center Optimization
California Primary Care Association

Exhibit 7

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF OREGON, STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

ROBERT F. KENNEDY JR., in his official capacity as the Secretary of U.S. Department of Health and Human Services, the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DR. MEHMET OZ, in his official capacity as the Administrator of the Centers for Medicare anU.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as

Case No. TBD1:25-cv-12118-IT

DECLARATION OF ADELA FLORES-BRENNAN

Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

I, Adela Flores- Brennan, declare as follows:

1. I am the Colorado Medicaid Director at the Colorado Department of Health Care Policy and Financing (HCPF). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. HCPF serves as Colorado's single state Medicaid agency. HCPF operates many Colorado health programs, including Colorado's Medicaid program known as Health First Colorado, and Children's Health Plan Plus (CHP+) program.

3. As the Colorado Medicaid director, I am responsible for overseeing the daily operations of Health First Colorado. Through these responsibilities, I am familiar with Health First Colorado's and CHP+'s family planning related benefits offered to Colorado Medicaid and CHP+ members. I am also familiar with the funding sources used to pay for these services.

4. I have served in the role as Colorado's Medicaid director since July 2022.

Health First Colorado

5. Health First Colorado is Colorado's approved Medicaid program. Health First Colorado provides comprehensive medical coverage for poor and low-income people in Colorado.

6. Health First Colorado is both fee-for-service and managed care. This means that Medicaid members may receive services directly from providers or through managed care entities.

7. Fee-for-service benefits are administered directly to members through Medicaid providers like hospitals, clinics, and pharmacies. These providers then seek reimbursement from Colorado Medicaid on a claim-by-claim basis.

8. Colorado members are enrolled into regional accountability entities (RAEs) which assist with the coordination of certain care to members. RAEs are responsible for developing and managing a network of primary care physical health providers and behavioral health providers to ensure access to appropriate care for Health First Colorado members. RAEs also contract with Primary Care Medical Providers, who serve as the medical home for Colorado members and partner with RAEs to coordinate that care.

9. Planned Parenthood of the Rocky Mountains (Planned Parenthood) contracts with Colorado's RAEs as a Primary Care Medical Provider. Nearly 5,000 members are connected to Planned Parenthood of the Rocky Mountains as their Primary Care Medical Provider.

10. Health First Colorado is authorized and funded in part through a Medicaid federal-state partnership. Colorado administers Health First Colorado pursuant to broad federal requirements as well as the terms of its "plan for medical assistance," also known as a State Plan. State Plans are approved by the U.S. Centers for Medicare and Medicaid Services (CMS). HCPF receives a federal Medicaid funding contribution, known as "Federal Financial Participation" (FFP), which covers a percentage of Health First Colorado's expenditures on eligible enrollees.

11. Most Health First Colorado members are eligible for coverage paid for by joint federal and state funding. HCPF uses FFP funding to pay for a significant portion of Health First Colorado's insurance coverage, while Colorado covers the remaining costs. To qualify for FFP funding, among other eligibility requirements, the member must either be a citizen of the United States or have some other qualifying immigration status; for example, a lawful permanent

residency. These individuals qualify for what is referred to as "full scope," federally funded Medicaid.

12. In 2014, Colorado opted into the Affordable Care Act's expanded Medicaid coverage, which expanded the eligible population. States receive a 90%, enhanced FFP reimbursement for individuals in the expansion population. Typical FFP is around 50% reimbursement. This means that federal funding finances 90% of spending for these individuals and states are responsible for the remaining 10% of costs.

13. In Colorado state fiscal year 2024, Health First Colorado had approximately 1.2 million members. As a result, approximately twenty percent of Colorado's population was covered under Health First Colorado.

14. Any person who meets eligibility requirements is entitled to coverage under Health First Colorado. Covered services generally include preventative and wellness services, health care provider visits, dental services, emergency services, behavioral health, pharmacy and durable medical equipment, physical, occupational and speech therapy, laboratory services, and long-term services and support.

15. The services that Health First Colorado covers also include family planning and reproductive health care services. Health First Colorado covers, among other services: doula care, including prenatal, labor and delivery, and postpartum support; access to midwives that provide care during labor, delivery, and after the birth of babies; family planning, which includes access to birth control pills and implanted devices, sterilization services, basic fertility assessments, sexually transmitted infection testing and treatment, and cervical cancer screening and prevention; and lactation support services.

16. In state fiscal year 2024, 90,213 Colorado Medicaid members received family planning or reproductive health care under Health First Colorado.

17. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by Health First Colorado, the federal government pays 90% of care costs and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually-transmitted infection testing and treatment. Those services are eligible for a federal match rate of 50%.

Child Health Plan Plus (CHP+)

18. HCPF also operates CHP+, which provides comprehensive health care benefits to uninsured children up to age 19 and pregnant people who do not qualify for Medicaid and meet income criteria (up to 260% of the federal poverty level).

19. The services covered under CHP+ include primary care, emergency care and urgent care, hospital services, dental care, prescriptions, immunizations, maternity care (prenatal, delivery and postpartum care), and mental/behavioral health care (excluding pediatric behavioral therapy).

20. In state fiscal year 2024, over 93,000 children and pregnant people were covered by CHP+. 6,408 CHP+ members received family planning or reproductive health care.

21. The federal match rate for services covered under CHP+ is 65%. This means for every service provided, federal funds cover 65% of the cost and state funds cover 35%.

22. Unlike Health First Colorado, CHP is 100% a managed care system. This means that all CHP members are enrolled into a managed care organization who oversees the management and delivery of care to these members.

Abortion availability and care

23. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in Colorado. *See* Colo. Rev. Stat. § 25-6-403. The State of Colorado considers the right to choose a fundamental human right as essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

24. Federal funds do not pay for abortion care under Health First Colorado unless such case is necessary to preserve the pregnant person's life or in cases of rape or incest. 10 C.C.R. § 2505-10:8770.

25. Effective January 1, 2026, however, Colorado will fund all abortion care through Health First Colorado and CHP+ with state only funds as part of recently signed state legislation in April 2025 (SB25-183, "Coverage for Pregnancy-Related Services") *See* C.R.S. §§ 25.5-2-106; 25.5-4-412; 25.5-8-107. This means that Colorado will not seek FFP for any abortion care provided through Health First Colorado or CHP+.

Planned Parenthood Entities

26. Planned Parenthood of the Rocky Mountains includes locations in Colorado, New Mexico, and Wyoming, and has been operating in Colorado for over 100 years. Planned Parenthood currently operates 11 health centers, and one telehealth center in Colorado. In fiscal year 2024, Planned Parenthood served Medicaid members in 62 of Colorado's 64 counties. This includes many of Colorado's rural and mountain counties.

27. Planned Parenthood of the Rocky Mountains provides high-quality comprehensive reproductive healthcare and family planning services in Colorado. Its locations provide the full range of reproductive healthcare in Colorado. Among other services, they

provide sexually-transmitted infection testing and treatment; contraception procedures, counseling, and management; cancer screening and prevention services and procedures; pregnancy tests and counseling; prenatal care; and abortion care. For many people, planning and reproductive health care is the primary health care they regularly receive.

28. Additionally, and as discussed above, Planned Parenthood of the Rocky Mountains contracts with Colorado's Managed Care Entities as a Primary Care Medical Provider. Nearly 5,000 members are connected to Planned Parenthood of the Rocky Mountains as their Primary Care Medical Provider.

29. Annually, between 11,000 - 14,000 Medicaid members are served at Planned Parenthood of the Rocky Mountains locations and via telehealth across the state. HCPF reimburses Planned Parenthood of the Rocky Mountains between $4.5 to $6 million per year for services provided to Colorado Medicaid members.

30. Planned Parenthood is a substantial provider of Family Planning services to Colorado Medicaid members.

31. Colorado does not have Medicaid providers who can absorb the patients that will be displaced if Planned Parenthood can no longer be compensated for treating under the Defund Provision. Providers do not have the capacity to provide the care that Planned Parenthood health centers currently provide. Moreover, Planned Parenthood health centers are unique to the extent they offer same day and walk-in appointments, and also dispense medication on site. There is simply no other provider in Colorado who would be able to see patients this quickly and/or offer a single-stop option for care and prescriptions, creating a critical gap in the state's health care system.

32. Capacity to provide the vital reproductive healthcare services especially does not exist in rural and underserved areas, which is where some of Planned Parenthood's health centers are located in Colorado. Health care services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

33. Planned Parenthood health centers in Colorado provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Colorado as providers.

Colorado's Actions to Implement the Defund Provision

34. To implement the Defund Provision, HCPF will need to expend significant staff and contractor time to ensure compliance with the requirements of the Defund Provision.

35. Colorado's compliance with the Defund Provision has required HCPF staff to: (1) develop and deploy a system to ensure the state does not make any fee-for-service physical health payments to Planned Parenthood; (2) communicate with Medicaid members who use Planned Parenthood as a primary care medical provider and expressed confusion as to the status of their provider; (3) disaffiliate Planned Parenthood from managed care networks; (4) determine which Colorado grants Planned Parenthood may receive as an integrated behavioral health provider; (5) evaluate alternative payment methodologies to determine whether any bundled payments or other alternative payments can reimburse Planned Parenthood for medically necessary services; (6) evaluate the modification of pharmacy payment systems to exclude Planned Parenthood; (7) identify alternative sources of care and assisting with referrals for Health First Colorado and/or CHP+ members previously seen at Planned Parenthood for healthcare visits; and (8) evaluate potential conflicts with Colorado statutes and regulations to ensure alignment with the Defund Provision.

36. Given the significant work required to comply with the Defund Provision, Colorado is still determining how to provide payment guidance to our managed care entities, providers and, most importantly, Health First Colorado and/or CHP+ members.

37. Failure to incorporate the necessary infrastructure changes would result in Colorado being at risk of having to return any federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby placing the costs directly onto Colorado and reducing federally provided matching Medicaid funds.

Impact of Defund Provision

38. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Colorado and Colorado's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in Colorado if it is excluded from Medicaid. If that occurs, that will compound the impact on Colorado's health system and residents.

39. Because capacity does not exist in the health care system in Colorado to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services.

40. Restricting federal funding to prohibited entities as defined in Section 71113 undermines access to care for Health First Colorado and CHP+ members, increases family planning and reproductive health care deserts, and raises network adequacy concerns across Colorado. HCPF committed to maintaining access to essential family planning and reproductive health services for all Health First Colorado members while complying with all applicable federal requirements.

41. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Colorado as they have done for decades, or the State of Colorado will have to cover the former federal share of Medicaid with state-only funding for the Planned Parenthood health centers in Colorado. This will require Colorado to use funds that could have otherwise covered other public services for Coloradans in a time when Colorado is already facing a significant state budget deficit.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 2 , 2025.



Adela Flores-Brennan

Exhibit 8

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF WILLIAM HALSEY

I, William Halsey, declare as follows:

1. I am the Medicaid Director at the Connecticut Department of Social Services (DSS). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business and upon information and belief. I would testify to the following if called as a witness.

2. As the Medicaid Director, I am responsible for the administration and oversight of the Medicaid Program for Connecticut, including family planning services. I have held this position for approximately one year and was Deputy or Acting Director of the Medicaid Program for three years. I have a Masters Degree in Social Work from Columbia University and Masters Degree in Business Administration from the University of Hartford. I have been with the Department of Social Services, the state Medicaid agency, since 2010.

Connecticut's State Medicaid program

3. "HUSKY health" or "HUSKY" is Connecticut's approved Medicaid program. HUSKY provides comprehensive medical coverage for poor and low-income people, including children and their families, seniors, disabled individuals and adults in Connecticut. To be eligible for HUSKY, residents must meet certain criteria, including residency, qualified non-citizen and income, and in certain eligibility groups, asset limits. In 2010, Connecticut was the first state in the nation to opt in to Affordable Care Act's expanded Medicaid coverage, which expanded the eligible population by including certain low-income childless adults. In state fiscal year 2024, approximately 29% percent of Connecticut's population was covered under HUSKY.

4. Federal Medicaid funding comprises a significant percentage of Connecticut's budget. It is one of the largest sources of federal revenue for Connecticut and generates more than $6 billion in federal revenue annually. Connecticut has over 900,000 Medicaid recipients under different coverage groups, including: "HUSKY A" for children and their parents and pregnant

women and "HUSKY C" for residents who are 65 years of age or older, and/or who are blind or disabled., and "HUSKY D," the ACA expansion group for single adults.

5. Any Connecticut resident who meets eligibility requirements is entitled to coverage under HUSKY. Covered services generally include medically necessary medical, behavioral health, dental and non-emergency medical transportation services. HUSKY Medicaid covers a wide variety of medically necessary services including, but not limited to, inpatient hospital, outpatient hospitals, maternity care, skilled nursing facilities, home health, home and community-based waivers for individuals who meet institutional level of care, inpatient and outpatient services, primary care, family planning, and durable medical equipment. The services that HUSKY covers, and receives federal funding to provide, also include family planning and reproductive health care services.

6. Upon information and belief, in state fiscal year 2025, 115,230 residents received family planning or reproductive health care under HUSKY during the course of 384,674 visits or encounters. The family planning services category encompasses a wide range of services, including counseling, prevention and treatment services. Specifically, family planning includes contraceptive services, screening services and pregnancy testing, gynecological exams and reproductive health counseling.

7. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other preventive services for those covered by HUSKY, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually-transmitted infection testing and treatment. Those services are eligible for a federal match rate based on the Medicaid member's eligibility category, rather than the service type. Connecticut's federal match rates range from 50% to 90% based on the eligibility group.

8. Care under HUSKY is provided under a fee for service system. All healthcare providers must enroll in the Medicaid program and comply with all provisions of the Medicaid

provider enrollment agreement. Medicaid beneficiaries have freedom of choice to select their healthcare provider unless a waiver of freedom of choice or to permit selective contracting has been prior authorized by the Centers for Medicare and Medicaid Services ("CMS") through appropriate federal authority.

9. Federal funds may not be used to not pay for abortion care under the Medicaid program. Connecticut elects to use state funds to pay for abortion care and therefore no federal claiming occurs for abortion care.

10. Connecticut also operates a second Medicaid program under its State Plan that it calls the Family Planning-Limited Benefit, which covers family planning and family-planning-related services for those who are not insured and not eligible for coverage under Connecticut's Medicaid program.

11. Eligibility requirements for the Family Planning-Limited Benefit program include that the individual does not otherwise qualify for full Medicaid coverage, an income standard of 250% of the Federal Poverty Level (FPL) and the individual meets Medicaid citizenship and residency requirements. The services covered under the Family Planning-Limited Benefit program include reproductive health exams (including family planning patient counseling & education), screening, testing, treatment and pre- and post-test counseling for sexually transmitted infections and HIV, voluntary sterilizations in accordance with federal guidelines 42 CFR 441.257 and 42 CFR 441.258, FDA approved contraceptives and birth control options, human papilloma virus vaccinations, family planning related surgical treatments and drugs relevant to the treatment of family planning and related services,

12. Upon information and belief, in state fiscal year 2025, of the overall patients and visits under HUSKY described in paragraph 6, 110,058 Connecticut residents received family planning or reproductive health care under Medicaid during the course of 359,584 visits or encounters.

13. The federal match rate for family planning services covered under the Family Planning-Limited Benefit program is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%. Family-planning-related services are matched at the State's regular Federal medical assistance percentage.

14. Services covered under the Family Planning-Limited Benefit program are administered the same as services covered under Medicaid. Both are administered by the state through the Connecticut Medical Assistance Program (CMAP). The same network of providers enrolled for coverage of full Medicaid services may provide services covered under the Family Planning-Limited Benefit program as defined by program rules. Individuals covered by the Family Planning-Limited Benefit program access the same administrative services for provider search and connection as individuals covered under full Medicaid. These services are provided through the contracted entity serving as the medical administrative service organization for the state.

15. Federal funds do not pay for abortion care under the Family Planning-Limited Benefit program.

Abortion Availability and Care

16. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in Connecticut. *See* Conn. Gen. Stat. § 19a-602. The State of Connecticut considers the right to choose a fundamental human right that is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

17. Connecticut funds 100% of the cost of abortion care for participants of the state Medicaid program and Family Planning-Limited Benefit program. Abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally funded health care services.

Planned Parenthood Entities in Connecticut

18. Planned Parenthood of Southern New England (PPSNE) is the sole Planned Parenthood affiliated health care provider in Connecticut. PPSNE currently operates 14 health centers in Connecticut

19. PPSNE provides high-quality comprehensive reproductive healthcare and family planning services in Connecticut. They provide the full range of reproductive healthcare. Among other things, they provide sexually-transmitted infection (STI) testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

20. Upon information and belief, in state fiscal year 2025, the last year for which data is available, Planned Parenthood health centers in Connecticut provided care at approximately 83,716 visits to 24,053 unique patients using HUSKY funding. Upon information and belief, overall Medicaid-funded visits in state fiscal year 2025 to Planned Parenthood health centers in Connecticut totaled approximately 82,537.

21. These Planned Parenthood health centers in Connecticut provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. Upon information and belief, Planned Parenthood provides approximately 22% of the total family planning services in Connecticut for HUSKY patients. Connecticut does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating under Section 7113 of "An Act to provide reconciliation pursuant to title II of H. Con. Res. 14" (the Defund Provision). Capacity does not exist to provide the care that Planned Parenthood health centers currently provide.

22. Capacity to provide the vital reproductive healthcare services especially does not exist in rural and underserved areas, where some of Planned Parenthood's health centers are

located in Connecticut. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

23. Planned Parenthood health centers in Connecticut provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Connecticut as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of Defund Provision

24. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Connecticut and Connecticut's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in Connecticut if it is excluded from participating in Medicaid. If that occurs, that will compound the impact on Connecticut's health system and residents.

25. Because capacity does not exist in the health care system in Connecticut to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. The result is likely to be higher rates of unintended pregnancies due to loss of access to contraceptives; increased cost and difficulty treating patient with cancer due to loss of access to routine cancer screenings and the resulting delay in diagnosis and treatment; and increased costs and harm for treatment of STIs, both for the patient and others who have been exposed to the patient due to lost or delayed access to STI testing and treatment.

26. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Connecticut as they have done for decades, or the State of Connecticut would need to pay the former federal share of that healthcare. Although the State of Connecticut has not ruled out state-funding HUSKY care at Planned Parenthood, to date it has not provided sufficient funding to cover the former federal share of Medicaid for the

Planned Parenthood health centers in Connecticut. With the numerous other cuts in federal funding, both to Medicaid and other programs across the state, finding state funding to backfill all programs may not be possible and Connecticut will be forced to make extremely difficult decisions regarding how to allocate its limited resources.

27. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of Connecticut, but it will also have a significant impact on Connecticut's entire health care system and the state budget. Planned Parenthood provides preventive care to Medicaid members in addition to their family planning services. Other providers in the state will not be able to easily absorb the additional caseloads if Planned Parenthood is no longer able to provide these services. Access to care will decrease, wait times will likely increase and potential delay in diagnosis of cancer or infectious diseases will worsen patient outcomes.

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

EXECUTED on August 25, 2025.

William Halsey

William Halsey, Medicaid Director
Connecticut Department of Social Services

Exhibit 9

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA; STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118

DECLARATION OF ANDREW WILSON

I, Andrew Wilson, declare as follows:

1. I am the Director at the Division of Medicaid and Medical Assistance (DMMA) of Delaware Health and Social Services (DHSS). I make this declaration from personal

knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Director, I am responsible for overseeing the administration of Delaware's Medicaid program, including eligibility policy, benefits design, managed care operations, and provider reimbursement. This includes responsibility for federally funded reproductive health and family planning services under the state's Medicaid plan and Section 1115 family planning waiver, ensuring compliance with federal requirements and access to covered services through approved Medicaid providers. I have held this position since December 2023. I have a law degree from Albany Law School.

3. Federal Medicaid funding comprises a significant percentage of Delaware's budget. It is one of the largest sources of federal revenue for Delaware. Delaware has 2 relevant Medicaid programs: Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP+).

