

No. 25-1829

IN THE
United States Court of Appeals for the First Circuit

THE FAMILY PLANNING ASSOCIATION OF MAINE,
D/B/A MAINE FAMILY PLANNING,

Plaintiff-Appellant

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health & Human Services; CENTERS FOR MEDICARE & MEDICAID SERVICES; MEHMET OZ, in his official capacity as the Administrator of the Centers for Medicare & Medicaid Services;
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Maine

No. 1:25-cv-00364-LEW, Hon. Lance E. Walker

OPENING BRIEF OF PLAINTIFF-APPELLANT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, Plaintiff-Appellant The Family Planning Association of Maine, d/b/a Maine Family Planning, hereby states it has no parent corporation, and there is no publicly held corporation that owns 10% or more of its stock.

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REASONS WHY ORAL ARGUMENT SHOULD BE HEARD

Plaintiff-Appellant respectfully requests that the Court schedule oral argument in this matter. Oral argument will aid the Court in the resolution of this case by ensuring counsel are available to address any questions that the Court may have regarding the legal arguments advanced by the parties.

INTRODUCTION

Appellant Maine Family Planning (“MFP”) delivers award-winning, essential health care—including cancer screenings, gynecological exams, and the diagnosis and treatment of common acute and chronic conditions—to thousands of Mainers every year. MFP is devoted to ensuring that patients from underserved areas and populations can access health services, and nearly half of MFP’s patients who receive services other than abortion care rely on Medicaid to pay for their health care. Yet because MFP provides abortion care among its many medical services and satisfies other arbitrary criteria that Congress designed to target a group it disfavors, Congress has prohibited MFP from receiving reimbursements of federal Medicaid dollars—even though federal Medicaid funding already does not cover the cost of abortions outside of extremely limited exceptions—for care provided through its primary care and family planning practices.

That deprivation of funding comes as a result of Section 71113 of the “One Big Beautiful Bill Act,” Pub. L. No. 119-21, 139 Stat. 72, 300-01 (July 4, 2025) (“the Defunding Provision”), which Congress enacted with the goal of defunding Planned Parenthood—and including at least one other provider so that it could do so consistent with Senate procedural rules. Although Defendants argued before the district court that Congress intended to target a group it calls “Big Abortion,” nothing in the Defunding Provision is designed to capture entities that provide the greatest

number of abortions nationwide. Indeed, abortion care constitutes a small portion of the total care provided at MFP clinics, and some entities affected by the Defunding Provision do not provide abortions at all. Such irrational line-drawing violates the Fifth Amendment's guarantee of equal protection and inflicts irreparable and devastating harm on MFP and the thousands of patients who receive critical family planning, reproductive health, and primary care services at MFP each year.

The Defunding Provision's effects are as grave as they are unjustified. MFP is the only health care provider many of its patients see in a given year, and many MFP patients live in rural, medically underserved areas of the state where there are few other Medicaid providers. But without Medicaid reimbursements, MFP will be forced to close its primary care practice by October 31. Due to a shortage of Medicaid providers in Maine, these patients will likely struggle to receive preventive care and treatment for chronic conditions like diabetes and asthma in a timely manner, with potentially devastating health consequences. While MFP continues to see family planning patients, it anticipates having to reduce family planning services as well without the ability to bill Medicaid.

The district court denied MFP's motion for a preliminary injunction, concluding that MFP failed to "make a strong showing that its equal protection challenge . . . has merit." Addendum ("A") 22, Order on Mot. For Prelim. Inj. 19, ECF No. 31 ("Op."). In doing so, the court failed to offer any persuasive reasoning

as to why the Defunding Provision’s draconian consequences—which the court acknowledged were “weighty” and likely “not fully redressable once realized,” A19–20 (Op. 16–17)—should be imposed on MFP. Because the likelihood of success on the merits, significant irreparable harm, and the balance of the equities all weigh in favor of granting a preliminary injunction, the district court should be reversed.

JURISDICTIONAL STATEMENT

MFP invoked the district court’s jurisdiction under 28 U.S.C. § 1331. *See* Joint Appendix (“JA”) 12. The district court denied MFP’s motion for a preliminary injunction on August 25, 2025, JA6, and MFP timely appealed on August 29, 2025, JA67. This Court has jurisdiction under 28 U.S.C. § 1292(a)(1).