Diamond State Health Plan (DSHP)

4. The Diamond State Health Plan (DSHP) is Delaware's approved Medicaid program. DHSP provides comprehensive medical coverage for poor and low-income people in Delaware. To be eligible for Medicaid, residents must meet certain criteria, including income and resource limits, state residency, U.S. citizenship or eligible immigration status, and qualifying under specific eligibility categories such as low-income children, pregnant individuals, parents, older adults, or people with disabilities. In 2014, Delaware opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. In state fiscal year 2024, approximately 25 percent of the Delaware's population was covered under Medicaid.

5. Any person who meets eligibility requirements is entitled to coverage under Delaware's Medicaid program. Covered services generally include hospital and physician visits, prescription drugs, mental and behavioral health services, long-term services and supports, preventive care, laboratory and imaging services, and other medically necessary treatments and

supports approved under Delaware's Medicaid State Plan and waivers. The services that Delaware's Medicaid program covers, and receives federal funding to provide, also include family planning and reproductive health care services such as contraception, pregnancy testing and counseling, sexually transmitted infection (STI) testing and treatment, preventive screenings like Pap smears, and sterilization procedures, consistent with federal requirements and Delaware's Section 1115 family planning waiver.

6. In state fiscal year 2024, 47,840residents received family planning or reproductive health care under Delaware' Medicaid Program in 111,952 visits or encounters.

7. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by Delaware's Medicaid program, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually transmitted infection testing and treatment. Those services are eligible for a federal match rate of approximately 60%.

8. Care under Delaware's Medicaid program is provided predominantly under a managed care system. Providers participate in Delaware Medicaid either by enrolling with one or more of the Managed Care Organizations (MCOs). Medicaid participants are generally required to choose an MCO upon enrollment. If they do not make a selection, one is assigned to them. Enrollees access care through their MCO's network of providers, and referrals or prior authorizations may be required for certain services, depending on the MCO's policies.

9. Federal funds do not pay for abortion care under Delaware's Medicaid program except in cases allowed by the federal Hyde Amendment—that is, to preserve the life of the mother, or when the pregnancy results from rape or incest.

Abortion availability and care

10. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in 24 Del. C. § 1790. The State of Delaware considers the right to choose a

fundamental human right that is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

11. Delaware funds 100% of the cost of abortion care for participants of the Delaware Medicaid program. Except for few Hyde Amendment cases, abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally-funded health care services.

Planned Parenthood entities

12. Planned Parenthood of Delaware is a Medicaid provider in Delaware. This Planned Parenthood entity currently operates 4 health centers in Delaware.

13. Planned Parenthood of Delaware provide high-quality comprehensive reproductive healthcare and family planning services in Delaware. They provide the full range of reproductive healthcare in Delaware. Among other things, they provide sexually transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

14. The Planned Parenthood health centers in Delaware provide important access to Medicaid-funded reproductive health care and family planning services. They provide the full range of reproductive healthcare in Delaware. Among other things, they provide sexually transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care.[1] In 2024, Planned Parenthood health centers in Delaware provided reproductive health care and family planning services at 2,388 visits to 1,656

unique patients using Delaware Medicaid program funding. For many women, family planning and reproductive health care is the primary health care they regularly receive.

15. The Planned Parenthood health centers in Delaware provide important access to Medicaid-funded reproductive health care and family planning services.

16. Planned Parenthood provides capacity to provide vital reproductive healthcare services, especially those that do not exist in rural and underserved areas.[1]

17. Planned Parenthood health centers in Delaware provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Delaware as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of defund provision

18. I am concerned that Planned Parenthood may need to close health centers in Delaware if it is excluded from Medicaid.

19. Because Planned Parenthood provides capacity in underserved areas, it is possible that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. For those patients, the result is likely to be delayed or foregone care, increased rates of unintended pregnancy, higher incidence of untreated sexually transmitted infections, and worsened maternal health outcomes. This result is expected

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[1] Rural Health Information Hub. (2023, Feb 24). *Rural Healthcare Workforce Overview - Rural Health Information Hub*. https://www.ruralhealthinfo.org/topics/health-care-workforce; Bureau of Health Workforce. (2023, Sep 30). *Designated health professional shortage areas statistics*. Health Resources and Services Administration (HRSA). https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport; Office of Health Equity. (2022, Jul 1). *What is health equity?* Centers for Disease Control and Prevention. https://www.cdc.gov/healthequity/whatis/index.html

because Planned Parenthood serves patients who face barriers such as low income, lack of transportation, or limited provider availability.

20. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Delaware as they have done for decades, or the State of Delaware would need to pay the former federal share of that healthcare. The State of Delaware has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in Delaware.

21. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of Delaware, but it will also have an impact on the Delaware's entire health care system and the state budget. Planned Parenthood plays a role in delivering cost-effective preventive care—such as contraception, cancer screenings, and STI testing—that reduces the need for more expensive emergency, prenatal, and neonatal services. Without access to these services, many patients may delay or forego care altogether, leading to increased rates of unintended pregnancies, higher maternal and infant health costs, and a greater reliance on emergency departments. These downstream effects will increase uncompensated care burdens on hospitals and safety net providers, drive up Medicaid expenditures over time, and strain already limited public health infrastructure.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 29, 2025.



Andrew Wilson, Director

Exhibit 10

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF JUDY MOHR PETERSON

I, Judy Mohr Peterson, declare as follows:

1. I serve as the Med-QUEST Division Administrator, which is the title for the Medicaid Director, for the State of Hawai'i's Department of Human Services. I have held this

position for 10 years, since July 2015. Prior to that, I served as the Medicaid Director for the Oregon Health Authority in the State of Oregon (2009 – June 2015).

2. I make this declaration from personal knowledge, and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

3. As the Medicaid Director, I am responsible for executive-level oversight and administration of State of Hawai‘i’s Medicaid program, QUEST.

4. Federal Medicaid funding comprises a significant percentage of Hawai‘i’s budget. It is one of the largest sources of federal revenue for Hawai‘i.

5. The Department of Human Services is the single state agency responsible for administering the State of Hawai‘i Medicaid program, QUEST, through its Med-QUEST Division. Med-QUEST provides low-income individuals with medical assistance for comprehensive healthcare coverage and access to affordable, integrated, and high-quality healthcare at no or low cost. Med-QUEST’s coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care. It also includes reproductive health care, including family planning services, maternity and newborn care, pregnancy-related services, contraceptives, and the diagnosis and treatment of sexually transmitted diseases.

6. To be eligible for QUEST, residents must meet certain criteria, including income limits, citizenship requirements, and in some circumstances, asset limits. In 2013, Hawai‘i opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. In state fiscal year 2025, approximately 28 percent of Hawai‘i’s population is covered under QUEST.

7. In 2023, 26,659 Hawai‘i residents received 54,472 family planning or reproductive health care procedures under QUEST.

8. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by QUEST, the federal government pays 90% and the state pays the remainder. Some

reproductive healthcare services are not eligible for the 90% match rate, such as sexually-transmitted infection testing and treatment. Those services are eligible for a federal match rate of 59.08%.

9. Care under QUEST is provided under a managed care system with five managed care organizations (MCOs), all providing services statewide, except one that covers two counties. Individual providers are screened and enrolled with Med-QUEST, and then negotiate contracts with the individual MCOs. QUEST enrollees choose or are assigned to one of the MCOs, and then choose or are assigned a primary care provider. For the provision of family planning services, QUEST members may choose to see any family planning provider, even if that provider is out of the MCO's provider network.

10. Federal funds do not pay for abortion care under QUEST.

11. The right to choose to terminate the pregnancy of a nonviable fetus is protected by law in Hawai'i. Haw. Rev. Stat. § 453-16. The State of Hawai'i considers the right to choose a fundamental human right, essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

12. The State of Hawai'i funds 100% of the cost of abortion care for participants of QUEST. Abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally-funded health care services.

13. Planned Parenthood of the Great Northwest and the Hawaiian Islands provide high-quality comprehensive reproductive healthcare and family planning services in Hawai'i. Planned Parenthood entities currently operate two health centers and a virtual clinic in Hawai'i. They provide the full range of reproductive healthcare in Hawai'i. Among other things, they provide sexually-transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

14. In 2023, the last year for which data is available, Planned Parenthood health centers in Hawai‘i provided care for 1,700 unique patients using QUEST Medicaid funding.

15. Capacity to provide vital reproductive healthcare services especially is limited in rural and underserved areas, which Planned Parenthood's virtual health center helps address.

16. Planned Parenthood health centers in Hawai‘i provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Hawai‘i as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

17. To implement the Defund Provision, Med-QUEST has already had to implement billing system changes and finance system holds, and instructed MCOs to make changes to their system. These changes required staff time and resources.

18. Failure to incorporate the necessary infrastructure changes would result in Hawai‘i being at risk of having to return any federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby reducing federally provided matching Medicaid funds for essential family planning and reproductive healthcare services.

19. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision actually takes effect, Hawai‘i has already faced inquiries from MCOs and impacted entities, which has taken staff time and resources.

20. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Hawai‘i and Hawai‘i's residents would be great. I am concerned that Planned Parenthood may need to close health centers in Hawai‘i if it is excluded from Medicaid. If that occurs, that will seriously negatively impact Hawai‘i's health systems and our residents.

21. Because capacity is already limited, the health care system in Hawai‘i will be unable to fully compensate for the loss of Planned Parenthood as a Medicaid provider. Thus, it is highly likely that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. The result is likely to be

stressful and challenging for Hawai‘i’s QUEST members. This result is expected because of the already limited capacity in Hawai‘i for family planning and reproductive health care services.

22. If Planned Parenthood is excluded as a Medicaid provider or forced to close, there is a risk of increased unplanned pregnancies, untreated sexually transmitted infections, and missed early cancer diagnoses. This in turn would likely lead to increased health care costs and an increased need for social services for affected patients, and therefore, increased costs to the State.

23. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Hawai‘i as they have done for decades, or the State of Hawai‘i would need to pay the former federal share of that healthcare. The State of Hawai‘i has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in Hawai‘i.

24. Therefore, the exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of Hawai‘i, but it will also have a negative impact on the Hawai‘i’s health care system and the state budget.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 15, 2025.

JUDY MOHR PETERSON
MEDICAID DIRECTOR
DEPARTMENT OF HUMAN SERVICES
STATE OF HAWAI‘I

Exhibit 11

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF LAURA PHELAN

I, Laura Phelan, declare as follows:

1. I am the Administrator of the Division of Medical Programs at the Illinois Department of Healthcare and Family Services (HFS). I am the designated State Medicaid Director for the Illinois State Medicaid and CHIP Programs at HFS. I make this declaration from

personal knowledge and the records of HFS that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. I have worked in the health care field since 2009. During that time, I have served the public in both federal and state government positions, including at HHS on the CMS portfolio. I have worked for HFS for over a decade and became the Administrator in 2025.

3. HFS is the designated single state agency responsible for administering Illinois' medical assistance programs. The Division of Medical Programs administers and, in conjunction with the federal government, funds medical services provided to about 25 percent of the Illinois population.

4. The Illinois Medical Assistance programs, consisting of Medicaid and numerous other medical programs, provide health-care coverage to about 3.2 million Illinoisans. The programs cover children, parents or relatives caring for children, pregnant women, veterans, seniors, adults, and persons who are blind and persons with disabilities.

5. Illinois's Medical Assistance programs are primarily administered under provisions of the Illinois Public Aid Code; and Titles XIX and XXI of the federal Social Security Act. The department's mission is to improve access to quality health care for the individuals enrolled in its programs, while simultaneously containing costs and maintaining program integrity.

6. Many of Illinois's Medical Assistance programs are authorized and funded in part through a Medicaid federal-state partnership. Illinois administers its federally matched programs pursuant to broad federal requirements as well as the terms of its "plan for medical assistance," also known as a State Plan, approved by the U.S. Centers for Medicare & Medicaid Services (CMS). HFS receives federal Medicaid dollars, known as "Federal Financial Participation" (FFP), which reimburses Illinois for a percentage of its expenditures on eligible enrollees.

7. Most enrollees in Illinois Medical Assistance programs are eligible for coverage paid for by joint federal and state funding. HFS uses FFP funding to reimburse the state for a

significant portion of the costs of Illinois Medical Assistance Programs, while Illinois covers the remaining costs using state funds.

6. The services that the Illinois Medical Assistance Program covers, and receives federal funding to provide, include family planning and reproductive health care services. These services include reproductive preventative health, contraceptive services, and screening and testing for sexually transmitted infections.

7. I am familiar with certain changes required to be made to the Medicaid program by Section 71113 of H.R. 1, which was signed into law on July 4, 2025.

8. Section 71113 has created significant operational uncertainty for how HFS can ensure compliance with the provision. Section 71113 restricts HFS's ability to reimburse certain healthcare providers, which it defines as "prohibited entities," for qualifying items and services. It is difficult for HFS discern who are "prohibited entities" under the provision. As a result of this uncertainty, HFS is working to identify changes to its systems and processes that will be needed to comply with section 71113, but the lack of clarity in the statutory text coupled with the lack of formal guidance from CMS make it exceptionally challenging to align on an implementation approach.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 23, 2025.

Laura Phelan

Laura Phelan

Exhibit 12

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, ET AL., *Plaintiffs*, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., *Defendants*,	Case No.: 1:25-cv-12118 DECLARATION OF SHARON BOYLE

I, Sharon C. Boyle, declare as follows:

1. I am the General Counsel of the Massachusetts Executive Office of Health and Human Services ("EOHHS"), a position I have held since 2018. EOHHS is a cabinet-level secretariat in Massachusetts that directly manages the MassHealth program and oversees eleven state agencies charged with promoting the health, resilience, and independence of the Commonwealth's residents.

2. Between 2003 and 2018, before assuming my current role, I held several titles within the EOHHS general counsel's unit, including First Deputy General Counsel and Chief MassHealth Counsel. From 1995 to 2003, I worked as an assistant general counsel in the Division of Medical Assistance.

3. As EOHHS General Counsel, I have personal knowledge of the rules, regulations, and processes governing EOHHS and its agencies. I have personal knowledge, or knowledge based

on review in my capacity as General Counsel of information and records gathered by EOHHS and agency staff, of the matters set forth below.

4. I am familiar with the information in the statements set forth below either through personal knowledge, consultation with EOHHS and constituent agency staff, or from my review of relevant documents and information.

MassHealth

5. In Massachusetts, EOHHS administers the Medicaid program and the Children's Health Insurance Program ("CHIP") through a single program called MassHealth, pursuant to federal law and regulations as well as the terms of federally approved State Plans and a Section 1115 Demonstration Project. EOHHS is the single state agency responsible for administering MassHealth.

6. To be eligible for MassHealth, individuals must meet certain criteria, including residency, income and immigration status requirements. Massachusetts expanded Medicaid coverage under the Affordable Care Act in 2014, expanding the eligible population. In state fiscal year 2024, roughly 2 million Massachusetts residents or approximately 27-28% percent of the Commonwealth's population was covered by MassHealth.

7. Any person who meets eligibility requirements is entitled to coverage under MassHealth. MassHealth's coverage includes medical, dental, mental health and substance use treatment, long-term services and supports, and long-term care. MassHealth's mission is to improve the health outcomes of its members and their families through services which sustainably and equitably promote health, well-being, independence, and quality of life.

8. Among the broad array of services it covers for its members, MassHealth covers comprehensive sexual and reproductive health care services, including family planning, cancer and STI screenings, and critical preventative care.

9. In state fiscal year 2024, about 20,000 residents received family planning or reproductive health care from MassHealth-enrolled family planning providers in about 30,000 visits.

10. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by MassHealth, the federal government pays 90% and the state pays the remainder.

11. MassHealth insures approximately 2 million people, including over 720,000 children, and approximately 525,000 seniors and people with disabilities. Care under MassHealth is provided through our fee for service provider network and our contracted managed care plans. MassHealth members have free choice to access any MassHealth family planning provider in the Commonwealth regardless of enrollment in fee-for-service or managed care. If family planning services provided through Planned Parenthood are no longer Medicaid covered services, members will not be able to make a robust federally funded choice.

Abortion Availability and Care for MassHealth Members

12. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in Massachusetts. M.G.L. c.12 § 11I 1/2. The Commonwealth of Massachusetts considers the right to choose a fundamental human right is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

13. Federal funds do not pay for abortion care under MassHealth. The Commonwealth of Massachusetts funds 100% of the cost of abortion care provided to MassHealth members through MassHealth's fee for service network. Additionally, MassHealth pays for abortion care provided by MassHealth's contracted managed care plans through a separate 100% state funded contract.

Planned Parenthood Entities in Massachusetts

14. Planned Parenthood League of Massachusetts operates six health centers in Massachusetts located in Boston, Marlborough, Worcester, and Springfield.

15. Planned Parenthood entities provide comprehensive reproductive healthcare and family planning services in Massachusetts. They provide the full range of reproductive healthcare in Massachusetts. Among other things, they provide sexually-transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

16. In state fiscal year 2024, the last year for which data is available, Planned Parenthood health centers in Massachusetts provided care at 14,223 visits to 9,748 unique patients using MassHealth funding.

17. These Planned Parenthood health centers in Massachusetts provide a significant portion of Medicaid-funded reproductive health care and family planning services delivered by MassHealth family planning providers (over 50%).

18. Planned Parenthood health centers in Massachusetts specialize in reproductive healthcare and family planning and, for that reason, are well known throughout Massachusetts as providers of such care.

Impact of Defund Provision

19. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will have a negative consequence on the health and well-being of individuals in Massachusetts by limiting their federally funded choices for reproductive health care and family planning services.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 15, 2025.



Sharon C. Boyle
General Counsel, Massachusetts Executive Office of Health and Human Services

Exhibit 13

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF MICHELLE PROBERT

I, Michelle Probert, declare as follows:

1. I am the Director at the Office of MaineCare Services ("OMS"), for the State of Maine Department of Health and Human Services. I make this declaration from personal

knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Director, I am responsible for strategic planning, oversight, and administration of: MaineCare, which is the State's Medicaid program; and the Children's Health Insurance Program (CHIP); as well as a small number of state-funded benefits (which include state-funded abortion services). I have held this position for six years (since February 2019) and served OMS in a prior role as Director of Strategic Initiatives from 2011 to 2014. I have an undergraduate degree from Carleton College and a master's degree in public policy from the University of California, Berkeley.

3. Federal Medicaid and CHIP funding comprises a significant percentage of Maine's budget. It is one of the largest sources of federal revenue for Maine.

State Medicaid and CHIP program

4. OMS is the single state agency responsible for administering MaineCare, Maine's Medicaid Program. OMS also administers CHIP Program. In addition, OMS administers a small, non-Medicaid, state-funded program to provide coverage for certain services and to certain low-income residents. MaineCare provides free or low-cost comprehensive health insurance and other health benefits to Mainers who meet certain requirements, largely based on income, disability, or age. MaineCare helps to ensure that eligible Maine people are able to access the critical health services, both preventive and emergency, which enable them to live healthy, safe, and resilient lives. MaineCare's coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care services. In 2019, Maine opted in to Affordable Care Act expanded Medicaid coverage, which expanded the Medicaid-eligible population. At the end of state fiscal year (SFY) 2025, approximately 30% percent of the Maine's population was covered under MaineCare.

5. Any person who meets eligibility requirements is entitled to coverage under MaineCare. Covered services generally include medically necessary services such as primary

care visits, family planning services, prescription medications, and behavioral health services. The services that MaineCare covers, and receives federal funding to provide, also include family planning and reproductive health care services. For example, covered services include contraceptive services; pregnancy testing; gynecological exams; breast exams; colposcopies; screening for cervical and breast cancer; and screening, diagnosis, and treatment of sexually transmitted infections.

6. In SFY 2025, more than 14,191 residents received family planning or reproductive health care under MaineCare through 31,121 encounters.

7. The federal match rate for qualified family planning services delivered to Medicaid and CHIP members is 90%. This means that for qualified family planning medical exams, procedures, or other services covered by MaineCare, the federal government pays 90% and the state pays the remaining 10%. A broader set of family planning-*related* services not qualified to receive the 90% match rate, such as testing and treatment for sexually transmitted infections, are eligible for the standard federal match rate based on the population receiving the service. In Maine the standard, non-expansion or CHIP population match rate is 62.06% in current federal fiscal year 2025.

8. MaineCare does not use Medicaid Managed Care to administer or take on financial risk and care coordination for its services; instead, providers enroll in and are paid directly by MaineCare. Maine offers several payment and care delivery models to support team-based, whole-person care, including a primary care integrated care model, several health home services, and an accountable care program. These models require and/or incent coordinated care delivery across service settings. Maine Family Planning ("MFP") qualifies as a provider under MaineCare's primary care model.

9. With the exception of abortion services that are within the restrictions of the Hyde Amendment, federal funds do not pay for abortion care under MaineCare.

Limited Family-planning Medicaid Benefit

10. Maine also operates a Medicaid Limited Family Planning Benefit under MaineCare for certain eligible populations, which covers family planning services and reproductive health care services, including contraceptive services; pregnancy testing; gynecological exams; breast exams; colposcopies; screening for cervical and breast cancer; and screening, diagnosis, and treatment of sexually transmitted infections.

11. This program serves individuals with incomes up to 214% of the federal poverty level who are not pregnant and who, but for this limited MaineCare service, are not otherwise eligible for MaineCare.

12. In SFY 2025, 808 residents received family planning or reproductive health care under the Limited Family Planning Benefit through 1,936 encounters.

13. The federal match rate for qualified family planning services covered under the Limited Family Planning Benefit is 90%. This means that for those qualified family planning medical exams, procedures, or other services covered by MaineCare, federal funds cover 90% of the cost and the state pays the remaining 10%. A broader set of family planning-*related* services not qualified to receive the 90% match rate, such as testing and treatment for sexually transmitted infections, are eligible for the standard federal match rate based on the population receiving the service. In Maine the standard, non-expansion match rate is 62.06% in current federal fiscal year 2025.

14. The Limited Family Planning Benefit provides limited family planning services for individuals of any age who, but for this limited MaineCare service, are not otherwise eligible for MaineCare and provides reimbursement to eligible providers who deliver family planning and family planning-related services to eligible individuals. Eligible providers are any MaineCare-enrolled provider that delivers family planning and family planning-related services.

15. Federal funds do not pay for abortion care under the Limited Family Planning Benefit.

16. There is an additional limited coverage benefit in Maine called the Maine Breast and Cervical Health program (MBCHP), which is administered by OMS. The services that individuals can access through this program are funded through non-Medicaid, United State Center for Disease Control and Prevention dollars. Individuals who are age 21 and older, uninsured or underinsured, and with incomes up to 250% of the federal poverty level are eligible for the MPCHP, which offers free breast and cervical cancer screenings and diagnostic and treatment services. Both Planned Parenthood and MFP delivered services under this benefit to over 30 patients in state fiscal year 2025.

Abortion availability and care

17. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in Maine. 22 M.R.S. § 1598(1). The State of Maine considers the right to choose a fundamental human right that is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

18. The State of Maine covers the cost of abortion services for members eligible for MaineCare pursuant to a state-funded program. 22 M.R.S. § 3196; 10-144 C.M.R. Ch. 104. Abortion services covered under this law are not federally approved Medicaid services; they are provided on a fee-for-service basis but do not receive federal matching dollars.

Planned Parenthood Entities in Maine

19. Planned Parenthood of Northern New England ("PPNNE") provides services to people in New England. Among them, these Planned Parenthood entities currently operate four health centers in Maine in Biddeford, Sanford, Portland and Topsham.

20. PPNNE provides high-quality comprehensive reproductive healthcare and family planning services in Maine. PPNNE's health centers offer a broad range of essential health care services to Maine patients, including well-patient checkups with some primary care services; annual gynecological exams; screening for cervical, colorectal and breast cancer; family

planning counseling; erectile dysfunction treatment; birth control and contraception services; preconception consultation; screening, diagnosis and treatment of urinary tract, vaginal, and sexually transmitted infections; biopsies for gynecological issues; vaccines for influenza, human papilloma virus, and monkeypox; perimenopause and menopause care; and miscarriage and abortion care.

21. In the 2024 fiscal year, the most recent year for which data is publicly available, PPNNE health centers in Maine provided care to 7,100 total patients. In SFY2025, 2,136 MaineCare members received services through 5,129 encounters at these health centers.

Maine Family Planning

22. Maine Family Planning ("MFP") is a Maine non-profit that offers a range of family planning, reproductive health and primary care services. MFP currently operates 18 health centers in Maine, with at least one site in twelve of Maine's sixteen counties. MFP's family planning clinics are located in Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Thomaston, Rumford, Skowhegan, and Waterville. MFP also has a mobile health clinic and provides funding through subcontracts that support 44 additional sites. MFP is an "essential community provider" in the family planning category on the HHS Rolling Draft Essential Community Provider List for the federally facilitated marketplace. Essential community providers serve predominantly low-income, medically underserved individuals, per 45 C.F.R. § 156.235(c).

23. MFP provides a range of critical family planning and reproductive health care services, including contraceptive services; pregnancy testing and options counseling; family planning (or preconception) counseling; referrals for adoption; prenatal consultation;

gynecological biopsies; annual wellness visits; gynecological exams; breast exams; pap tests; colposcopies; screening for cervical and breast cancer; screening, diagnosis, and treatment of STIs, vaginal infections, and urinary tract infections; intrauterine insemination; vasectomy; consultations and prescriptions for HIV pre-exposure prophylaxis; miscarriage care; gender-affirming health care; and family support services for pregnant women, new mothers, and their families.

24. In calendar year 2024, MFP clinics served over 8,000 total patients, including 7,215 family planning patients. Family planning patients had over 10,000 visits and primary care patients had over 2,000 visits. In SFY2025, 4,006 MaineCare members received services through 8,453 encounters at these health centers. Without MaineCare, many of these patients could not afford to see a health care provider and might postpone or forgo care altogether.

25. These PPNNE and MFP health centers in Maine provide a significant portion of all Medicaid-funded reproductive health care and family planning services. In SFY 2025, 43% of MaineCare members receiving family planning or reproductive health care received that care from PPNNE and MFP. Maine does not have Medicaid providers who can absorb all the patients that PPNNE and MFP will no longer be compensated for treating under H.R. 1. Capacity does not exist to provide the care that Planned Parenthood and MFP health centers currently provide.

26. Maine patients already face significant barriers to care, including financial and logistical challenges of accessing providers, challenges that are particularly acute in the more rural areas of the state. Maine also faces a shortage of health care providers, including primary care providers. Capacity to provide the vital reproductive healthcare services especially does not exist in rural and underserved areas, which is where some of PPNNE and MFP's health centers

are located in Maine. Healthcare services are already limited in many of these areas and, as a result, PPNNE and MFP health centers provide especially vital needed care.

27. PPNNE and MFP health centers in Maine provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Maine as providers. I am not aware of any legitimate basis for excluding either PPNNE or MFP from Medicaid reimbursement for the care they provide.

Maine Actions to Implement the Defund Provision

28. To implement the Defund Provision, OMS has already had internal and external discussions of required changes to claims billing and payment processes to impacted providers and implemented a claims pending and manual review process. These changes required staff time and resources.

29. Failure to incorporate the necessary process changes would result in Maine being at risk of having to return any federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby placing the costs directly onto Maine and reducing federally provided matching Medicaid funds.

30. OMS has also had to issue guidance to MaineCare members and to the provider organizations subjected to the defund provision. OMS drafted, reviewed, and issued these sets of guidance, which used staff time and resources.

31. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision actually takes effect, OMS has already faced inquiries from potentially affected entities, which has taken and will continue to take staff time and resources.

Impact of defund provision

32. If PPNNE and MFP are excluded from federal Medicaid reimbursement, the impact on Maine and Maine's residents would be profound. I am concerned that PPNNE and/or MFP may need to close health centers in Maine if they are excluded from Medicaid. If that occurs, that will compound the impact on Maine's health system and residents.

33. Because capacity does not exist in the health care system in Maine to compensate for the loss of PPNNE and/or MFP as Medicaid providers, it is inevitable that some proportion of patients of PPNNE and MFP will be unable to find a provider for reproductive healthcare and family planning services. For example, about half of the 10,000 patients MFP annually serves rely on MaineCare for healthcare coverage; the loss could force members into longer travel to find other providers—turning a 20- to 30-minute trip into a two to three-hour journey. Not having timely access to preventive care like sexually transmitted infection and cancer screenings will cause delayed diagnoses and care, contributing to increased acute and emergent care utilization that will drive up healthcare costs and lead to poorer health outcomes.

34. PPNNE and MFP being excluded from federal Medicaid reimbursement also has a potential impact on the provision of and access to Maine's state-funded abortion services, given that the substantial reduction in Medicaid funding could result in closure of these organizations. In addition, MaineCare members may be less likely to seek needed services through these organizations as they may well not be aware that the new federal prohibition on coverage of services to these provider organizations does not apply to state-only services.

35. For individuals receiving coverage through the Limited Family Planning Benefit, the potential closure of PPNNE and MFP would impact their overall healthcare access. Given that the Limited Family Planning Benefit is a benefit that some individuals have because they are

otherwise uninsured, it is an important link to the overall healthcare system. Without these organizations, individuals may lose the ability to receive preventive care and screenings, identify unmet healthcare needs, and get connected to additional healthcare to meet unmet needs.

36. To avoid these negative outcomes, the federal government would either need to fund the PPNNE and MFP health centers in Maine as they have done for decades, or the State of Maine would need to pay the former federal share of that healthcare. The State of Maine has not provided sufficient funding to cover the former federal share of Medicaid for the PPNNE and MFP health centers in Maine.

37. The exclusion of PPNNE and MFP health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of Maine, but it will also have a significant impact on Maine's entire health care system and the state budget. PPNNE and MFP provide family planning, family planning-related, primary care, behavioral health, and general preventive care screening services in every county across Maine. At a time when Maine is facing physician shortages and healthcare access challenges, further cutting off essential access to community-based providers will reduce access to timely care, increase wait lists, and drive-up costs related to emergent care utilization for unmet healthcare needs.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 14, 2025.



Michelle Probert
Director, Office of MaineCare Services
11 State House Station
Augusta, ME 04333

Exhibit 14

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF MEGHAN GROEN IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

DECLARATION OF MEGHAN GROEN

I, MEGHAN GROEN, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a resident of the State of Michigan. I am over the age of 18 and have personal knowledge of the matters set forth below or have knowledge of the matters based on my review of the information and records, I believe them to be true. I would testify to the following if called as a witness.

2. I am the Senior Chief Director for Health Services at the Michigan Department of Health and Human Services (MDHHS). In this role, I am Michigan's Medicaid director.

Michigan Medicaid

3. Federal Medicaid funding comprises a significant percentage of Michigan's budget. It is the largest source of federal revenue for Michigan.

4. MDHHS administers Michigan's Medicaid program—a comprehensive healthcare coverage program for poor and low-income Michiganders. To be eligible, residents generally fall into one of the following categories: (1) elderly adults; (2) blind or disabled adults; (3) pregnant women; (4) families or caretakers of dependent children; or (5) very low-income children (generally under 110% of the federal poverty level).

5. In 2013, Michigan opted in to the Affordable Care Act, which expanded Medicaid coverage, creating the Healthy Michigan Plan (HMP), which broadened the eligible population to those who meet the following criteria: (1) age 19 through 64 years; (2) income at or below 133% of the federal poverty level; (3) do not qualify for, or are not enrolled in, Medicare; (4) do not qualify for, or are not enrolled in, other Medicaid programs; (5) are not pregnant at the time of application; and (6) are residents of the State of Michigan.

6. MDHHS also administers a Children's Health Insurance program, called MIChild, which provides healthcare coverage to children in families that make too much to be eligible for Medicaid, but too little to afford private care. Children who meet the following criteria are eligible for coverage through MIChild: (1) age 0 through 18 years; (2) income above traditional Medicaid eligibility levels, but at or below 212% of the federal poverty level under the Modified Adjusted Gross Income (MAGI) methodology; (3) do not have other comprehensive medical insurance; (4) do not qualify for other MAGI-related Medicaid programs; and (5) are residents of the State of Michigan.

7. In state fiscal year 2024, approximately 2.6 million people—over 25% of Michigan's population—were covered under Michigan Medicaid and MIChild.

8. Any person who meets eligibility requirements is entitled to coverage under Michigan Medicaid. Covered services generally include medical, dental, mental health, substance use disorder treatment, and long-term care. The services that Michigan Medicaid covers, and receives federal funding to provide, also include family planning and reproductive health care services. Family planning services are defined as any Medicaid covered contraceptive service, including diagnostic evaluation and supplies for voluntarily preventing or delaying pregnancy. Covered services include office visits; pharmaceuticals (including some over-the-counter products); supplies and devices; and sterilization procedures, which include tubal ligation and vasectomy, when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider and billed with a family planning diagnosis. Limited infertility services are covered, including diagnostic, counseling, and treatment services related to the underlying causes of infertility, such as lab tests, sperm analysis, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy.

9. In the first six months of state fiscal year 2025, a monthly average of 1,844,040 residents were eligible to receive family planning or reproductive health care under Michigan Medicaid.

10. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services provided to those covered by Michigan Medicaid, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services, considered family planning-related services, are not eligible for the 90% match rate, such as sexually transmitted infection testing and treatment. Those services are eligible for the typical federal match rate under the program in which the patient is enrolled: 65.13% for the traditional Medicaid program, 90% for HMP, and 75.59% for MIChild.

11. Care under Michigan Medicaid is largely provided under a managed care system, where most beneficiaries are enrolled in managed care organizations. But a fee-for-service

system also exists for services not provided through and/or to individuals not enrolled in a managed care organization.

12. With limited exception—consistent with the federal Hyde Amendment and Michigan's state-law counterpart—Michigan Medicaid and MIChild do not provide coverage for abortion care using either state or federal dollars.

Plan First program

13. Michigan also operates a Medicaid program that it calls Plan First, which covers family planning services for those who are not insured and not eligible for coverage under Michigan Medicaid or MIChild.

14. Plan First is a limited Medicaid benefit that covers a broad range of family planning services, including annual wellness exams, contraception, sexually transmitted infection testing and treatment, vaccines, pregnancy testing and counseling, and more. Plan First enrollees may obtain covered family planning services from any qualified Medicaid-enrolled provider.

15. Coverage through Plan First is available to individuals who: (1) are any age or gender; (2) are not pregnant at the time of application; (3) are a U.S. citizen or qualified immigrant; (4) are residents of the State of Michigan; (5) are not covered under another Medicaid benefit; and (5) have income at or below 195% of the federal poverty level under the MAGI methodology.

16. In the first six months of state fiscal year 2025, a monthly average of 130,206 Michiganders were enrolled in Plan First and eligible for reproductive health care services.

17. The federal match rate for services covered under Plan First is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

18. Plan First does not provide coverage for abortion care using either state or federal dollars.

Planned Parenthood of Michigan

19. Upon information and belief, Planned Parenthood of Michigan (PPMI)—a member of Planned Parenthood Federation of America—currently operates ten in-person health

centers and one virtual health center in Michigan. PPMI qualifies as a prohibited entity under H.R. 1 as it is a tax-exempt entity under 501(c)(3) of the Internal Revenue Code of 1986, that serves as a "essential community provider" primarily engaged in family planning services, reproductive health, and related medical care including abortion services when rape, incest or risk of death is not a factor, and PPMI received over $800,000 in Medicaid program funding in FY23.

20. PPMI's health centers provide high-quality comprehensive reproductive healthcare and family planning services in Michigan. They provide the full range of reproductive healthcare. Among other things, they provide sexually transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive healthcare is the primary healthcare they regularly receive.

21. In 2024, the last year for which data is available, PPMI's health centers provided care in 8,934 family planning visits to 6,315 unique patients using Medicaid funding through Michigan's Medicaid programs. Overall Medicaid-funded family planning visits to PPMI health centers totaled $922,662 in 2024.

22. In fiscal year 2024, PPMI provided 53.4 % of the total family planning services performed within Medicaid-enrolled family planning clinics in Michigan.

Impact of defund provision

23. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Michigan and Michigan's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in Michigan if it is excluded from Medicaid. If that occurs, that will compound the impact on Michigan's health system and residents.

24. Capacity does not exist in the health care system in Michigan to compensate for the loss of PPMI as a provider. Capacity to provide the vital reproductive healthcare services

especially does not exist in rural and underserved areas. Healthcare services are already limited in many of these areas. Ultimately, PPMI health centers provide especially vital needed care.

25. It is therefore inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services, and, in turn, Michigan will lose federal Medicaid funds for such lost services.

26. In addition to the impact of the Defund Provision on PPMI, PPMI faces broader funding uncertainty, which has already forced PPMI to take steps to restructure, including closing several clinics, to stay operational. Any additional loss in federal funding will exacerbate the impacts of the Defund Provision and is likely to result in a decrease in the number of clients served by the Michigan Title X Family Planning Program. This network of family planning agencies serves as a critical safety net providing reproductive health services and overall preventive and wellness healthcare. In calendar year 2024, the program served 42,159 clients. Of the total number served, 28,536 (67.7%) were served at PPMI locations. The Michigan Title X Family Planning Program strives to ensure access to underserved populations and is a trusted source for cervical, breast and testicular cancer screenings; access to referrals and linkages for needed medical/social care follow up and resources; preventive healthcare; and reproductive health needs. This lack of access could result in delayed cancer diagnoses, delayed diagnosis of chronic health conditions (e.g., hypertension, obesity, etc.), increased unplanned pregnancies, increased teen pregnancies, delayed prenatal care initiation, increased sexually transmitted infection rates, and a host of other health and social consequences, including but not limited to higher health care costs.

27. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of Michiganders, but it will also have a significant impact on Michigan's entire health-care system. Planned Parenthood is a key safety net provider in the state, providing critical services in underserved areas and to patients that otherwise face challenges accessing such care. Patients who are forced to switch providers if Planned Parenthood clinics are excluded from Medicaid

may face long wait times and similar barriers to establishing care elsewhere. As a result, many will delay or forgo essential care altogether, increasing the risk of unintended pregnancies, late-stage diagnoses, and untreated infections. These outcomes not only harm individual health, but also drive-up long-term health care costs, which ultimately fall on all Michiganders through higher health insurance premiums, increased strain on emergency departments, and increased pressure on taxpayer-funded programs.

28. Moreover, Michigan has enshrined a fundamental right to reproductive freedom in its state constitution. Mich. Const. art. 1, § 28. Michigan considers the right to choose a fundamental human right that is essential for personal and bodily autonomy, and respects everyone's freedom to make intimate and personal reproductive decisions with their chosen medical provider.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 20, 2025.

Meghan Groen
Senior Chief Director for Health Services
Michigan Department of Health and Human Services

Exhibit 15

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF JOHN CONNOLLY

I, John Connolly, declare as follows:

1. I am the Deputy Commissioner and State Medicaid Director for the Minnesota Department of Human Services ("MDHS"). I make this declaration from personal knowledge

and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Deputy Commissioner and State Medicaid Director, I am responsible for overseeing all aspects of Minnesota's state Medicaid programs, including the Minnesota Family Planning Program. I have served as State Medicaid Director for one year and as Deputy Commissioner since February 2025. I previously served as Assistant Commissioner for the Health Care Administration within MDHS. Prior to joining the Department, I served as chief strategist for the Los Angeles County Department of Public Health, where I focused on advancement of Medicaid-funded services and programs, regulation of health facilities, homelessness, and emergency response. I have a doctorate degree in health policy from Harvard University.

3. Federal Medicaid funding comprises a significant percentage of Minnesota's budget. It is one of the largest sources of federal revenue for Minnesota. Minnesota has two relevant Medicaid programs: Medical Assistance and the Minnesota Family Planning Program.