STATEMENT OF ISSUES

1. Whether the Defunding Provision violates the Equal Protection Clause as incorporated into the Fifth Amendment because it discriminates against certain health care providers without serving a legitimate government interest, and because Defendants provide no reasonable justification for this disparate treatment of MFP.

2. Whether the district court abused its discretion in denying MFP’s request for a preliminary injunction of the Defunding Provision where MFP is suffering and will continue to suffer irreparable harm without relief and where the balance of equities and the public interest weigh in favor of granting a preliminary injunction.

STATEMENT OF CASE

A. Maine Family Planning

MFP is a 501(c)(3) nonprofit organization whose mission is “to ensure that all people have access to high-quality, culturally relevant and affordable sexual and reproductive health care services.” Decl. of Evelyn Kieltyka in Supp. Pl.’s Mot. for a TRO and/or Prelim. Inj. ¶ 6, JA41 (“Kieltyka Decl.”). MFP operates eighteen clinics spanning twelve counties, including some of the most rural counties in the state. JA41–43 (*Id.* ¶¶ 8, 10). MFP also launched a mobile health care facility in 2024 to provide urgent primary care, wound care, and sexual and reproductive health services to underserved populations who may not otherwise be able to access such care. JA47 (*Id.* ¶ 20)

Medicaid is essential to MFP. Approximately 20 to 25 percent of MFP’s annual budget—roughly \$1.9 million dollars—comes from Medicaid reimbursements. JA49 (*Id.* ¶ 24). Specifically, between July 1, 2022 and June 30, 2023, 22.7 percent of MFP’s budget came from Medicaid. *Id.* In federal fiscal year 2023, MFP received more than \$800,000 from Medicaid reimbursements. *Id.* MFP does not use or receive any federal funds, whether from Medicaid or Title X, to pay for abortion care outside of the limited exceptions permitted under the Hyde Amendment. JA49 (*Id.* ¶ 25).

MFP serves thousands of Mainers every year. In 2024, MFP served 8,735 patients, including 645 abortion patients, 633 primary care patients, and 7,215 family planning patients. JA43–44 (*Id.* ¶ 11). Two MFP clinics are listed as essential community providers in the family planning category on the HHS Rolling Draft Essential Community Provider List for the Federally-facilitated Marketplace. JA42–43 (*Id.* ¶ 10). By definition, essential community providers serve “predominantly low-income, medically underserved individuals.” 45 C.F.R. § 156.235(c).

MFP has accepted Medicaid since 1998. JA48–49 (Kieltyka Decl. ¶ 23). MFP clinics serve Maine counties with some of the highest rates of Medicaid enrollment, including Aroostook, Washington, and Somerset Counties, where approximately 40 percent of the population relies on Medicaid. JA51 (*Id.* ¶ 30). Between July 1, 2022 and June 30, 2023, 41 percent of MFP’s 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 qualified for free or reduced services. *Id.* In calendar year 2024, nearly 50 percent of MFP’s patients who received care other than abortion were on Medicaid. *Id.*

The Medicaid-covered services that MFP provides include primary care, annual wellness exams, routine gynecologic exams, screenings for cervical and breast cancer, STI testing, and contraceptive care. JA41, JA46–47, JA51 (*Id.* ¶¶ 7, 18, 20, 31). For many patients on Medicaid, MFP is the only provider where they

can practically obtain care because they live in rural, underserved areas; have challenges identifying another provider who will accept Medicaid; or have difficulty traveling to brick and mortar clinics. JA47, JA50, JA52 (*Id.* ¶¶ 20, 27, 34). Without Medicaid, these patients would not be able to afford or access care. JA50–51 (*Id.* ¶¶ 27, 30); Decl. of Cassidy Jarvis in Supp. Pl.’s Mot. for a TRO and/or Prelim. Inj. ¶ 5–6 (JA36–37) (“Jarvis Decl.”).