Medical Assistance

4. MDHS is the single state agency responsible for administering Minnesota's Medicaid program, which is known as Medical Assistance. Medical Assistance provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Medical Assistance's coverage includes children and families, pregnant women, adults without children, seniors, and people who are blind or have disabilities. MDHS's mission is to support all Minnesotans in living their healthiest and fullest lives. Medical Assistance is the largest single source of health insurance in Minnesota. Today,

Medical Assistance provides health coverage for almost 1.2 million Minnesotans, or approximately one in every five state residents.

5. MDHS is responsible for provider enrollment, claims processing, program design, and responding to the public. Care is provided under a combination of managed care and fee-for-service systems. Fee-for-service, providers may enroll if they meet all program requirements, have obtained certifications for the type of service provided, have not been placed on an excluded provider list, have obtained a provider identification number, and have submitted all required enrollment documents. For individuals served by managed care, enrollees select providers from their health plan's provider network

6. The federal funds Minnesota receives to administer Medicaid are critical to ensuring that the program can continue to deliver essential healthcare services. Medical Assistance in Minnesota is a federal-state partnership, wherein the costs of services, including sexual and reproductive health services, provided through Medical Assistance are shared between the state and federal government. The rate of federal funding for individuals enrolled in Medicaid through Medical Assistance varies between 50 percent and 90 percent. In state fiscal year 2025, total Medical Assistance payments in Minnesota are projected to exceed $20 billion. Of that amount, 57 percent is paid by the federal government, 42 percent is paid by the state, and 1 percent is paid by other entities including counties and school districts.

7. Medical Assistance provides coverage for comprehensive sexual and reproductive health services. Medical Assistance covers abortions and abortion-related services, including proabortion services and follow-up services. State law recognizes the fundamental right of Minnesotans to make independent decisions about their reproductive health, including the right to obtain an abortion. *Doe v. Gomez*, 542 N.W.2d 17, 27 (Minn. 1995); Minn. Stat. § 145.409

(2024). Medical Assistance collects federal funding for abortions provided consistent with the Hyde Amendment, and the remainder are funded solely with state dollars.

8. This scope of coverage is important because a significant percentage of Medical Assistance recipients need access to full-scope reproductive healthcare. In 2021, about half of reproductive age female Medicaid enrollees received family planning services in Minnesota.

9. Planned Parenthood health centers play an essential role in providing those services. In Minnesota, Medical Assistance helps patients get lifesaving and life-changing healthcare at Planned Parenthood health centers, including cancer screenings, birth control, annual exams, breast/chest exams, STI testing and treatment, miscarriage management, menopause management, fertility care, screening and treatment for anxiety/depression, vaccinations, colposcopy and LEEP, and vasectomy.

10. Planned Parenthood health centers in Minnesota provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout the state as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

11. Since 2021, Planned Parenthood health centers have provided care to an average of over 20,000 unique patients at over 35,000 visits through Medical Assistance each year in Minnesota. According to an analysis by the Kaiser Family Foundation, in 2021, one in six female Minnesota Medicaid enrollees aged 15 to 49 who received family planning services received care at Planned Parenthood.

Minnesota Family Planning Program

12. Minnesota also operates the Minnesota Family Planning Program, which covers family planning services for those who are not enrolled for coverage under Medical Assistance.

13. To qualify, an individual must be a Minnesota resident, a U.S. citizen or a noncitizen with a Medicaid qualifying immigration status, not pregnant, not enrolled in Medical Assistance, and have income not exceeding 200 percent of the federal poverty guidelines. The services covered under Minnesota's Family Planning Program are the same family planning services covered within the Medical Assistance Program.

14. In 2024, a total of 14,639 people received family planning or reproductive health care through the Minnesota Family Planning Program during the year, with an average of approximately 4,000 beneficiaries enrolled in the program for any given month. In 2024, approximately 4,500 enrollees in the Minnesota Family Planning Program received care from Planned Parenthood over approximately 5,860 visits.

15. The federal match rate for services covered under Minnesota's Family Planning Program is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

16. The Minnesota Family Planning Program is run through fee-for-service, meaning providers enroll and receive payment directly from MDHS.

Impact of the Defund Provision

17. I am concerned that Planned Parenthood health centers may need to close or limit services in the state if they are excluded from Medicaid. To avoid this outcome, either the federal government would need to continue funding these health centers as they have for decades, or the State of Minnesota would need to take on the former federal share of these healthcare services. The estimated cost to the State of Minnesota of fully covering the services offered by Planned Parenthood is approximately $9 million.

18. Regardless of whether Minnesota is able to allocate state funds to cover the lost federal reimbursements for Planned Parenthood health centers or is forced to require participants in all state-administered medical assistance programs to forego care at Planned Parenthood health centers, Minnesota will incur administrative costs to implement the Defund Provision. MDHS, which administers Medical Assistance and the Minnesota Family Planning Program, must ensure compliance with the Defund Provision, which will require staff time and resources.

19. First and foremost, the definition of "prohibited entity" in the Defund Provision is vague and it will be difficult to determine how to comply. For example, the Defund Provision includes that the "prohibited entity" be an essential community provider that "primarily engages in family planning services, reproductive health, and related medical care." MDHS has never had to determine what type of services its participating providers "primarily engage in," nor does the statute set out criteria for making that determination.

20. Additionally, Minnesota does not have a system in place that can identity and exclude a "prohibited entity" based on the criteria in the Defund Provision. MDHS will need to restructure its policies and systems in order to implement the Defund Provision.

21. MDHS will also need to devote resources to educating Medicaid providers and patients in the state about the new requirements, including redirecting Medical Assistance and Minnesota Family Planning Program enrollees to alternative providers where necessary.

22. If MDHS fails to comply with the Defund Provision, MDHS could face significant penalties from CMS for noncompliance, such as a claw back of funds or stalled federal funding, which would place costs directly onto Minnesota and reduce federally provided matching Medicaid funds.

23. In sum, MDHS will have to expend time and resources to implement the Defund Provision or risk significant penalties from CMS.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 15, 2025.

/s/ John Connolly
John Connolly
Deputy Commissioner and State Medicaid Director
Minnesota Department of Human Services

Exhibit 16

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF NOYA WOODRICH

I, Noya Woodrich, declare as follows:

1. I am the Division Director for the Child and Family Health Division at the Minnesota Department of Health (MDH), a position I have held since April 2022.

2. In my role at MDH, I am responsible for directing and managing the Child and Family Health Division's programs and services. I also contribute to the development and improvement of policies and initiatives related to child and family health.

3. I make this declaration in my official capacity. I am a resident of the state of Minnesota, and I am over the age of 18. I am familiar with the information in the statements set forth below either through personal knowledge or in consultation with MDH staff.

4. MDH is Minnesota's state public health agency and works to protect, maintain, and improve the health of Minnesotans in a variety of ways, including by:

- monitoring infectious diseases and responding to outbreaks, including sexually transmitted infections (STI) and human immunodeficiency virus (HIV);
- supporting statewide food and nutrition programs for infants, children, and women;
- assessing the health needs of mothers, children, adolescents, and families, including sexual and reproductive health needs;
- evaluating the impact of maternal, child, adolescent, and reproductive health activities on the health status of Minnesotans;
- promoting health before, during, and after pregnancy by providing programming related to preventative and primary care services, including prenatal, delivery, postpartum, and interconception care (the time period between pregnancies);
- reducing infant and maternal mortality and the incidence of preventable diseases, congenital conditions, and disabling conditions in children;

- expanding access to evidence-based sexual and reproductive health services, such as contraception, pregnancy testing and counseling, and STI/HIV prevention and treatment;
- advancing policies and programs to prevent chronic diseases, improve mental health, and address social determinants of health that affect maternal and child outcomes;
- inspecting hospitals, nursing homes, birthing centers, and certain other types of health care facilities to ensure quality care; and
- offering grants and contracts to community organizations, local public health agencies, and Tribal governments to support their efforts to improve the health of the communities they serve.

5. I am providing this declaration to provide information on how eliminating Planned Parenthood clinics from federal Medicaid reimbursement may impact the health of the residents of the state of Minnesota.

6. MDH administers statewide maternal and child health initiatives including sexual and reproductive health programs related to prevention, surveillance, and access. These initiatives and programs include oversight, coordination and improvement efforts in the following areas: the Sexual Reproductive Health Services (SRHS) grant program; maternal mortality and morbidity; infant mortality reduction; Pregnancy Risk Assessment Monitoring System (PRAMS) data collection and analysis; expansion of maternal care access, including doula and midwifery services; adolescent sexual health education through sexual risk avoidance and personal responsibility programs; prenatal and postnatal newborn screening; abortion

surveillance reporting; congenital syphilis surveillance; breast and cervical cancer programming; and data collection and policy system response to declining hospital birth services in rural areas.

7. Planned Parenthood health centers receive funding under the SRHS grant program. The SRHS grant program supports pre-pregnancy family planning services for people of reproductive age in Minnesota who experience barriers to health services, whether geographic, cultural, financial, or other, in access to such services. These Planned Parenthood health centers are located in rural and metropolitan counties in Minnesota and are part of Planned Parenthood North Central States (PPNCS). PPNCS is an affiliate of Planned Parenthood Federation of America operating in 5 states: Iowa, Minnesota, Nebraska, North Dakota, and South Dakota. PPNCS operates 15 health centers in the region, including 10 centers in Minnesota. PPNCS operates 6 locations in metropolitan areas: Brooklyn Park, Duluth, Eden Prairie, Little Canada, Minneapolis, and St. Paul. The remaining rural serving Planned Parenthood health centers include those located in Blue Earth (Mankato), Clay (Moorhead), Olmsted (Rochester), and Benton (St. Cloud) counties. These health centers also serve Martin, Morrison, Nicollet, Stearns, and Wilken counties, among others. The Planned Parenthood health centers provide care for approximately one third of patient visits to SRHS grantees.

8. Planned Parenthood health centers also provide other reproductive healthcare and family planning services in Minnesota. Among other things, they provide testing and treatment for STIs, contraception, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. They specialize in affordable reproductive healthcare and family planning and, for that reason, are known throughout the state. For many women, family planning and reproductive health care is the primary health care they regularly receive.

9. I am concerned that Planned Parenthood may need to close health centers in Minnesota if it is excluded from Medicaid. Planned Parenthood health center closures would increase reproductive healthcare deserts in rural and underserved areas. In Minnesota, thirty-seven percent of rural counties do not have publicly funded sexual and reproductive health clinics located within the county itself, requiring residents who need low cost or no cost health care to travel greater distances to receive care. Further, Planned Parenthood health centers in Douglas and Beltrami counties recently closed. These closed health centers also served patients in Clearwater, Hubbard, and Lake of Woods counties. PPNCS has four remaining locations serving rural areas in Minnesota in Blue Earth, Clay, Olmsted, and Benton counties. These remaining rural health centers also serve patients in Martin, Morrison, Sherburne, Nicollet, Stearns, and Wilkin counties. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide vital and needed care that cannot easily be replaced by Minnesota's other health care systems.

10. If the Planned Parenthood health centers close, it is likely that some proportion of patients of Planned Parenthood health centers will be unable to find alternative providers that offer the full range of contraceptive methods, reproductive healthcare, and family planning services currently offered by Planned Parenthood health center providers. Increased travel distances, limited transportation options, higher out-of-pocket costs, and a shortage of rural providers with equivalent reproductive healthcare expertise and resources are factors that may make it more difficult for individuals to find equivalent healthcare care and family planning services. Reduced reproductive health care and family planning services may also result in cascading health impacts. Examples of these impacts include:

- Increased transmission of sexually transmitted infections, such as syphilis, due to lack of diagnosis and treatment. When syphilis is left untreated, it can impact the long-term health of the individual and, if the individual is pregnant, can result in congenital syphilis with severe or fatal outcomes for the infant.
- Lack of access to contraceptives that individuals need to maintain autonomy and control over their bodies, especially for those individuals experiencing domestic or intimate partner violence.
- Increased risk of harm for morbidity and mortality from ectopic pregnancies, a life-threatening condition in which a fertilized egg implants outside of the uterus if early diagnosis and treatment are not available, including maternal death.
- Higher rates of unintended pregnancies, which are associated with delayed or inadequate prenatal care, increased maternal and infant morbidity, and adverse economic and social consequences for families.

These impacts are more likely in rural areas and for those who experience barriers to care, such as insufficient insurance coverage.

11. The exclusion of Planned Parenthood health centers from Medicaid reimbursement may also result in increased costs for Minnesota's hospitals and health care systems. Planned Parenthood health centers are major providers of care for low-income and uninsured individuals. If these health centers reduce services or close, the burden of care may shift to other providers, including hospitals, potentially increasing emergency rooms visits and increasing costs incurred by individuals who are not covered by Medicaid but who otherwise would have sought care at a Planned Parenthood health center.

12. Planned Parenthood health centers also offer preventive services like cancer screenings and STI testing, which can prevent more serious and more expensive health issues in the future. If individuals lose access to these services, they may not receive timely diagnoses and treatment, leading to poorer health outcomes and potentially increased reliance on emergency room visits or hospital care for more advanced conditions.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 14, 2025.

NOYA WOODRICH

Exhibit 17

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF MELANIE BUSH, ASSISTANT SECRETARY, NC MEDICAID

I, MELANIE BUSH, declare as follows:

1. I am the Assistant Secretary of NC Medicaid at the North Carolina Department of Health and Human Services. I make this declaration from personal knowledge and the records of

the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Assistant Secretary, I am responsible for day-to-day administration of the North Carolina Medicaid Program including its reproductive health and family planning federal funding sources and its operation of family planning programs. I have held this position since May of 2025. Previous roles at NC Medicaid include Deputy Medicaid Director and Chief Operating Officer. Prior to employment with Medicaid, I worked as a nonpartisan Fiscal Analyst for Medicaid at the NC General Assembly and as a Senior Policy Analyst at Texas Medicaid. I have a Master of Public Affairs from the University of Texas at Austin and a Bachelor of Science in Foreign Service from Georgetown University.

3. Federal Medicaid funding comprises a significant percentage of North Carolina's budget. It is one of the largest sources of federal revenue for North Carolina. North Carolina has one Medicaid program with various categories of coverage and multiple delivery systems.

NC Medicaid

4. NC Medicaid is North Carolina's approved Medicaid program. NC Medicaid provides comprehensive medical coverage for poor and low-income people in North Carolina. To be eligible for NC Medicaid, residents must meet certain criteria, including income at certain percentages relative to the federal poverty level. In 2023, North Carolina opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. In state fiscal year 2025, approximately 25 percent of North Carolina's population was covered under NC Medicaid.

5. Any person who meets eligibility requirements is entitled to coverage under NC Medicaid. Covered services generally include comprehensive physical, behavioral, and pharmacy benefits. The services that NC Medicaid covers, and receives federal funding to provide, also include family planning and reproductive health care services. Services include

reproductive preventive health, contraceptive services, screening and testing for sexually transmitted infections.

6. As of August 2025, more than 3.1 million North Carolinians have access to full Medicaid coverage, including family planning.

7. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by NC Medicaid, the federal government pays 90% and the state pays the remainder.

8. Care under NC Medicaid is delivered through fee-for-service or managed care depending on eligibility and choice. Beneficiaries have access to Medicaid enrolled providers or their Plan's network. Doctors can be found by using the 'NC Medicaid Provider and Health Plan Lookup Tool' available online.

9. Federal funds do not pay for abortion care under NC Medicaid except as allowed by the Hyde Amendment, i.e. rape, incest, or when the pregnant woman's life is at risk.

NC Medicaid's Family Planning Only program

10. NC Medicaid includes Family Planning as a category of coverage under the Medicaid program.

11. NC Medicaid's Family Planning coverage category is an entitlement and includes reproductive preventive health, contraceptive services, screening and testing for sexually transmitted infections to all eligible people of reproductive age and genders, whose income is at or below 195% of the federal poverty level.

12. As of August 2025, NC Medicaid covers 160,403 individuals under the family planning category.

13. The federal match rate for services covered under NC Medicaid is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

Planned Parenthood entities

14. Planned Parenthood South Atlantic operates in North Carolina and currently operates 11 health centers in North Carolina.

15. Planned Parenthood South Atlantic provides high-quality comprehensive reproductive healthcare and family planning services in North Carolina. They provide the full range of reproductive healthcare in North Carolina. Among other things, they provide sexually-transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, and prenatal care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

16. In state fiscal year 2023, Planned Parenthood health centers in North Carolina filed 7,887 claims with NC Medicaid for 4,878 unique patients. Overall Medicaid-funded visits in SFY 2023 to Planned Parenthood health centers in North Carolina totaled $890,819.86.

17. These Planned Parenthood health centers in North Carolina provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. North Carolina does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating under the Defund Provision. Capacity does not exist to provide the care that Planned Parenthood health centers currently provide.

18. Capacity to provide the vital reproductive healthcare services especially does not exist in rural and underserved areas, which is where some of Planned Parenthood's health centers are located in North Carolina. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

19. Planned Parenthood health centers in North Carolina provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout North Carolina as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of the Defund Provision

20. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on North Carolina and North Carolina's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in North Carolina if it is excluded from Medicaid. If that occurs, that will compound the impact on North Carolina's health system and residents.

21. If capacity does not exist in the health care system in North Carolina to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. The inability to access reproductive healthcare and family planning services provided by Planned Parenthood has significant consequences on individuals, families, communities, and healthcare systems. Loss of access may result in reduced access to reproductive health care, an increase in unintended pregnancies, higher rates of preventable illness including cancers and sexually transmitted infections, increased maternal mortality, increased infant mortality, and rising healthcare costs. This is because their clinics are located in vulnerable communities where access to healthcare is limited.

22. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in North Carolina as they have done for decades, or the State of North Carolina would need to pay the former federal share of that healthcare. The State of North Carolina has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in North Carolina.

23. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of North Carolina, but it will also have a significant impact on North Carolina's entire health care system as access will be limited, driving up wait times for critical services for remaining providers.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 25, 2025.

Melanie E Bush

Melanie Bush

Exhibit 18

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF SARAH ADELMAN

I, Sarah Adelman, declare as follows:

1. I am the Commissioner of the New Jersey Department of Human Services ("DHS"). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Commissioner, I am responsible for overseeing the work of DHS, which administers many of New Jersey's federally funded public benefits, including Medicaid, Children's Health Insurance Program ("CHIP"), Supplemental Nutrition Assistance Program ("SNAP"), and Temporary Assistance for Needy Families ("TANF"). I have held this position since January 2021.

3. Federal Medicaid funding comprises a significant percentage of New Jersey's budget. It is one of the largest sources of federal revenue for New Jersey.

NJ FamilyCare

4. Within DHS, the Division of Medical Assistance and Health Services ("DMAHS"), administers several programs that enable qualifying New Jersey residents to access free or low-cost healthcare coverage. These are referred to as "NJ FamilyCare" programs.

5. NJ FamilyCare is publicly funded health insurance. It includes New Jersey's partially federally funded Medicaid program, in addition to New Jersey's entirely State-funded initiatives. NJ FamilyCare provides comprehensive healthcare coverage for a wide range of services, including primary care, hospitalization, laboratory tests, x-rays, prescriptions, mental health care, dental and vision care, preventive screenings, mental health services and substance use services.

6. Currently more than 1.8 million people, or approximately 19.8% of New Jersey's population, are enrolled in NJ FamilyCare.

7. NJ FamilyCare also administers the Plan First Program, which provides family planning services to individuals who do not have access to such services through insurance. The Plan First Program covers many family planning needs, including, but not limited to, birth control; family planning counseling; pregnancy tests; condoms; family planning lab tests; and vasectomies

for men 21 years of age or older. Typical enrollees in Plan First are low income but are ineligible for full NJ FamilyCare benefits.

8. Eligibility for NJ FamilyCare health insurance programs, including eligibility for Federal-State Medicaid and the Children's Health Insurance Program ("CHIP"), depends in part on age, immigration status, and household income.

9. In general, children under the age of 18 meet the income eligibility requirement for Federal-State Medicaid in New Jersey if their household's modified adjusted gross income ("MAGI") is less than 142% of the federal poverty level ("FPL"). Similarly, children under the age of 18 meet the income eligibility requirement for CHIP in New Jersey if their household's MAGI is less than 350% of the FPL.