Specifically, for thousands of Mainers, MFP is the only comprehensive family planning and reproductive health care provider accessible to them. *See* JA42–44, JA47, JA51–52 (Kieltyka Decl. ¶¶ 10–13, 19–20, 32, 34). Additionally, MFP’s family planning network subcontracts with forty-four sites that likewise provide family planning and reproductive health care. JA43–44 (*Id.* ¶ 11). Outside of these subgrantees and MFP, family planning services in Maine are generally only available through private gynecologists, non-specialists, Federally Qualified Health Centers (“FQHCs”), MaineHealth Maine Medical Center, and an independent health center, Mabel Wadsworth Center (“Mabel’s”). JA44 (*Id.* ¶ 12). Recent closures of hospital labor and delivery units and the accompanying loss of providers have exacerbated this existing provider shortage. JA46 (*Id.* ¶ 17). Moreover, many patients prefer to be seen at MFP because MFP specializes in family planning and reproductive health care, and patients trust MFP to provide sensitive care in a nonjudgmental and confidential manner. JA52 (*Id.* ¶ 33); JA35–36 (Jarvis Decl. ¶ 3).

MFP has also served Medicaid patients through its primary care practice. MFP's primary care services include wellness and preventive care; diagnosis and treatment of common acute and chronic conditions like diabetes, strep throat, or asthma; and geriatric health services. JA46–47 (Kieltyka Decl. ¶ 18). MFP started offering primary care at one clinic in 2015 and expanded primary care to two other clinics in 2022 in response to a growing need for primary care providers in certain areas of the state. *Id.*; JA64 (Kieltyka Supp. Decl. ¶ 7). Due to provider shortages, patients in those regions were facing long wait times to access care. JA46–47 (Kieltyka Decl. ¶ 18); JA64 (Kieltyka Supp. Decl. ¶ 7). MFP modeled its primary care practice specifically to serve Medicaid patients. JA46–47 (Kieltyka Decl. ¶ 18); JA64 (Kieltyka Supp. Decl. ¶ 7).

B. The Defunding Provision

Congress established Medicaid in 1965 to provide federal financial assistance to states for the provision of health care to individuals and families, *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985), “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence and self-care.” 42 U.S.C. § 1396-1. Prior to the Defunding Provision, Congress had restricted federal Medicaid funds from paying for abortion care outside of extremely limited exceptions, Pub. L. No. 94-439, § 209 (initial version

of Hyde Amendment), but had not excluded particular providers based on their offering any health care services outside of the Medicaid program.

Yet, for years, Congress had tried to exclude Planned Parenthood specifically from the Medicaid program. During a previous attempt to defund Planned Parenthood using the budget reconciliation process, Congress sought to bar Medicaid reimbursement for “prohibited entit[ies]” that met criteria substantively identical to the Defunding Provision, but with a threshold of \$350,000,000 in Medicaid payments.¹ This attempt failed when the Senate Parliamentarian determined that “prohibit[ing] *only* Planned Parenthood from receiving Medicaid funds for one year” violated the Byrd Rule, a procedural rule that prevents inclusion of “extraneous” non-budgetary provisions in budget reconciliation legislation and therefore requires 60 votes to pass (rather than the ordinary 51 votes for budget reconciliation legislation).²

¹ American Health Care Act of 2017, H.R. 1628, 115th Cong. § 103 (2017).

² Comm. on the Budget, 115th Cong., Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff (2017); Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong., § 123 (2017) (July 20, 2017 discussion draft); Bill Heniff Jr., Cong. Rsch. Serv., RL30862, The Budget Reconciliation Process: The Senate’s “Byrd Rule” 3–5 (2022). Anti-abortion senators responded by reducing the threshold for “prohibited entities” from \$350 million to \$1 million. S. Amend. 267 to H.R. 1628, 115th Cong. § 106 (2017). The Parliamentarian allowed the bill to proceed with the \$1 million threshold, though the bill ultimately failed to pass. *Id.*

As enacted on July 4, 2025, the Defunding Provision provides that “[n]o federal funds that are considered direct spending and provided to carry out a State plan under [Medicaid] 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” Pub. L. No. 119-21, H.R. 1, 119th Cong., § 71113(a) (2025). A “prohibited entity” is defined as any entity that meets the following criteria as of “the first day of the first quarter beginning after the date of enactment”:

- (1) is organized as a 501(c)(3) and exempt from tax under 501(a) of the Internal Revenue Code of 1986;
- (2) is an essential community provider under 45 C.F.R. § 156.235 and “primarily engaged in family planning services, reproductive health, and related medical care”;
- (3) provides abortions for reasons other than to terminate pregnancies caused by rape or incest or where the patient is at risk of death without an abortion; and
- (4) received more than \$800,000 in federal and state expenditures under Medicaid in fiscal year 2023. *Id.*

MFP falls within the Defunding Provision’s criteria for prohibited entities. JA44, JA53 (Kieltyka Decl. ¶¶ 13, 36). As such, MFP has stopped billing Medicaid for covered services. JA49 (*Id.* ¶ 24); JA36–37 (Jarvis Decl. ¶ 5). The Defunding Provision does *not* prohibit family planning providers that are similarly situated to MFP from receiving federal Medicaid dollars. For example, at least three other

providers in Maine are not impacted, even though they provide similar family planning and primary care services and serve similar patient populations as MFP. JA44–46 (Kieltyka Decl. ¶¶ 14–16). The Defunding Provision will also not save taxpayers any money. To the contrary, the Congressional Budget Office estimates that the Defunding Provision will cost taxpayers \$52 million over the next 10 years, and an additional \$1 million was appropriated for implementation costs in fiscal year 2026 alone.³

C. The Defunding Provision’s Devastating Impact

MFP cannot continue serving its Medicaid patients if it cannot bill Medicaid. In particular, MFP cannot sustain its primary care practice without Medicaid reimbursements. JA64–65 (Kieltyka Supp. Decl. ¶ 8). MFP stopped accepting new Medicaid patients seeking primary care when the law took effect. JA48 (Kieltyka Decl. ¶ 22); JA36 (Jarvis Decl. ¶ 4). MFP has determined that without Medicaid reimbursements, it must close its primary care practice entirely on October 31, 2025. JA48 (Kieltyka Decl. ¶ 22). MFP also has to lay off two primary care providers; without these providers, MFP will likely not be able to reopen its primary care

³ Cong. Budget Off., *Estimated Budgetary Effects of an Amendment in the Nature of a Substitute to H.R. 1, the One Big Beautiful Bill Act* (2025) (“Title VII” tab, Section 71115 “Federal Payments to Prohibited Entities”); Pub. L. No. 119-21, H.R. 1, 119th Cong., § 71113(c) (2025).

practice in the future when Medicaid reimbursements are restored. JA65 (Kieltyka Supp. Decl. ¶ 9).

Many of MFP's Medicaid patients, and the new Medicaid patients that MFP has had to turn away, may be unable to find a new provider due to far distances, high costs, and Maine's existing shortage of providers—particularly providers who are willing to accept additional Medicaid patients into their practice. JA50, JA52–53 (Kieltyka Decl. ¶¶ 27, 34–35); JA36–37 (Jarvis Decl. ¶¶ 4–5). In many of the rural locations where MFP has clinics, there are limited other health care providers, and none that specialize in family planning care. JA52 (Kieltyka Decl. ¶ 34). In fact, as many as 70 percent of MFP's patients do not see any health care provider besides MFP in a given year. JA47 (*Id.* ¶ 19). The most medically underserved areas are also the areas where the most patients are on Medicaid. JA42–43, JA51 (*Id.* ¶¶ 9–10, 30). Similarly, most of the patients seen by MFP's mobile health care facility are Medicaid-enrolled and would not be able to access care without the mobile clinic. JA52 (*Id.* ¶ 34). Even patients who may be able to access care elsewhere could be forced to travel long distances and face months-long wait times due to the already overstretched health care system in Maine, which may lead some to forgo care entirely. JA52–53 (*Id.* ¶ 35). These additional hardships will fall on patients who, by definition, already face significant hurdles in accessing care based on their demographics. JA52 (*Id.* ¶ 34).