10. Enrollment of New Jersey's low-income population in NJ FamilyCare has a positive impact on public health in the state. Individuals enrolled in NJ FamilyCare are more likely to receive preventative care services. This reduces the need for more intensive health care treatments, including emergency care, as illnesses develop. It also reduces the financial burden on health care providers from providing care to uninsured individuals and ensures that families are not left with medical bills that they are unable to pay. In addition, sick individuals with health insurance coverage are more likely to see a health care provider and receive treatment, limiting the spread of infectious illnesses across the state.

11. Having insurance coverage also makes it less likely that individuals will have to visit an emergency room to treat preventable illnesses because it is more likely that they will receive medical care before a treatable medical issue becomes an emergency. This reduces the resource strain and uncompensated care burden on hospitals.

12. In federal fiscal year 2023, more than 43,000 residents received family planning or reproductive health care from NJ FamilyCare family planning providers representing over 150,000 claims of visits or encounters.

13. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by NJ FamilyCare, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually transmitted infection testing and treatment. Those services are eligible for a federal match rate of 50% or 65% depending on the service and the eligibility category of the member receiving services.

14. Care under NJ FamilyCare is provided by a predominantly managed care system. A small percentage of members or services are served through a fee-for-service (FFS) model. Providers participate in NJ FamilyCare by joining the state Medicaid program as a provider and then joining one or all of the managed care networks to provide services to their members. Members can receive services from providers that participate in their managed care organization network or the state FFS system.

15. Federal funds do not pay for abortion care under NJ Family Care based on federal law.

Abortion Availability and Care

16. The right to choose whether, how, and when to terminate or keep a pregnancy is protected by state law in New Jersey. N.J.S.A. § 10:7-2. New Jersey considers the right to choose a fundamental human right that is essential for personal and bodily autonomy. The right to choose is also the essential freedom to make the most intimate and personal decisions of one's life.

17. New Jersey funds 100% of the cost of abortion care for participants of NJ FamilyCare. Abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally funded health care services.

Planned Parenthood Entities

18. There are two Planned Parenthood affiliates in New Jersey: (i) Planned Parenthood of Northern, Central, and Southern New Jersey; and (ii) Planned Parenthood of Metropolitan New Jersey. These two affiliates operate 20 centers across the state. Both NJ FamilyCare enrollees and Plan First participants access services at Planned Parenthood locations throughout the state.

19. Planned Parenthood affiliates provide high-quality comprehensive reproductive health care and family planning services in New Jersey. Among other things, they provide sexually transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

20. In FY 2023, for example, approximately 28,990 NJ FamilyCare enrollees received care at New Jersey Planned Parenthood locations.

21. The two New Jersey Planned Parenthood affiliates collectively billed $6.9 million to NJ FamilyCare in FY 2023 for fee-for-service and managed care services. New Jersey paid approximately $1.4 million of those claims, and the federal government paid $5.4 million.

22. These Planned Parenthood health centers provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. New Jersey does not have a sufficient number of Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating. Adequate additional capacity does not exist to provide

the care that Planned Parenthood health centers currently provide. Absent the care Planned Parenthood provides, New Jersey patients will lack sufficient reproductive health care and family planning services likely leading to worse health outcomes.

23. Capacity to provide these vital reproductive healthcare services is particularly important in rural and underserved areas, where some of Planned Parenthood's health centers are in New Jersey. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

24. Planned Parenthood health centers in New Jersey provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout New Jersey as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the quality of care they provide.

New Jersey Actions to Implement the Defund Provision (if applicable)

25. To implement the Defund Provision, DHS has already had to conduct an analysis to determine the effects of the Provision on the population of New Jersey. New Jersey is also developing guidance for New Jersey-based Medicaid providers and is working to understand what systems-level changes will be necessary for implementation. This has required staff time and resources, and imminent changes will require additional staff time and resources.

26. Failure to incorporate the necessary infrastructure changes would result in New Jersey being at risk of having to return any federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby placing the costs directly onto the State and reducing federally provided matching Medicaid funds.

27. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision takes effect, DHS will likely face inquiries from potentially affected entities, which will also take staff time and resources.

Impact of Defund Provision

28. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on New Jersey and the State's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in New Jersey if it is excluded from Medicaid. If that occurs, that will compound the impact on New Jersey's health system and residents.

29. DHS, which administers New Jersey's Medicaid program, must ensure that NJ FamilyCare complies with the Defund Provision. This will impose a significant administrative burden on the state.

30. The statutory definition of "prohibited entities" is unworkable and vague. New Jersey does not have a system in place that can identify and exclude only certain providers from Medicaid participation based on the criteria specified in the Defund Policy. DHS will need to exclude Planned Parenthood health centers from its Medicaid program by building and applying individual provider-based blocks to billing in its FFS and managed care systems. This will impose an additional administrative burden on the state and DHS. Financial and resource-based costs include state employee time to scope, design, and oversee the changes; contractor time to code, test, and deploy the changes; and leadership time to monitor outcomes and ensure accurate deployment. Predicting what will be necessary is very difficult but this will likely take months and will ultimately cost the state money and will shift employees' focus from other projects.

31. New Jersey has not budgeted for these contingencies. Nevertheless, if DHS does not promptly take steps to comply with the Defund Provision, the state could be subject to federal audits, claw back demands, or set offs of future payments.

32. Further, because capacity does not exist in the health care system in New Jersey to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. This will likely result in the unavailability of care and interrupted continuity of care for patients, which has the potential to lead to negative health outcomes.

33. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in New Jersey as they have done for decades, or the State of New Jersey would need to pay the former federal share of that healthcare. The State of New Jersey has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in New Jersey.

34. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of New Jersey, but it will also have a significant impact on the State's entire health care system and the state budget.

35. The exclusion of Planned Parenthood health centers from Medicaid reimbursement is also in direct conflict with the State's focus on improving perinatal health. The New Jersey Maternal and Infant Health Innovation Center Act was signed into law in July 2023 and created the New Jersey Maternal and Infant Health Innovation Authority. The Authority oversees the New Jersey Maternal and Infant Health Innovation Center in Trenton, New Jersey, and the Nurture NJ

program, which is the statewide program to reduce the maternal and infant mortality epidemic in New Jersey and ensure equitable care among women and children of all races and ethnicities. Exclusion of Planned Parenthood health centers from Medicaid reimbursement will set the State back in these efforts.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 23, 2025.

Sarah Adelman
Commissioner
New Jersey Department of Human Services

Exhibit 19

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as the Secretary of the U.S. Department of Health and Human Services, CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as the Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 25-cv-12118

DECLARATION OF ALEX CASTILLO SMITH, DEPUTY SECRETARY OF NEW MEXICO HEALTH CARE AUTHORITY

I, Alex Castillo Smith, declare as follows:

1. I am the Deputy Secretary at New Mexico's Health Care Authority (HCA). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Deputy Secretary, I am responsible for supporting the administration of the state's Medicaid program, specifically, its reproductive health/family planning federal funding sources/operation of family planning programs, and all other components of Medicaid, amongst many other divisions in the HCA. The HCA is the single state agency responsible for administering New Mexico's Medicaid program, Turquoise Care. Turquoise Care provides low-income individuals with comprehensive healthcare coverage and access to affordable, integrated, high-quality healthcare at no or low cost. Turquoise Care's coverage includes medical, dental, mental health, substance use disorder treatment, and long-term care. HCA's mission is to

improve the overall health and well-being of all New Mexicans. I have held this position for two and a half years. I have a bachelor's degree from the College of William and Mary and a Master of Public Health and a Master of Social Work from the University of Washington.

3. Federal Medicaid funding comprises a significant percentage of New Mexico's budget. It is one of the largest sources of federal revenue for New Mexico. New Mexico has two relevant Medicaid programs: managed care and fee-for-service.

4. HCA is the largest healthcare purchaser in New Mexico as New Mexico Medicaid covers almost forty percent of the state's population. In total, as of July 9, 2025, New Mexico Medicaid insures 796,076 people. This includes 334,200 children under 21 years of age, 389,740 adults between the ages of 21 and 64, and 72,136 members age 65 and older.

State Medicaid Program

5. The Medical Assistance Division (MAD) administers Turquoise Care, the name of the state's approved Medicaid program. Turquoise Care provides comprehensive medical coverage for poor and low-income people in New Mexico. To be eligible for New Mexico's Medicaid, residents must meet certain criteria, including financial (e.g., income and resources) and non-financial (e.g., citizenship) requirements. Medicaid coverage for children, pregnant individuals, and adults 19-64 have an income eligibility limit. Long-term care coverage, such as nursing home and home and community-based programs, have both an income and resource limit. In 2014, New Mexico opted in to the Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. In state fiscal year 2024, approximately 40% of New Mexico's population was covered under Turquoise Care.

6. Any person who meets eligibility requirements is entitled to coverage under New Mexico's Turquoise Care. Covered services are provided through contracted managed care organizations (MCO). Each MCO is responsible for fully integrated care, including physical health, behavioral health, and long-term services, and must deliver care in every county of New Mexico. New Mexico also has a small fee-for-service population; these are primarily Native

Americans who may opt out of managed care services. Turquoise Care provides the full scope of benefits including primary care, preventative care, dental, inpatient and outpatient services, prescription drugs, home care, behavioral healthcare, and reproductive health services. The services that HCA MAD covers, and receives federal funding to provide, also include family planning and reproductive health care services such as contraception, testing for and treatment of STIs, and preventative care.

7. On an annual basis, New Mexico Medicaid spends approximately $23.7 million total fund ($2.4M general fund) on family planning services, of which $1million total fund ($100,000 general fund) is for individuals only eligible for family planning services under Medicaid, and the remainder is for all other Medicaid members.

8. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services, for those covered by Turquoise Care, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually transmitted infection testing and treatment. Those services are eligible for a federal match rate of 71-73%.

9. Care under Turquoise Care is provided under both a managed care system and fee for service system. Providers must first enroll in the State Medicaid program and then can select to apply for credentialing and contracting through each of the four managed care organizations. Managed care organizations can select the providers with which they wish to contract with, and providers and plans negotiate rates.

Medicaid enrollees select an MCO during open enrollment and may choose a primary care provider from within that MCO's network. Members can change providers as needed, and MCOs are required to offer assistance in locating participating providers who meet a member's health care needs, including language and cultural preferences. For reproductive health services, members are permitted to select a provider out of network as well as within their managed care network.

10. Native American members may select either fee-for-service or one of the four managed care plans. For populations served on a fee-for-service basis—primarily Native Americans who opt out of managed care—members may access any enrolled Medicaid provider. All other Medicaid members must select a managed care plan during open enrollment. Within managed care, members are eligible for care coordination. After initial assessments, called the Health Risk Assessment and Comprehensive Needs Assessment, members are connected to appropriate services.

Family Planning Medicaid program

11. New Mexico also operates a second Medicaid program that it calls Family Planning Medicaid, which covers family planning services for those who are not insured and not eligible for coverage under Turquoise Care.

12. Family Planning Medicaid has an income limit of 250% of the Federal Poverty Level. New Mexico, effective July 1, 2025, eliminated age restrictions for Family Planning Medicaid. Family Planning is optional for states. However, New Mexico law requires that New Mexico provide Family Planning Medicaid. For women, services covered under Family Planning Medicaid include an annual reproductive health exam including a breast exam, laboratory tests for cervical cancer screening and screening for sexually transmitted diseases, pregnancy tests, counseling services for family planning including natural family planning, birth control methods including medications, contraceptive rings, Depo-Provera, Intrauterine Devices (IUD), foams, diaphragms, emergency contraceptive pills (ECPs), sterilization, and Gardesil-HPV Virus Vaccine. For men, services include birth control (condoms), vasectomies, office visits for the purpose of contraceptive management and family planning counseling, and screening and treatment for sexually transmitted infections.

13. In state calendar year 2024, 26,351 unique residents received family planning or reproductive health care under Family Planning Medicaid in 200,400 encounters.

14. The federal match rate for services covered under the State Family Planning program is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

15. The Family Planning Medicaid program is a fee-for-service program. Members do not participate in managed care. They are free to choose from any provider who is enrolled in Medicaid, however it is a more limited package.

16. Federal funds do not pay for abortion care under New Mexico's Family Planning Services program. Although federal law permits limited funding for abortion services in cases of rape, incest, or life endangerment to the pregnant person under the Hyde Amendment, New Mexico does not claim federal financial participation for any abortion services. All abortion care provided under Medicaid, including services that could fall within the Hyde parameters, is paid entirely with state funds.

Abortion Availability and Care

17. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in state law in New Mexico. NMS § 24-35-1 *et. seq*. The State of New Mexico considers the right to choose a fundamental human right and essential for personal and bodily autonomy.

18. New Mexico funds 100% of the cost of abortion care for participants of New Mexico's Turquoise Care Medicaid program. Abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally-funded health care services.

Planned Parenthood Entities

19. The Planned Parenthood of the Rocky Mountains currently operate three health centers in New Mexico.

20. Planned Parenthood of the Rocky Mountains provides high-quality comprehensive reproductive healthcare and family planning services in New Mexico. They provide the full range of reproductive healthcare in New Mexico. Among other things, they provide sexually transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

21. In 2024, the last year for which data are available, Planned Parenthood Health Centers in New Mexico provided care at 5,457 visits to 3,187 unique patients using Medicaid funding. Planned Parenthood Health Centers in New Mexico provided care at 577 visits to 305 unique patients using the Family Planning Medicaid funding. Overall Medicaid-funded visits in 2024 to Planned Parenthood Health Centers in New Mexico totaled 6,034 visits to 3,452 unique patients.

22. These Planned Parenthood Health Centers in New Mexico provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. New Mexico may not have enough Medicaid providers to absorb the members that Planned Parenthood will no longer be compensated for treating under the One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025). It is not known if capacity exists to provide the care that Planned Parenthood Health Centers currently provide. If Planned Parenthood Health Centers were to close, HCA would be required to act to assure compliance with Network Adequacy Standards and to assure free choice of provider. This could involve the need to increase rates, ". . . to assure that payments are . . . sufficient to enlist enough providers so that care and services are available . . .." 42 USCA 1396a(a)(30)(A).

23. Planned Parenthood Health Centers in New Mexico provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout New Mexico as providers. I am not aware of

any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of Defund Provision

24. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on New Mexico and New Mexico's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in New Mexico if it is excluded from Medicaid. If that occurs, that will compound the impact on New Mexico's health system and residents.

25. Because capacity does not exist in the health care system in New Mexico to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of members of New Mexico Medicaid who access services at Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. The result is likely to be an increase in sexual transmitted infections, decrease in routine contraception usage, and a lack of screening for treatable conditions such as cervical cancer. The rates of cervical cancer screening, a completely preventable cancer, in New Mexico, are currently under 40%. This number is likely to worsen with a potential closure of Planned Parenthood. Based on the 2024 New Mexico Healthcare Workforce Report, New Mexico is short 334 Primary Care Physicians, 59 Obstetrics and Gynecology Specialists, 204 Nurse Practitioners, and 281 Physician Assistants. If Medicaid stops payment on Planned Parenthood services, the preventive health services, sexually transmitted infection services, and reproductive health services will be directed towards a smaller group of providers, potentially increasing the strain on an already overburdened system. The result may be longer wait-times for services, potentially leading to more unwanted pregnancies and increased STI prevalence in NM. New Mexico already has the 10th highest rate of STIs nationwide and the 2nd highest rate of syphilis.

26. Following the enactment of the Defund Provision, the New Mexico Health Care Authority (HCA) engaged in daily coordination with Planned Parenthood to navigate the

resulting confusion around Medicaid payment suspensions. This engagement required the diversion of multiple full-time staff from other responsibilities to manage data inquiries, claims systems analysis, and real-time communications. During this period of uncertainty, Planned Parenthood temporarily halted services to Medicaid enrollees for several days. Medicaid members were turned away and denied access to contraceptive care, STI testing, and preventive screenings, directly harming patient care and undermining public health. Since this was reported publicly by the media, countless other members self-selected to skip appointments when hearing that Planned Parenthood had closed its doors to Medicaid members from the news.

27. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood Health Centers in New Mexico as they have done for decades, or the State of New Mexico would need to pay the former federal share of that healthcare. The source of funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood Health Centers in New Mexico is yet to be determined. To continue providing services at Planned Parenthood Health Centers using only state funds without Federal Financial Participation (as defined in 42 C.F.R. § 400.203), HCA would be required to develop a burdensome and costly invoicing process to segregate claims from a single provider. That process would include custom claims edits, parallel reporting workflows, and ongoing monitoring to avoid triggering federal match reimbursement—all of which impose additional administrative burdens on the state. If unable to implement such a system or fund services from general revenue, New Mexico would face the loss of a critical access point for reproductive healthcare, with no realistic alternatives in many areas of the state.

28. The exclusion of Planned Parenthood Health Centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of New Mexico, but it will also have a significant impact on New Mexico's entire health care system and the state budget.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 4, 2025.

Alex Castillo Smith

Exhibit 20

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF JOHANNE MORNE

I, Johanne Morne, declare as follows:

1. I am the Executive Deputy Commissioner at the New York State ("NYS") Department of Health ("DOH" or "Department"). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the NYS DOH Executive Deputy Commissioner, I am responsible for administrative, operational, and programmatic oversight of the Department. I have been with the NYS DOH for more than 18 years and have held this position for almost two years. I have a graduate degree in education and counseling from The College of St. Rose. Prior to this role, I served as the Deputy Commissioner, Office of Health Equity and Human Rights for the NYSDOH. I was appointed in August 2022 to establish the new Office and serve as a member of the Department's Executive Leadership Team. From 2007 to 2022, I served in various programmatic and policy making positions in the AIDS Institute. I served as the Director from 2016 - 2022. As the Director of the AIDS Institute, I spearheaded the implementation of essential policy changes to promote expanded access to prevention, treatment, and care for Human Immunodeficiency Virus ("HIV"), sexually transmitted infections ("STI"), and Hepatitis C. This includes the successful advancement of the nation's first 'Ending the Epidemic' movement, the expanded access of pre-exposure prophylaxis as an HIV prevention tool, and the continued expansion of drug user health initiatives to reduce opioid overdose and infectious disease transmission. I served as a board member on the National Alliance of State and Territorial AIDS Directors ("NASTAD") from 2018-2022, sitting as Chair for three years, and was an advisory member to the CDC/ HRSA Advisory Committee on HIV, Viral Hepatitis, STI Prevention and Treatment. I have a 30-year career in which I have consistently contributed to the advancement of public health.

3. Federal Medicaid funding comprises a significant percentage of NYS' budget. It is one of the largest sources of federal revenue for NYS.

The New York State Medicaid Program

4. In NYS, the state Medicaid program, overseen by the DOH, provides comprehensive health coverage to around 7 million New Yorkers annually.[1] Medicaid pays for a wide range of services, depending on the enrollee's age, financial circumstances, family situation, or living arrangements through a large network of health care providers.

5. To be eligible for NYS Medicaid, NYS residents must meet certain criteria, including, but not limited to, income level, age, household size, and other medical considerations. In 2014, NYS opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. Any person who meets eligibility requirements is entitled to NYS Medicaid coverage.

6. NYS provides Medicaid coverage through the state-administered Medicaid fee-for-service program and through managed care arrangements. The majority of NYS Medicaid members are covered under Medicaid Managed Care.[2] Medicaid fee-for-service and Medicaid Managed Care both cover family planning services and reproductive health services.[3]

7. Medicaid-covered sexual and reproductive health care services are wide-ranging, and include family planning/contraception, STI screenings, diagnosis and treatment, and primary and preventative health care. Medically necessary abortion services are covered by NYS Medicaid as fully funded by the state with no federal matching funds. Federal funds do not pay for abortion care under NYS Medicaid.

8. Free Access is a NYS Medicaid policy required by Federal law. Free Access applies to Medicaid Managed Care enrollees, and it allows enrollees to obtain family planning

[1] (https://www.health.ny.gov/health_care/medicaid/enrollment/).

[2] (https://www.health.ny.gov/health_care/managed_care/#:~:text=Medicaid%20Managed%20Care%20offers%20many,for%20themselves%20and%20their%20families).

[3] "Reproductive health services" includes, but is not limited to, abortion services.

and reproductive health services from any qualified Medicaid participating provider (in or out of a managed care plan's network), without a referral or prior approval of the health plan.

9. NYS provides sexual and reproductive health service coverage to Medicaid eligible individuals and additionally to an expanded population through its Family Planning Benefit Program ("FPBP"), a public health insurance program for New Yorkers who need family planning services only. FPBP is a fee-for-service product. FPBP is intended to increase access to confidential family planning services and to enable teens, women, and men of childbearing age to prevent and/or reduce the incidence of unintended pregnancies. Individuals may be eligible if they meet residential, citizenship, and income requirements, and are not already enrolled in Medicaid.[4]

10. The costs of covering Medicaid services, including sexual and reproductive health services, are shared between the state and federal government with a Federal Medical Assistance Percentage ("FMAP") that varies but generally provides 50% matching federal funding for most services, and up to 90% matching federal funds for defined family planning services. For example, if NYS Medicaid paid $100 for a covered family planning service, the federal government would pay between $50 and $90 in federal matching funds, and the state would pay the remaining $10 to $50.

11. Reproductive healthcare services, such as STI testing and treatment, fall under the standard federal funding participation which is generally 50%. Abortion services, however, are 0% federally funded. As NYS is one of the most populous states in the country with nearly 20 million residents and a median age just under 40 years old,[5] many New Yorkers need sexual and reproductive health services.

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4 (https://www.health.ny.gov/health_care/medicaid/program/longterm/familyplanbenprog.htm#:~:text=You%20may%20be,health%20insurance%20coverage).

5 (https://www.census.gov/programs-surveys/acs/data/data-via-ftp.html).

12. In State Fiscal Year 2024 (the most recent year for which complete data are available), about a quarter of NYS Medicaid Members, nearly 2 million individuals, received a covered reproductive healthcare service, inclusive of family planning benefit services.

13. About 65% of total Medicaid enrollees are below the age of 45,[6] and over 30% of Medicaid enrollees are females of reproductive age (10-55 years). Whether enrolled in Medicaid or privately insured, however, New Yorkers in every area of the state need access to sexual and reproductive health services.

Planned Parenthood Entities in New York State

14. There are five Planned Parenthood affiliates in NYS: Planned Parenthood of Central and Western New York, Planned Parenthood of Greater New York, Planned Parenthood Hudson Peconic, Planned Parenthood of the North Country and Upper Hudson Planned Parenthood. Among them, these Planned Parenthood entities currently operate 49 health centers in 35 counties across NYS.

15. Planned Parenthood health centers in NYS are well known as reproductive healthcare and family planning providers. The reproductive healthcare and family planning services provided by Planned Parenthood affiliates include, but are not limited to: cancer screening, prevention services and procedures; pregnancy tests and counseling, including parenting and adoption; basic infertility services; referrals to meet client needs, including primary care, prenatal care, sexual and intimate partner violence assistance programs, and transportation providers; STI and HIV prevention education, infection testing, and treatment; contraception methods, counseling, and management; and abortion care. For many women, family planning and reproductive health care is the only form of primary health care they regularly receive.

[6] (https://www.kff.org/medicaid/state-indicator/medicaid-enrollees-by-age/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

16. These five Planned Parenthood affiliates provide a substantial portion of all Medicaid-funded reproductive health care and family planning services.

17. In State Fiscal Year 2024, approximately 88,500 individual Medicaid enrollees sought care at Planned Parenthood affiliates across the state, with approximately 156,000 claims processed for services provided by Planned Parenthood affiliates based in NYS.

18. There are areas of NYS in which Planned Parenthood has provided 100% of the total Medicaid-funded reproductive health care and family planning services to the Medicaid populations. For example, in 17 counties (over a quarter of NYS counties), most of which are rural, Planned Parenthood has provided 98-100% of the Family Planning benefit services that qualify for the higher FMAP.

19. Based on this, there is a heightened concern that, in some areas of the State, should Planned Parenthood no longer be able to serve these patients, there simply may not be an available provider of those services.

NYS Actions Necessary to Implement the Defund Provision

20. NYS will suffer administrative burdens if the Defund Provision, as defined in the complaint in this matter, goes into effect because the definition of Prohibited Entities is unworkable.

21. To prepare to implement the Defund Provision, NYS DOH is working to identify impacted Planned Parenthood providers and estimate the total financial impact to those providers.

22. However, DOH will otherwise struggle to identify impacted providers other than Planned Parenthood entities. Specifically, the statute includes among its criteria that the "Prohibited Entity" be an essential community provider that "primarily engages in family planning services, reproductive health, and related medical care." In its normal course of

business, DOH generally does not determine what type of services its participating providers "primarily engage in," nor does the statute set out criteria for making that determination.

23. The Defund Provision does not specify whether "primarily engage in" is assessed by self-designation of the entity in question, which the DOH does not currently ask for, or whether the State is to make that determination itself. And if it is the latter, the Defund Provision does not describe how the State would go about doing so; the Defund Provision does not specify what universe the "primarily engage in" criterion is measured against—whether it is limited to the universe of Medicaid billing or whether it includes services billed to private insurance or private pay, which data the State does not collect. And assuming it can even be determined under the Defund Provision's vague terms which entities are considered prohibited, NYS will also have to provide guidance to participating providers about whether they are or are not considered a Prohibited Entity.

24. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision actually takes effect, the DOH will likely face inquiries from potentially affected entities, which will also take staff time and resources to answer.

25. Further, NYS is conducting a review of its claims payment and processing system to identify the necessary changes that will have to be made. No infrastructure currently exists to filter out such providers falling under the definition of "Prohibited Entities". DOH currently has no system in place to identify and exclude only certain providers from Medicaid participation based on the criteria specified in the Defund Provision. The Medicaid Management Information System ("MMIS"), the system that manages claims, payments, and other related data for the state's Medicaid program, is approximately 30 years old and is extremely inflexible. Minor changes to this system often take over 12 months.

26. Implementing the Defund Provision would cost money and time as DOH would be required to develop a new strategy and supporting infrastructure to identify such transgressors from scratch, before being able to remove providers that violate the policy.

27. Following the identification of impacted providers, DOH will have to provide guidance to these Prohibited Entities as to how the restrictions impact billing for services previously provided and to be provided, given that providers have 90 days to initially submit claims to Medicaid. DOH may have to communicate with Prohibited Entity providers to direct them not to bill for any services once the Defund Provision goes into effect.

28. Failure to incorporate the necessary infrastructure changes would result in NYS DOH being at risk of having to return any federal funds used to pay claims submitted by Prohibited Entities defined under the Defund Provision, thereby placing the costs directly onto NYS and reducing federally provided matching Medicaid funds.

Impact of the Defund Provision

29. If Planned Parenthoods along with any other Prohibited Entities are excluded from federal Medicaid reimbursement, the impact on NYS and its residents would be profound. DOH is concerned that these entities may need to close health centers in NYS once excluded from Medicaid. If that occurs, that will compound the impact on NYS' health system and residents. For example, the estimated additional cost to NYS of fully covering the services offered by Planned Parenthood, if matching federal funds cannot be accessed, is $21 million.

30. At an estimated cost of $21 million for Planned Parenthood alone, without federal matching funds, NYS Medicaid is not currently prepared to fully cover the cost of the variety of healthcare services provide by Planned Parenthood affiliates to NYS Medicaid members, as well as the additional investments in State infrastructure and operations that would be necessary.

31. Without matching federal funding, Planned Parenthood affiliates and any other Prohibited Entities will be at risk of folding, ceasing continued operations and provision of services. This would create a gap in access to needed services for all New Yorkers, including some our most vulnerable residents covered by Medicaid.

32. It is inevitable that some patients who went to Planned Parenthood or other Prohibited Entities for services will be unable to find a provider for reproductive healthcare and

family planning services. The result would likely be a multitude of adverse outcomes for those who can no longer find care or have to travel far distances to access care, including, but not limited to, lack of timely prenatal care, cancer screenings, and prevention and treatment of STIs.

33. To avoid these negative outcomes, the federal government would need to again provide federal funding for these health centers in NYS as it has done for decades.

34. The exclusion of Planned Parenthood and other Prohibited Entities from Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of NYS but it will also have a significant impact on NYS's entire health care system and the state budget.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 28, 2025.

Johanne E Morne

JOHANNE MORNE

Exhibit 21

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA; STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN.

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants,

No. 1:25-cv-12118

DECLARATION OF EMMA SANDOE

I, Emma Sandoe, declare as follows:

1. I am the Medicaid Director at Oregon Health Authority (OHA). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Medicaid Director, I am responsible for the administration of the state's full benefit Medicaid program. I have held this position since July 2024. Prior to that I served as the Deputy Director of Medicaid Policy for North Carolina Medicaid. I have a PhD in Health Policy from Harvard University and Masters in Public Health from The George Washington University.

3. OHA administers Oregon's Medicaid programs and ensures that they comply with federal law.

4. Federal Medicaid funding comprises a significant percentage of Oregon's budget. It is one of the largest sources of federal revenue for Oregon. Oregon has two relevant Medicaid programs: the Oregon Health Plan and Oregon ContraceptiveCare. The cost of providing care through those programs is shared between the federal government and Oregon.

Oregon Health Plan

5. The Oregon Health Plan (OHP) is Oregon's full benefit Medicaid program. OHA's Medicaid Program administers OHP. OHP provides comprehensive medical coverage for poor and low-income people in Oregon. To be eligible for OHP, residents must meet certain criteria, including income and residency requirements. Income limits for OHP vary based on age and specific OHP program, but generally, adults are eligible with household incomes of up to 138% of the federal poverty level. To qualify for OHP, individuals must also be Oregon residents.

6. Nearly 97% of Oregonians have health insurance, which includes coverage in the individual market and OHP. Of those with coverage, 32% (about 1.4 million people) have Medicaid coverage through OHP.

7. Any person who meets eligibility requirements is entitled to coverage under OHP. Covered services include diagnostic and preventive physical health care, behavioral health care, dental care, eye and vision care, pregnancy care, emergency care and urgent care, and care coordination. The services that OHP covers, and receives federal funding to provide, also include comprehensive family planning and reproductive health care services. OHP covers annual

wellness visits that include reproductive cancer screening, contraception, pregnancy testing, prenatal care, sexually transmitted infection testing, and voluntary sterilization.

8. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by OHP, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually transmitted infection testing and treatment. Those services are eligible for Oregon's base federal match rate. The base federal match rate is under 60%.

9. Care under OHP is provided under a combination of managed care entities, called Coordinated Care Organizations (CCOs), and fee for service. Approximately 92% of OHP members are enrolled in a CCO, while the remainder of members receive coverage for their care through the Oregon Health Authority's fee for service program. There are currently 16 CCOs across Oregon that are responsible for coordinating the care of their members. Each CCO establishes and maintains a network of local providers to deliver care to their members. Providers may also directly enroll with the Oregon Health Authority to serve fee for service members. When a provider seeks to enroll with OHP through either fee for service or a CCO, the provider is screened to ensure they meet enrollment requirements and are not excluded from participating in Medicaid. *See* Or. Admin. R. 410-120-1260(8) – (12) (describing enrollment requirements and process). To enroll, a provider must be appropriately licensed to perform the services they seek to perform. *See, e.g.,* Or. Rev. Stat. § 414.613 (prohibiting CCOs from barring a provider acting within their scope of practice from participating in the CCO's network). OHP members may seek family planning services from any enrolled OHP provider.

10. Both CCOs and fee for service providers receive funding directly from the state. The CCOs receive an annual budget from OHA, and they reimburse providers for services. CCOs submit data about those reimbursements to OHA. Fee for service providers bill OHA directly for services provided. OHA submits data to the federal government detailing the services

provided, and the federal government then reimburses the state using the applicable matching rate for services provided.

11. Federal funds are not used for any abortion services under OHP.

Oregon ContraceptiveCare

12. Oregon also operates a second Medicaid program that it calls Oregon ContraceptiveCare (CCare), which covers family planning services for those who meet eligibility requirements and are not enrolled in OHP. OHA's Reproductive Health Program administers CCare.

13. CCare is a Section 1115 family planning Medicaid demonstration waiver that expands eligibility for family planning services for individuals with incomes up to 250% of the federal poverty level. CCare covers office visits for contraceptive management services, sexually transmitted infection (STI) screening services within the context of a contraceptive management visit, and contraceptive devices and supplies.

14. In state fiscal year 2025, 8,779 Oregon residents received family planning or reproductive health care covered by CCare in 14,081 visits or encounters.

15. The federal match rate for services covered under CCare is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

16. CCare is administered through a statewide network of providers certified with the Oregon Health Authority's Reproductive Health Program. Individuals enrolled in CCare may access care directly from any CCare participating provider. Individuals may enroll in CCare through a participating provider clinic.

17. Federal funds are not used for any abortion services under CCare.

Abortion Availability and Care

18. The right to choose whether, how, and when to terminate or keep a pregnancy is protected under state law in Oregon. Or. Rev. Stat. § 435.210. State law prohibits public bodies from interfering with the exercise of reproductive health rights, subjecting a person to any penalty for exercising or supporting the exercise of reproductive rights, or depriving a person

from their right to choose how to exercise their reproductive rights. Or. Rev. Stat. § 435.240(1). The State of Oregon considers the right to choose a fundamental human right that is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

19. Oregon funds 100% of the cost of abortion care for OHP members through state-only funds. Abortion care is always provided on a fee-for-service basis and is billed and paid separately from other covered and federally-funded health care services.

Planned Parenthood Entities

20. There are two Planned Parenthood entities in Oregon: Planned Parenthood of the Columbia Willamette (PPCW) and Planned Parenthood of Southwestern Oregon (PPSO). Both are enrolled providers under OHP and certified providers under CCare. These two Planned Parenthood entities currently operate eleven (11) health centers in Oregon and one (1) in Vancouver, Washington.

21. PPCW and PPSO provide high-quality comprehensive reproductive healthcare and family planning services. Among other things, they provide sexually transmitted infection testing and treatment, contraception, cancer screening and prevention services and procedures, pregnancy tests and counseling, and abortion care. For many people, family planning and reproductive health care is the primary health care they regularly receive.

22. PPCW and PPSO are the only providers in Oregon that are affected by Section 71113 of "An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14" ("the Defund Provision").

23. In state fiscal year 2025, OHP reimbursed PPCW and PPSO for 56,989 family planning and reproductive health visits or encounters provided to 35,096 unique patients. In state fiscal year 2025, CCare reimbursed PPCW and PPSO for 8,466 family planning visits or encounters provided to 5,730 unique CCare patients. Overall Medicaid-funded visits in state fiscal year 2025 to PPCW and PPSO totaled 65,455.

24. In state fiscal year 2025, PPCW and PPSO received a total of $24,662,275 in Medicaid payments. Of that total, $16,700,143 were federal Medicaid payments and $7,962,132 were state Medicaid payments.

25. These Planned Parenthood health centers in Oregon provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. In calendar year 2024, PPCW and PPSO served 68% of OHP members who accessed family planning and reproductive health services at Reproductive Health Program-contracted clinics. In state fiscal year 2025, PPCW and PPSO health centers served 65% of unique CCare patients. Oregon does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating if the Defund Provision goes into effect. Capacity does not exist to provide the care that Planned Parenthood health centers currently provide.

26. Capacity to provide the vital reproductive healthcare services especially does not exist in rural and underserved areas, which is where some of Planned Parenthood's health centers are located in Oregon. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

27. Planned Parenthood health centers in Oregon provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Oregon as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of Defund Provision

28. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Oregon and Oregon's residents would be profound. I am concerned that Planned Parenthood may need to close health centers or limit health center hours or services in Oregon if it is excluded from Medicaid. If that occurs, that will compound the impact on Oregon's health system and residents.

29. Because capacity does not exist in the health care system in Oregon to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that the

loss of federal Medicaid funding will cause some proportion of patients of Planned Parenthood to be unable to find a provider for reproductive healthcare and family planning services. The result is likely to be a reduction in access to and utilization of preventive health services including cancer screenings, STI services, and contraception services. Family planning provider exclusions have been shown to result in clinic closures and a significant reduction in the receipt of preventive health services. A study of family planning clinic closures in Ohio found that each additional 10 minutes of driving time was associated with significant decreases in the receipt of preventive care such as clinical breast exams.[1] A study from Iowa found that residents of counties with family planning clinic closures were approximately twice as likely to have a reported gonorrhea infection after clinic closures compared to the period prior to closure.[2] A study of family planning clinic closures in Texas and Wisconsin found that an increase in distance to the nearest clinic was associated with significant decreases in receipt of preventive care including cervical cancer screenings.[3] A study of family planning provider exclusions and funding cuts in Texas found significant reductions in utilization of contraception and receipt of cervical cancer screenings.[4]

30. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Oregon as they have done for decades, or the State of Oregon would need to pay the former federal share of that healthcare. The State of Oregon has allocated some funding to fill the gap left by the Defund Provision, but it has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in Oregon. Specifically, in the just-concluded 2025 legislative session,

[1] Ellison J, Griffith K, Thursby M, Slusky DJG, and Bor J. The impact of driving time to family planning facilities on preventive service use in Ohio. *Am J Prev Med*, 2021 April; 60(4) 542-545. https://doi.org/10.1016/j.amepre.2020.11.009

[2] Srinivas M *et al*. Sexually transmitted infection rates and closure of family planning clinics because of abortion restrictions in Iowa. *JAMA Network Open*, 2022 Oct 14;5(1):e2239063. https://doi.org/10.1001/jamanetworkopen.2022.39063

[3] Lu Y and Slusky DJG. The impact of women's health clinic closures on preventive care. *American Economic Journal: Applied Economics,* 2016, 8(3): 100-124. http://dx.doi.org/10.1257/app.20140405

[4] White K *et al*. The impact of reproductive health legislation on family planning clinics in Texas. *Am J Public Health* 2014 105:851-858. https://doi.org/10.2105/AJPH.2014.302515

the Oregon Legislative Assembly appropriated $10 million to OHA to assist the two Planned Parenthood entities in Oregon to provide the full scope of reproductive health services to as many people as possible across Oregon. This temporary funding will delay but will not prevent the Defund Provision from having harmful impacts in Oregon.

31. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of residents of Oregon but it also is also likely to have a significant impact on Oregon's entire healthcare system and the state budget. Preventive services provided in family planning clinics are highly effective in reducing future government healthcare costs by helping patients avoid not only unintended pregnancy, but also cervical cancer, HIV and other sexually transmitted infections, infertility, and preterm and low birth weight births. These avoided health conditions are much more costly than the preventive services provided in family planning clinics.[56] A study of Medicaid claims data found that the cost of contraception services represented only 6.6% of the cost of unintended pregnancy care (per member per month costs were $0.54 for contraception care and $8.15 for unintended pregnancy care).[5] A national study of publicly funded family planning services found that care provided during publicly funded family planning visits results in net government cost savings of over $7.00 per every public dollar spent.[7] Reduced access to these services will result in higher costs to the state.

32. In addition to those impacts, OHA has already been forced to expend significant staff time and resources to comply with the Defund Provision. OHA staff have spent approximately 0.75 FTE over the last month to, among other things, conduct data analysis, coordinate responses across OHA, and develop communications to impacted providers. OHA's

[5] Laliberté, F., Lefebvre, P., Law, A. *et al.* Medicaid spending on contraceptive coverage and pregnancy-related care. *Reprod Health* **11**, 20 (2014). https://doi.org/10.1186/1742-4755-11-20

[6] Amaral G *et al*. Public savings from the prevention of unintended pregnancy: a cost analysis of family planning services in California. Health Research and Educational Trust. *Health Serv Res*. 2007 Oct;42(5):1960-80. https://doi.org/10.1111/j.1475-6773.2007.00702.x

[7] Frost JJ, Sonfield A, Zolna MR, and Finer LB. Return on investment: A fuller assessment of the benefits and cost savings of the US Publicly Funded Family Planning Program. *The Milbank Quarterly*, 92(4), 2014 (pp. 667-720). https://doi.org/10.1111/1468-0009.12080

Reproductive Health Program and Medicaid Program have also had to develop new guidance for CCOs to understand how to process claims for covered services at Planned Parenthood clinics. That guidance includes instructing them how to process claims in compliance with state law and state regulations as well as the Defund Provision. In addition to providing that guidance, OHA will need to engage in rulemaking and develop sub-regulatory guidance to comply with the Defund Provision, and that will require additional staff time and resources.