Knowing that clinics may close is already causing fear and uncertainty for MFP staff, who do not know whether they will still have jobs. JA37 (Jarvis Decl. ¶ 7). Medicaid patients who rely on MFP for reproductive health care, such as birth control, are scared and confused about what the Defunding Provision means for their care, including patients who already travel significant distances to receive care at MFP's rural clinics. JA36–37 (Jarvis Decl. ¶ 5). While MFP is able to continue serving low-income family planning patients for now through the Title X family planning program, without Medicaid, it will likely soon have to reduce care to these patients as well. JA64–65 (Kieltyka Supp. Decl. ¶ 8). MFP's family planning patients will then find themselves forced to make potentially life-changing decisions about, for example, whether they can afford to pay \$25 per month out of pocket for birth control and still pay for other necessities like heating or electricity, or risk experiencing an unplanned pregnancy. JA36–37 (Jarvis Decl. ¶ 5).

D. Prior Proceedings

MFP filed a Complaint for declaratory and injunctive relief on July 16, 2025. JA8–33. MFP asserts that the Defunding Provision violates the Fifth Amendment's equal protection guarantee. MFP also filed a motion for a preliminary injunction on July 16, 2025. *See* JA4. The district court held a hearing on the motion and requested supplemental briefing before ultimately denying the motion, despite noting that the

effects were “weighty” and “not fully redressable,” because it found that MFP had not shown a likelihood of success on the merits. A19–20 (Op. 16–17).

The district court improperly mischaracterized MFP’s legal argument as a policy dispute and stated that it could not weigh in to “which policy outcomes it prefers.” A12 (*Id.* at 9). The court also hypothesized that Congress could have been motivated by “a rational desire to withhold a Medicaid subsidy from the primary providers of non-qualifying abortions,” crediting Defendants’ atextual claim that the Defunding Provision was designed to target entities that provide more abortions. A14 (*Id.* at 11).

On August 29, 2025, MFP filed a notice of appeal and moved for an injunction pending appeal. *See* JA67–68, JA7. The district court denied the motion. JA69–76, (Order on Emergency Mot. For Prelim. Inj. Pending Appeal, ECF No. 38). MFP moved for an injunction pending appeal before this Court on September 17, 2025, which this Court denied on October 16, 2025.

SUMMARY OF ARGUMENT

This Court should reverse the district court’s denial of the preliminary injunction. The Defunding Provision is unconstitutional as applied to MFP because it prohibits MFP, but not other similarly situated providers, from billing Medicaid for covered health care, without rationally advancing a legitimate government interest. Instead, its gerrymandered criteria target only a tiny subset of abortion

providers out of “a bare congressional desire to harm a politically unpopular group.” *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 534 (1973). MFP has been irreparably harmed and will continue to experience further harm if Medicaid billing is not restored.

1. MFP will succeed on the merits of its claim that the Defunding Provision violates the Fifth Amendment’s guarantee of equal protection. The Defunding Provision does not treat like health care providers alike. It does not even treat like health care providers that provide abortions alike. Instead, the gerrymandered criteria identifying “prohibited entities” are not rationally related to a legitimate government interest, including to any interest that the government may have in reducing the net number of abortions or in reducing government funding for abortion.

That disparate treatment is not a bug, but a feature. As the provision’s conjunctive criteria and enactment history makes clear, the Defunding Provision is the culmination of congressional efforts to defund Planned Parenthood. But Congress may not draw such distinctions solely out of a desire to harm a select group of entities that provide abortion.

2. The Defunding Provision has caused and will continue to cause MFP irreparable harm. MFP is ending its primary care practice, laying off providers, and discharging patients from its care on October 31 because of the Defunding Provision.

Without relief from this Court, MFP anticipates having to likewise cut or reduce services to family planning patients after its Title X grant funding runs out. This sort of forced contraction in services is precisely the type of harm to an organization that courts have recognized as irreparable.

3. An injunction is in the public interest, and the balance of equities weighs in favor of granting an injunction. First, an injunction will impose no harm on Defendants, who will not be required to either cover services or expend funding that they would not otherwise have been willing to cover or spend. Additionally, an injunction restoring Medicaid billing for MFP does not interfere with any of Congress's powers to effectuate legislation because the Defunding Provision does not decrease or increase funding for Medicaid programs or change the scope of services that Medicaid covers. Finally, the public interest factor favors injunctive relief, as preserving access to health care for low-income patients is in the public interest.