33. Before the Defund Provision was enacted, OHA processed OHP and CCare claims from Planned Parenthood health centers in an automated, streamlined manner, just as claims from all other providers are processed. Claims are typically submitted to and processed by electronic software systems that approve or deny claims without any need for manual adjudication.

34. The Defund Provision forced OHA to develop new processes for manually reviewing claims from Planned Parenthood health centers. To ensure State of Oregon Medicaid will not make automatic payments if the Defund Provision goes into effect, OHP staff spent time initially adjusting the status of the impacted providers in the State Medicaid Management Information System (MMIS) to ensure all claims submitted go into a suspend status. Those claims will need to be worked manually by staff who review the date(s) of service, procedures, and diagnosis codes billed before either denying or releasing the claims for payment. Similarly, the Reproductive Health Program has already spent multiple hours to update its claims processing system and will also need to manually review claims if the Defund Provision goes into effect. Implementation of the Defund Provision will inevitably require staff resources to

implement, above and beyond what has already been expended, regardless of the implementation methods that OHP and the Reproductive Health Program ultimately use.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 13, 2025.



EMMA SANDOE

Exhibit 22

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND

Case No. 1:25-cv-12118-IT

DECLARATION OF KRISTIN PONO SOUSA

MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

I, Kristin Pono Sousa, declare as follows:

1. I am the Director of the Rhode Island Medicaid Program. I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Director of the Rhode Island Medicaid Program, I am responsible for: collaborating with State agencies to ensure all publicly financed health care services are integrated and coordinated; filtering, translating, and communicating key state and federal, policy, legislation, and regulatory updates; engaging Medicaid stakeholders in a comprehensive review of the Medicaid program and making recommendations for short and long-term plans to transform Medicaid; program evaluation and making recommendations for quality improvement and cost saving measures to meet specific system transformation goals; monitoring and ensuring adherence to Federal and State requirements, including operating the Program within budget constraints; ensuring that Medicaid-financed health care services are evidence-based, effective, and responsive to Medicaid eligible persons' needs; and oversight and management of contracts and agreements with managed care organizations and providers. I have served in the Executive Office of Health and Human Services (EOHHS), the single State agency to administer the Rhode Island Medicaid program, since 2018, first as Managed Care Director, then as Deputy Medicaid Program Director, and I have been in my current role as Director since April, 2022. I hold a bachelor of science degree from Providence College in Health Service Administration.

3. Federal Medicaid funding comprises a significant percentage of Rhode Island's budget. It is one of the largest sources of federal revenue for Rhode Island.

Rhode Island Medicaid program

4. Rhode Island's Medicaid Program provides comprehensive medical coverage for low-income people in our state. To be eligible for Rhode Island's Medicaid program, residents must meet certain criteria: individuals must be Rhode Island residents and meet citizenship/immigration requirements. Individuals must have income under the required limits based on the eligibility group to which they belong (e.g., children under age 19, pregnant people, adults ages 19-64, elderly and disabled people, individuals requiring long-term services and

supports, etc.). Certain populations also must have limited assets (e.g., elderly and disabled individuals requiring long-term services and supports). Individuals qualifying on the basis of disability or need for long-term services and supports must also meet clinical criteria.

5. In 2014, Rhode Island opted into the Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. As of July 2025, approximately one third (306,000) of Rhode Island's population was covered under the Rhode Island Medicaid Program.

6. Any person who meets eligibility requirements is entitled to coverage under Rhode Island's Medicaid Program. Covered services generally include:

- Mandatory services described at 42 C.F.R. Part 440, such as: inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory and x-ray services, nurse practitioner and nurse-midwife services, home health services (including DME), EPSDT, pregnancy-related services, family planning services and supplies, nursing facility services for individuals over age 21, and medical and surgical services of a dentist.
- Optional services as approved in our state plan, such as: medical or other remedial care provided by licensed practitioners, optometrist services, podiatrist services, chiropractor services, federally-qualified health center services, dental, physical therapy, occupational therapy, speech therapy, prescribed drugs, medication-assisted treatment, dentures, prosthetic devices, eyeglasses, preventive services (including doula, CHW, and family home visiting), screening and diagnostic services, tobacco cessation counseling, rehabilitative services (including a range of behavioral health care for children and adults), services for people over age 65 in an IMD, inpatient psychiatric services for people under age 21, ICF/IDD services, hospice, personal care, case management, non-emergency transportation brokerage program, skilled nursing for people under 21, health home services, and PACE.
- 1115 Waiver services, including 1915(c)-like home and community-based services; home stabilization, Behavioral Health Link, SUD treatment in IMDs, peer recovery specialist, family/youth support specialist, and window replacement for lead poisoning remediation.

7. Care under the Rhode Island Medicaid Program is provided under both managed care and fee-for-service delivery systems, with approximately 90% of beneficiaries enrolled in managed care.

8. The Rhode Island Medicaid Program also covers family planning services, consistent with section 1905(a)(4)(C) of the Social Security Act. This includes approved methods of contraception; screening for sexually-transmitted infections during a family planning visit, Pap smears, and pelvic exams; drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements; and contraceptive management, patient education, and counseling. The state also

covers family planning related benefits, such as: colposcopy; treatment of STIs (except for HIV/AIDS and hepatitis); STI diagnosis and treatment pursuant to a family planning visit; drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders that are identified/diagnosed during a routine family planning visit; other medical diagnosis, treatment, and preventive services routinely provided pursuant to family planning services in a family planning setting; and treatment of major complications arising from a family planning procedure.

9. Rhode Island law protects an individual's ability to terminate a pregnancy prior to fetal viability and whenever necessary to preserve the life or health of that individual (R.I. Gen. Laws § 23-4.13-2).

10. Federal funds are not used to pay for abortion care under the Rhode Island Medicaid program, except where allowable under the Hyde Amendment.

11. The state of Rhode Island, through its general revenue, funds 100% of the cost of abortion care for participants of Rhode Island's Medicaid program where not allowable under the Hyde Amendment, pursuant to R.I. Gen. Laws § 42-12.3-3(b).

Planned Parenthood entities

12. Planned Parenthood of Southern New England ("PPSNE") operates one Planned Parenthood facility in Rhode Island ("PPRI").

13. PPRI provides high-quality comprehensive reproductive healthcare and family planning services in Rhode Island. They provide the full range of reproductive healthcare, which includes both preventative and primary care, including but not limited: to STI testing and treatment; contraception procedures, counseling, and management; cancer screening and prevention services and procedures; pregnancy tests and counseling; prenatal care; and abortion care. For many women, family planning and reproductive healthcare is the only primary health care they regularly receive.

14. In state fiscal year 2025, the last year for which data is available, PPRI provided 3,716 visits to 2,334 unique Medicaid patients. Overall Medicaid-funded visits in state fiscal year 2025 to Planned Parenthood health centers in Rhode Island totaled approximately $900,000.

15. PPRI provides approximately 70% of all Medicaid-funded family planning and reproductive healthcare services. Rhode Island does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating under this legislation that defunds Planned Parenthood. Capacity does not exist in Rhode Island to provide the care that PPRI currently provides.

16. In fact, Rhode Island suffers from a severe shortage of primary care providers, which has worsened in the past year, as large practices have closed and additional provider groups have been unable to intake the tens of thousands of Rhode Islanders seeking primary care.

17. PPRI provides high-quality, competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Rhode Island as a provider. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Impact of defund provision

18. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Rhode Island and its residents would be significant. I am concerned that Planned Parenthood may need to close its only health center in Rhode Island if it is excluded from the Medicaid program. If that occurs, that will compound the impact on Rhode Island's increasingly fragile health system and its residents.

19. Because capacity does not exist in the health care system in Rhode Island to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some of the approximately 2,300 Medicaid patients cared for by PPRI will be unable to find a provider for reproductive healthcare, family planning services and basic preventative, primary care.

20. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of Rhode Island, but it will also have an impact on the Rhode Island's health care system and the state budget.

I declare under penalty of perjury that the foregoing is true and correct. EXECUTED on August 27, 2025.

Kristin Pono Sousa

Kristin Pono Sousa, Medicaid Program Director

Exhibit 23

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF CHARISSA FOTINOS, MD, MSc

I, Charissa Fotinos, declare as follows:

1. I am a resident of the State of Washington. I am over the age of 18 and make this declaration from personal knowledge, the records of the agency that are kept in the regular course of its business, as well as through HCA employees who have assisted me in gathering this information from our agency. I would testify to the following if called as a witness.

2. I am the Medicaid Director for the Washington State Health Care Authority (HCA). I have been employed with HCA since October 1, 2013. I have held the positions of Medicaid Director and Behavioral Health Medical Director since 2022 and Deputy Chief Medical Officer from 2013-2022.

3. Before joining HCA, I served as Chief Medical Officer for Public Health-Seattle & King County for 10 years, and I was a physician faculty member at the Providence Family Medicine Residency Program. I am board certified by the American Board of Family Medicine in Family Medicine and by the American Board of Preventive Medicine in Addiction Medicine. I hold a Master of Science in evidence-based health care from Oxford University, Kellogg College, in England, and an M.D. from the University of Colorado Health Sciences Center.

4. As the Medicaid Director, I am responsible for executive- level oversight and administration of Washington's Apple Health programs. The term "Apple Health" includes Medicaid and the Children's Health Insurance Program (CHIP), which are governed by federal statutes and rules and supported by federal funding but administered by the State. Apple Health also includes programs that are funded entirely by the State. Apple Health provides free or low-cost health insurance coverage to qualifying individuals and families, including children, pregnant women, adults, seniors, and individuals with disabilities.

5. Federal Medicaid funding comprises a significant percentage of Washington's budget. It is one of the largest sources of federal revenue for Washington.

6. Washington State pays for family planning services in partnership with the federal government through two programs, Apple Health Medicaid and Family Planning Only. Family Planning Only is approved by the Centers for Medicaid and CHIP Services as a Section 1115 demonstration waiver program.

State Medicaid program

7. The Medicaid program provides comprehensive medical coverage for low-income people in Washington. To be eligible, residents must meet certain criteria, including income, household size, health status, and immigration status. In 2014, Washington opted into the Medicaid expansion included in the Patient Protection and Affordable Care Act of 2010. As of July 2025, 1.9 million people in Washington were covered under Medicaid and other Apple Health programs.

8. Any person who meets eligibility requirements is entitled to coverage under Apple Health. Covered services generally include primary and specialty medical care, emergency services, maternity and pediatric care, behavioral health (mental health and substance use disorder treatment), dental care, and vision care. The services that Apple Health covers, and for which the State receives federal funding to provide, also include family planning and reproductive health care services.

9. In calendar year 2024, 447,902 residents received family planning or reproductive health care under Apple Health Medicaid in 754,520 visits or encounters.

10. The rate of federal match received for a given family planning service depends on the eligibility status of the person seeking care and the specific services. The level of federal matching funds for services provided to "Classic" Medicaid clients is 50%. The federal match is 90% for services provided to clients who gain eligibility under the Affordable Care Act. Certain family planning services and supplies are eligible for an enhanced federal match of 90%.

11. In general, under the Hyde Amendment, federal funds cannot be used to pay for abortions. Washington has created multiple safeguards in its Medicaid Management Information System to prevent the claiming of federal funds for abortions.

Family-planning Medicaid program

12. As noted above, Washington also operates a Section 1115 waiver program called Family Planning Only (FPO), which covers family planning and related services for those who are uninsured and not eligible for broader/more comprehensive Apple Health Medicaid or are insured and seeking confidential family planning services. The FPO program provides coverage for a limited set of services.

13. Eligibility for FPO is based on income, household size, and eligibility related to citizenship or having a "qualified" immigration status. FPO includes a comprehensive preventive family planning visit each year (and any necessary family planning related follow-up visits); counseling, education and/or risk reduction; education and supplies for FDA-approved contraceptives; permanent methods such as tubal sterilization or vasectomy; pregnancy testing; sexually transmitted infection screening, testing and treatment; cervical cancer screening; and human papillomavirus (HPV) and Hepatitis B vaccinations.

14. In state fiscal year (SFY) 2025 (the period of July 1, 2024, through June 30, 2025), there were 2,794 FPO enrollees. Of that population, 1,780 FPO clients received at least one family planning or family planning related service, with 3,724 unique services received.

15. The federal match rate for family planning services covered under FPO is 90%.

16. FPO services are available from any Apple Health enrolled provider whose licensure and scope allows them to provide family planning and reproductive health services.

17. The FPO program does not pay for abortions.

Abortion availability and care

18. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in Washington under Section 9.02.110 of the Revised Code of Washington. The State of Washington considers the right to choose to have an abortion as a fundamental right that is essential for personal and bodily autonomy as well as the freedom to make the most intimate and personal decisions of a person's life.

19. The State of Washington fully funds the cost of abortion care for Apple Health and FPO clients. Abortion care is excluded from the services covered under the Medicaid managed care contract and instead is provided on a fee-for-service basis using state-only funds.

Planned Parenthood entities

20. Planned Parenthood Great Northwest, Hawaii, Alaska, Indiana, and Kentucky (PPGNHAIK), Planned Parenthood of Greater Washington and North Idaho (PPGWNI), and Planned Parenthood Columbia Willamette (PPCW) provide sexual and reproductive services to communities in Washington. These entities operate 30 health centers in Washington.

21. PPGNHAIK, PPGWNI, and PPCW provide high-quality comprehensive reproductive healthcare and family planning services. Their services include birth control; sexually transmitted infection testing and treatment; cancer screening and prevention services and procedures; HIV services; pregnancy tests and counseling; and abortion care. For many women, family planning and reproductive health care are the primary health care they regularly receive.

22. In calendar year 2024 (the last year for which data is available), Planned Parenthood health centers in Washington provided 85,029 visits for family planning and reproductive health care to 42,223 unique patients using Apple Health Medicaid funding.

23. The Planned Parenthood health centers in Washington provide a substantial portion of family planning care to Apple Health clients (three out of every five visits). We are

concerned with the possibility that HCA may lack a sufficient number of Medicaid-enrolled providers to furnish the family planning and reproductive health care services for which Planned Parenthood will not be compensated under Section 71113(b)(1) of H.R. 1 (Public Law 119-21) (2025). It will be a significant challenge to ensure that clients receive the type of care that Planned Parenthood has been providing for decades in Washington.

24. The capacity to provide vital reproductive healthcare services is especially limited in more rural and underserved areas of the state, which is where some of Planned Parenthood's health centers are located (e.g., Friday Harbor, Moses Lake, Sunnyside, and Yakima). Healthcare services are already limited in many of these areas; as a result, the Planned Parenthood health centers are critical.

25. Planned Parenthood health centers in Washington are well known and respected as providing skilled and high-quality care. I am not aware of any provider or quality of care concerns that would be a legitimate basis for excluding Planned Parenthood from Medicaid reimbursement.

HCA's Actions to Implement the Defund Provision

26. HCA has created an implementation plan to attempt to address the directives set forth in Section 71113(b)(1) of H.R. 1 (Section 71113(b)(1)), which prohibits certain unspecified entities from receiving Medicaid funds. These efforts have been administratively burdensome.

27. The ambiguity of the terminology in Section 71113(b)(1) created work for HCA as it was not immediately clear which providers qualified as "prohibited entities" under the provision. HCA had to perform financial analyses of its providers to determine which providers were in fact "prohibited" in Washington under the section's financial criteria. Based on its analysis, HCA has determined that Planned Parenthood is the only organization in Washington that meets the financial criteria of Section 71113. HCA then had to communicate this

information to impacted and non-impacted providers, managed care plans, and Apple Health clients.

28. Section 71113(b)(1) is also unclear as to when an entity becomes a "prohibited entity" subject to defunding. Specifically, it is unclear whether the defunding provision takes effect as of July 4, 2025 (on the enactment date of H.R. 1) or as of October 1, 2025 (the earliest date an entity can qualify as a prohibited entity). HCA is in the process of updating its calendar year 2025 managed care capitation rates to exclude all of the amounts that had been projected for Planned Parenthood. The exclusion period will run from July 4, 2025, through December 31, 2025, unless that date is later revised to October 1, 2025. HCA is working on an "off-cycle" amendment to the managed care contract to reflect the prohibitions in Section 71113(b)(1).

29. HCA also is in the process of adjusting the calendar year 2026 managed care capitation rates to exclude Planned Parenthood experience from the base data. The period to which the prohibition will apply remains unclear. HCA is excluding experience for the entire calendar year in order to maintain the flexibility to add funding back in as part of a mid-year change if there is clarity on the end date, or continue to exclude it for the entire year and reimburse the Managed Care Organizations (MCOs) outside of rates for the full calendar year. Because this work is occurring outside of the normal rate development cycle, additional actuarial and agency resources have been required.

30. For any payments made by the MCOs that are not eligible for federal match, HCA will reimburse MCOs for paid claims with non-Medicaid state-only funds, with the reimbursement process estimated to begin in January 2026.

31. In light of the confusion surrounding Section 71113(b)(1), HCA also has had to issue guidance to Medicaid providers and clients. There has been significant staff time, resources, and expenses associated with the drafting, reviewing, and issuing this guidance and public-facing communications.

32. In sum, HCA has had to dedicate significant time and resources to interpreting and implementing Section 71113(b)(1), as well as to communicating with providers and stakeholders regarding its decisions.

Impact of defund provision

33. Because Planned Parenthood entities in Washington provide over half of the family planning services in Washington, it would be challenging for other providers to absorb this capacity. It is highly likely that some proportion of patients of Planned Parenthood would be unable to find a provider for family planning services. And for those that could find a provider, wait times for appointments would likely be exceedingly long. Delays in access to family planning and reproductive health services could lead to increased rates of unintended pregnancies, untreated sexually transmitted infections and diseases and delayed screening for cervical cancers. These impacts would not just impact the individual unable to obtain care but in the case of people unable to access care for STIs/STDs, their contacts would be at risk of exposure and further transmission.

34. To avoid these negative outcomes, Washington has agreed to pay both the federal and state share for services provided by Planned Parenthood and covered by Apple Health using state-only funds. We estimate that this will cost the State approximately $11 million per year. While the State has agreed to incur these expenditures to avoid the health impacts outlined above, it comes at the cost of other critical state services and a time of a significant state budget shortfall.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 17, 2025.

CHARISSA FOTINOS, MD, MSc

Exhibit 24

Declaration of Debra Standridge

I, Debra Standridge, declare as follows:

1. I am the Deputy Secretary of the Wisconsin Department of Health Services (WI-DHS). I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the Deputy Secretary, I oversee the work of WI-DHS, including the Division of Medicaid Services, which administers Medicaid for the state of Wisconsin.

3. Federal Medicaid funding comprises a significant percentage of Wisconsin's Medicaid budget. It is one of the largest sources of federal revenue for Wisconsin.

Wisconsin Medicaid program

4. WI-DHS administers Wisconsin Medicaid programs. Wisconsin Medicaid provides comprehensive medical coverage for low-income people and people with disabilities in Wisconsin. To be eligible for Wisconsin Medicaid, residents must meet certain criteria, including both financial criteria, which specifies the maximum income or assets an individual may have to be eligible, and non-financial criteria. In state fiscal year (SFY) 2024, approximately 20 percent of Wisconsin's population was covered by Wisconsin Medicaid.

5. Any person who meets eligibility requirements is entitled to coverage under the Wisconsin Medicaid program. Wisconsin Medicaid covers all required Medicaid services, including family planning services, and most optional Medicaid services. This means family planning services are included in the benefit package available to participants who receive "full benefit" Medicaid. When prescribed by a physician, Wisconsin Medicaid covers the following family planning services: an initial physical exam and health history, annual office visits and follow up visits, laboratory services, contraceptive supplies and devices, counseling services, and medication for specific treatments.

6. In SFY 2024, 36,360 Wisconsinites received family planning or reproductive health care under Wisconsin Medicaid, including Family Planning Only Services, which is

described in greater detail below, and for which providers billed almost 90,000 claims to Wisconsin Medicaid.

7. Most family planning services billed to Wisconsin Medicaid are eligible for a 90 percent federal match rate. This means for those medical exams, procedures, or other services covered by Wisconsin Medicaid, the federal government pays 90 percent, and the state pays the remainder. Health care services that are ineligible for the 90 percent match rate are eligible for Wisconsin's standard federal match rate, which is 60 percent.

8. Federal Medicaid requirements mandate "freedom of choice" of providers for family planning services. While Wisconsin's 13 contracted Medicaid health plans are encouraged to develop Memorandum of Understandings (MOU) with family planning clinics, family planning services are covered fee for service (FFS) when members seek family planning services from providers outside of a Health Maintenance Organization (HMO) network. Wisconsin Medicaid only covers abortion care per the requirements of the Hyde Amendment.

Family-planning Medicaid program

9. Wisconsin also operates a limited-benefit Medicaid program, Family Planning Only Services (FPOS).

10. FPOS is a limited-benefit program that provides routine contraceptive management and related services to low-income individuals who are of reproductive age and who are otherwise not eligible for Wisconsin Medicaid. Services are generally aligned with those family planning services covered for full benefit Wisconsin Medicaid members.

11. In SFY 2024, 9,575 Wisconsinites received family planning or reproductive health care under FPOS for which providers billed over 27,000 claims.

12. The federal match rate for services covered under FPOS is 90 percent. This means for every service provided, federal funds cover 90 percent of the cost and state funds cover 10 percent.

13. All FPOS services are reimbursed FFS by Wisconsin Medicaid.

14. Abortion is not a covered service under FPOS. Therefore, federal funds do not pay for abortion care under FPOS.

Abortion availability and care

15. The right to choose whether, how, and when to terminate or keep a pregnancy is protected in Wisconsin law under Wis. Stat. ch. 253.

Planned Parenthood entities

16. Planned Parenthood of Wisconsin, Inc (PP-W). currently operates 21 health centers throughout Wisconsin where they provide a full range of comprehensive reproductive healthcare and family planning services. Among other things, they provide sexually-transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

17. In SYF 2024, the last year for which data is available, Wisconsin Planned Parenthood health centers billed almost 66,000 claims for care provided to 27,621 unique patients using Wisconsin Medicaid program funding.

18. These Wisconsin Planned Parenthood health centers provide a substantial portion, about 75 percent, of all Wisconsin Medicaid-funded reproductive health care and family planning services. Wisconsin does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating under the Defund Provision.

19. Local health departments in Wisconsin provide family planning services for some Wisconsin Medicaid members living in the rural parts of the state. However, local health departments often have limited capacity, and Planned Parenthood is able to provide an additional access point by offering services via telehealth.

20. Wisconsin Planned Parenthood health centers specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout

Wisconsin as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Wisconsin Medicaid reimbursement for the care they provide.

Wisconsin Actions to Implement the Defund Provision

21. To implement the Defund Provision, WI-DHS would need to update the financial reporting system to appropriately exclude Planned Parenthood claims from federal financial claiming processes. These changes will require significant staff time and resources. Specifically, 200 hours of developer time is required to make the relevant updates to the financial reporting system. Since the federal funding pause is for one year only, these changes will all need to be done to reinstate federal funding with similar impacts to the Wisconsin Medicaid program.

22. To implement the Defund Provision, WI-DHS would need to establish a process to identify if any other entity meets the definition of "prohibited entity" and exclude their claims from federal financial claiming processes. Currently, WI-DHS does not have access to necessary information to determine if an entity is a "prohibited entity" as defined under the Defund Provision.

23. Failure to incorporate the necessary infrastructure changes would result in Wisconsin being at risk of having to return any federal funds used to pay claims submitted by "prohibited entities" defined under the Defund Provision, thereby placing the costs directly onto Wisconsin and reducing federally provided matching Medicaid funds.

24. If the Defund provision is allowed to stand, WI-DHS might have to issue guidance to members notifying them that while Planned Parenthood continues to be a Medicaid-enrolled provider, services provided by Planned Parenthood are not eligible for federal Medicaid reimbursement. This would require WI-DHS administrative resources to draft and publish the guidance; to train the member and provider call centers on the updated guidance; and to ensure that program partners have, understand, and can correctly communicate the guidance.

Impact of defund provision

25. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Wisconsin and Wisconsin's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in Wisconsin if it is excluded from Medicaid. If that occurs, that will compound the impact on Wisconsin's health system and residents.

26. Because capacity does not exist in the health care system in Wisconsin to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. Planned Parenthood is a trusted provider for many Medicaid members who would be forced to terminate established care relationships. If members cannot find another trusted provider, there could be increases in unintended pregnancies, undiagnosed or later diagnosed cancers, and sexually transmissible infections, as members no longer have access to appropriate contraceptive care, Pap tests and colposcopies, and effective STI treatments.

27. To avoid these negative outcomes, either the federal government would need to again fund the Wisconsin Planned Parenthood health centers as they have done for decades, or Wisconsin would need to pay the former federal Medicaid share. Wisconsin has not provided funding sufficient to cover the former federal share of Medicaid for the Wisconsin Planned Parenthood health centers.

28. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and well-being of Wisconsinites, but it will also have a significant impact on Wisconsin's health care system and the state budget. There would be enormous disruption to the patients who rely on Planned Parenthood for reproductive health care, who would have to find a new provider and perhaps travel a greater distance for care. Medicaid is required to provide non-emergency medical transportation (NEMT) for members, so increased member travel would increase NEMT costs

for the program. In addition, Wisconsin would need to provide additional funding to make up the 90 percent of costs that have been funded by the federal government

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on August 15, 2025.



Debra Standridge
Deputy Secretary
Wisconsin Department of Health Services

Exhibit 25

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF SALLY A. KOZAK

I, Sally A. Kozak, declare as follows:

1. I am the State Medicaid Director at the Pennsylvania Department of Human Services. I make this declaration from personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

2. As the State Medicaid Director, I am responsible for overseeing the administration of Pennsylvania's Medicaid program, which includes coverage for reproductive health and family planning services for eligible individuals, funded through state and federal Medicaid dollars. I have held this position for eight years. I have an associate of science degree in nursing from Mount Aloysius College and a master's degree in health care administration from St. Joseph's College. I am a Registered Nurse with experience working in hospitals and community-based settings, and I have professional experience developing population health management programs and quality improvement programs for healthcare.

3. Federal Medicaid funding comprises a significant percentage of Pennsylvania's budget. It is one of the largest sources of federal revenue for Pennsylvania.

Pennsylvania Medical Assistance Program

4. The Medical Assistance (MA) Program is the Commonwealth of Pennsylvania's approved Medicaid program. The MA Program provides comprehensive medical coverage for poor and low-income people in Pennsylvania. To be eligible for MA, residents must meet certain criteria, including resource, income, citizenship and residency requirements. In 2015, Pennsylvania opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. In state fiscal year 2024-25, approximately twenty-three percent of the Commonwealth's population was covered under the MA Program.

5. Any person who meets eligibility requirements is entitled to coverage under the MA Program. Covered services generally include inpatient, outpatient, primary care, pharmaceuticals, home health, dental and behavioral health services. The services that the MA Program covers, and receives federal funding to provide, also include family planning and

reproductive health care services. These services, which are provided to men and women, include office visits, pregnancy counseling, pharmaceuticals and supplies, testing and treatment for sexually transmitted infections, genetic counseling and testing.

6. Most family planning services billed to Medicaid are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services for those covered by Pennsylvania's MA Program, the federal government pays 90% and the state pays the remainder. Some reproductive healthcare services are not eligible for the 90% match rate, such as sexually-transmitted infection testing and treatment. Those services are eligible for a federal match rate of 55.09%.

7. Care under Pennsylvania's MA Program is provided under a fee-for-service or capitated managed care delivery system. Most MA Program beneficiaries receive services, including sexual and reproductive health care services, through a managed care plan under Pennsylvania's statewide mandatory managed care program. Sexual and reproductive health care services, including family planning services, are available both in- and out-of-network. Planned Parenthood facilities are a significant provider of sexual and reproductive health care services to Pennsylvanians through MA.

8. Pennsylvania's MA Program provides for abortion services consistent with federal and state law. Federal funds are claimed for abortion services when an abortion is necessary to avert the death of the pregnant woman or when the abortion is performed in the case of a pregnancy caused by rape or incest.

Pennsylvania Family Planning Services Program

9. Pennsylvania operates the Family Planning Services program, or FPS, within the Medicaid program. FPS covers family planning services for those who are not insured and not eligible for any other category of coverage under Pennsylvania's MA Program. FPS is provided through the state plan family planning option afforded by Section 2303 of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

10. FPS provides coverage of family planning and certain family planning-related services, pharmaceuticals and supplies at no cost to Pennsylvanians of reproductive age who are not otherwise eligible for any other category in the MA Program and have income at or below 215% of the Federal Poverty Limit and who are not pregnant. Family planning-related services are medical diagnosis and treatment services provided in a family planning setting as part of, or as follow-up to, a family planning visit and includes services for the prevention and treatment of sexually transmitted diseases. FPS is designed to assist individuals who have a medical necessity for family planning services, so that they can establish the timing, number, and spacing of their children, and maintain optimal reproductive health. The federal match rate for services covered under FPS is 90%. This means for every service provided, federal funds cover 90% of the cost and state funds cover 10%.

11. FPS services are rendered in the fee-for-service delivery system by enrolled providers. Planned Parenthood facilities are a significant provider of services to Pennsylvanians as part of the FPS program.

12. Abortion services are covered under FPS consistent with federal and state law. Federal funds are claimed for abortion services when an abortion is necessary to avert the death of the pregnant woman or when the abortion is performed in the case of a pregnancy caused by rape or incest.

Abortion availability and care

13. The right to choose whether to terminate or keep a pregnancy is protected and governed by state law in Pennsylvania. 18 Pa.C.S. §§ 3201-3220.

Planned Parenthood entities

14. Planned Parenthood Southeastern Pennsylvania, Planned Parenthood of Western Pennsylvania, and Planned Parenthood Keystone serve the Commonwealth of Pennsylvania. Among them, these Planned Parenthood entities currently operate 22 health centers in Pennsylvania.

15. Planned Parenthood Southeastern Pennsylvania, Planned Parenthood of Western Pennsylvania, and Planned Parenthood Keystone provide high-quality comprehensive reproductive healthcare and family planning services in Pennsylvania. They provide the full range of reproductive healthcare in Pennsylvania. Among other things, they provide sexually-transmitted infection testing and treatment, contraception procedures, counseling, and management, cancer screening and prevention services and procedures, pregnancy tests and counseling, prenatal care, and abortion care. For many women, family planning and reproductive health care is the primary health care they regularly receive.

16. These Planned Parenthood health centers in Pennsylvania provide a substantial portion of all Medicaid-funded reproductive health care and family planning services. Pennsylvania does not have Medicaid providers who can absorb the patients that Planned Parenthood will no longer be compensated for treating under the One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 1 (2025). Capacity does not exist to provide the care that Planned Parenthood health centers currently provide.

17. Capacity to provide the vital reproductive healthcare services is especially limited in rural and underserved areas, which is where some of Planned Parenthood's health centers are located in Pennsylvania. Healthcare services are already limited in many of these areas and, as a result, Planned Parenthood health centers provide especially vital needed care.

18. Planned Parenthood health centers in Pennsylvania provide high-quality competent care. They specialize in reproductive healthcare and family planning and, for that reason, are well known and respected throughout Pennsylvania as providers. I am not aware of any legitimate basis for excluding Planned Parenthood from Medicaid reimbursement for the care they provide.

Pennsylvania Actions to Implement the Defund Provision

19. To implement the Defund Provision, Pennsylvania's Department of Human Services (DHS) has already had discussions regarding policy, systems, and programmatic

changes that would be necessary, to include exclusion of these providers from the MA program and managed care organization networks, as well as systems edits needed to block payments to these entities. These changes require staff time and resources. To date, DHS staff have dedicated approximately 75 hours of staff time.

20. Failure to incorporate the necessary infrastructure changes would result in Pennsylvania being at risk of having to return any federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby placing the costs directly onto Pennsylvania and reducing federally provided matching Medicaid funds.

21. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision actually takes effect, DHS has already faced inquiries from potentially affected entities, which will also take staff time and resources. Medicaid managed care plans have requested direction about how to handle credentialing and payment of claims by Planned Parenthood providers, and Planned Parenthood leadership has been in close communication with DHS to analyze and attempt to mitigate impact.

Impact of defund provision

22. If Planned Parenthood is excluded from federal Medicaid reimbursement, the impact on Pennsylvania and Pennsylvania's residents would be profound. I am concerned that Planned Parenthood may need to close health centers in Pennsylvania if it is excluded from Medicaid. If that occurs, that will compound the impact on Pennsylvania's health system and residents.

23. Because capacity does not exist in the health care system in Pennsylvania to compensate for the loss of Planned Parenthood as a Medicaid provider, it is inevitable that some proportion of patients of Planned Parenthood will be unable to find a provider for reproductive healthcare and family planning services. The result is likely to be an increase in unplanned pregnancies, shortened spacing between pregnancies leading to poor outcomes for both parent

and baby, and lack of treatment and spread of sexually transmitted infections. This result is expected because they rely on Planned Parenthood for their reproductive care.

24. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health centers in Pennsylvania as they have done for decades, or the Commonwealth of Pennsylvania would need to pay the former federal share of that healthcare. The legislature of the Commonwealth of Pennsylvania has not provided funding sufficient to cover the former federal share of Medicaid for the Planned Parenthood health centers in Pennsylvania.

25. The exclusion of Planned Parenthood health centers from Medicaid reimbursement will not only have a negative consequence on the health and wellbeing of residents of Pennsylvania, but it will also have a significant impact on the Commonwealth's entire health care system and the state budget as a result of increased births and care necessary to treat poor birth outcomes and the spread of sexually transmitted infections.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 24, 2025.



Sally A. Kozak

Exhibit 26

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, STATE OF NEW YORK; STATE OF CONNECTICUT; STATE OF COLORADO; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW JERSEY; STATE OF NEW MEXICO; STATE OF NORTH CAROLINA; STATE OF OREGON; JOSH SHAPIRO, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF WASHINGTON; STATE OF WISCONSIN,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of the U.S. Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; DR. MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No. 1:25-cv-12118-IT

DECLARATION OF MELISA BYRD

I, Melisa Byrd, declare as follows:

1. I am a resident of the District of Columbia. I am over the age of 18 and understand the obligations of an oath.

2. I currently serve as the Senior Deputy Director and Medicaid Director at the District of Columbia Department of Health Care Finance ("DHCF"). I have held this position since October 2018. I make this declaration based on personal knowledge and the records of the agency that are kept in the regular course of its business. I would testify to the following if called as a witness.

3. As the Senior Deputy Director and Medicaid Director, I am responsible for the overall administration of the District of Columbia's Medicaid program, including covered benefits, eligibility and enrollment, and maintaining compliance with federal and local regulations and requirements. Family planning services are federally designated as mandatory services and the District's Medicaid program administers family services accordingly.

4. Federal Medicaid funding comprises a significant percentage of the District's budget. It is one of the largest sources of federal revenue for the District. The District's Medicaid program is known as DC Medicaid.

5. DHCF is the Single State Agency responsible for the administration of the Medicaid program for the District. DC Medicaid provides comprehensive medical coverage for District residents with disabilities and or low-income. To be eligible for DC Medicaid, residents must meet certain criteria, including residency and income requirements. In 2011, the District opted in to Affordable Care Act expanded Medicaid coverage, which expanded the eligible population. As of July 2025, approximately 273,000 District residents were enrolled in DC Medicaid – representing 39 percent of District's population.

6. Any person who meets eligibility requirements is entitled to coverage under DC Medicaid. The services DC Medicaid covers, and receives federal funding to provide, also include family planning and reproductive health care services. These services include contraceptive care, gynecological exams, cancer screenings, vaccinations, and STI/STD testing.

7. Most Medicaid family planning services are eligible for a 90% federal match rate. This means that for those medical exams, procedures, or other services covered by DC Medicaid,

the federal government pays 90% and the state pays the remainder. Other related services are not eligible for the 90% match rate. Instead, those services are eligible for a federal match rate of 70%.

8. Care under DC Medicaid is provided under both managed care and fee for service delivery systems, with most Medicaid beneficiaries enrolled in the managed care system. In fee for service, providers complete a provider screening and enrollment process to become a Medicaid provider. In managed care, providers complete a credentialing process and enter a contract to be in a managed care plan's provider network. Medicaid beneficiaries – in fee for service or managed care, are entitled to their choice of available providers.

9. DC Medicaid reimburses for abortion in accordance with the Hyde Amendment, which means that reimbursement is only allowable when the pregnancy will endanger the woman's life or when the pregnancy results from rape or incest. Federal funds do not pay for abortion care under DC Medicaid, except in accordance with the Hyde Amendment. A prior authorization is required for a Medicaid-funded abortion, including verification of pregnancy, verification of length of gestational period; clinical justification; and a police report for cases of rape or incest.

10. I am familiar with Section 71113, also known as the Defund Provision, of the congressional budget reconciliation bill enacted on July 4, 2025. Pub. L. No. 119-21, § 71113, 139 Stat. 300 (2025).

11. To implement the Defund Provision, the DHCF has already had to familiarize itself with Section 71113 and actively monitors judicial actions to ensure DC Medicaid remains compliant with federal law. Staff time and resources have been used to monitor the activity related to 71113, develop guidance for reimbursement, and determine how to implement the provision. This includes meeting with relevant staff, vendors (e.g. managed care plans), and potentially affected providers.

12. Failure to incorporate the necessary infrastructure changes would result in the District being at risk of having to return all federal funds used to pay claims submitted by entities defined under the Defund Provision, thereby placing the costs directly onto the District.

13. Due to the ambiguity regarding the entities that qualify as Prohibited Entities and the timing of when the Defund Provision actually takes effect, DHCF has already faced inquiries from potentially affected entities regarding how the Defund Provision will impact their ability to submit claims for reimbursement, which has taken staff time and resources.

14. Planned Parenthood of Metropolitan Washington, D.C. ("PPMW") operates three health centers, one in the District and two in Maryland. PPMW provides high-quality comprehensive reproductive healthcare and family planning services in the District. To date, in state fiscal year 2025, PPMW provided reproductive health services for approximately 2,000 District residents using DC Medicaid funding and received over $575,000 in Medicaid reimbursements.

15. If Planned Parenthood members, including PPMW, are excluded from federal Medicaid reimbursement, the impact on the District and its residents would be profound. I am concerned that PPMW may need to stop providing Medicaid-funded services or even close its D.C. health center if it is excluded from Medicaid. If that occurs, that will limit access to health care services and compound the impact on the District's health system and residents.

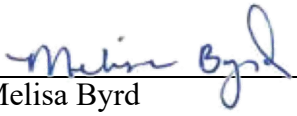
16. If PPMW must stop providing Medicaid-funded services, DC residents who are covered under DC Medicaid will have to look elsewhere for primary care, family planning and reproductive health care treatment.

17. Ensuring continuity of care will be at risk if patients of Planned Parenthood no longer have access to their preferred provider. Continuity of care can be at risk simply because it takes time and effort to identify a new provider and schedule appointments. Delay in care or not seeking preventive care at all can result in worsening health conditions that may later require more expensive and/or emergency treatment.

18. To avoid these negative outcomes, either the federal government would need to again fund the Planned Parenthood health center in the District as they have done for decades, or the District would need to pay the former federal share of that healthcare. Under the current budget, the District does not have sufficient funding to cover the former federal share of Medicaid for PPMW or any other entities that may be considered "prohibited entities" under the Defund Provision.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 24, 2025.



Melisa Byrd