STANDARD OF REVIEW

Courts grant preliminary injunctive relief where the plaintiff shows that (1) it “is likely to succeed on the merits” of its claim, (2) it “is likely to suffer irreparable harm in the absence of preliminary relief,” (3) “the balance of equities tips in [the plaintiff’s] favor,” and (4) “an injunction is in the public interest.” *Starbucks Corp. v. McKinney*, 602 U.S. 339, 346 (2024). This Court reviews the district court’s

decision to grant or deny a preliminary injunction for abuse of discretion. *Pineda v. Skinner Servs., Inc.*, 22 F.4th 47, 52 (1st Cir. 2021). “Within that framework, however, findings of fact are reviewed for clear error and issues of law are reviewed de novo.” *Id.* at 53 (citation omitted). Where the district court’s likelihood of success on the merits analysis “is made in error, the district court has abused its discretion and [this Court is] required to vacate” the lower court’s ruling. *Doe v. Trustees of Bos. Coll.*, 942 F.3d 527, 533 (1st Cir. 2019).

ARGUMENT

I. MFP Is Likely to Succeed in Showing that the Defunding Provision Violates Equal Protection

The Defunding Provision fails to serve a legitimate government interest and advances no purpose other than targeting Planned Parenthood. The statute accomplishes this goal by defunding “prohibited entities” that meet certain specific criteria which, though individually arbitrary, conjunctively “substantiate Congress’s intent to punish Planned Parenthood,” *Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, No. 1:25-CV-11913-IT, 2025 WL 2101940, at *20 (D. Mass. July 28, 2025).

The district court chose not to grapple with the provision’s animus toward Planned Parenthood and instead credited Defendants’ unsupported claim that Congress meant to target an amorphous group of providers that Defendants call “Big Abortion,” which supposedly consists of the entities that have been defunded. As a

district court in this Circuit found, the label “Big Abortion” appears to be merely a stand-in for “Planned Parenthood.” *See id.* at *11 (describing congressional statements expressing desire to defund “Big Abortion” as evidence of animus toward Planned Parenthood). But even if “Big Abortion” referred to a broader group of providers who Congress had intended to target, Congress would still need some rational basis for treating those defunded entities differently from other similarly situated providers. No such basis exists.

The lack of any cogent rationale for these classifications is no coincidence: Congress avowedly drafted the Defunding Provision with the “bare congressional desire” to target only some providers rather than to advance any legitimate government interest. *Moreno*, 413 U.S. at 534. As a result, MFP is likely to succeed in showing that the Defunding Provision is unconstitutional as applied to MFP.

A. The Defunding Provision Was Motivated by Unconstitutional Animus.

Individuals and incidents are similarly situated where a “prudent person, looking objectively at the incidents, would think them roughly equivalent and the protagonists similarly situated . . . Exact correlation is neither likely nor necessary . . .” *Barrington Cove Ltd. P’ship v. R.I. Hous. & Mortg. Fin. Corp.*, 246 F.3d 1, 8 (1st Cir. 2001) (citation modified). When government classifications treat similarly situated entities differently, equal protection requires that the legislative classification “bear[] a rational relation to some legitimate end.” *Romer v. Evans*,

517 U.S. 620, 631 (1996). This is so even where the classifications do not target constitutionally protected classes, *see F.C.C. v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993), and even where the classifications relate to federal benefits that Congress may, at its discretion, choose to fund or not, *see Moreno*, 413 U.S. at 529 (invalidating classification for those qualifying for food stamps program). Importantly, the “bare congressional desire to harm a politically unpopular group” is not a legitimate end. *Id.* at 534; *see also United States v. Windsor*, 570 U.S. 744, 770 (2013) (holding that classifications enacted solely to treat the classified individuals differently do not serve a legitimate government interest).

1. Here, the Defunding Provision’s goal was to defund Planned Parenthood specifically because of Congress’s “desire to harm” Planned Parenthood providers, “a politically unpopular group.” *Moreno*, 413 U.S. at 534. The legislative history is instructive here. *See Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252 (1977) (looking to evidence like “legislative or administrative history . . . , especially . . . contemporary statements by members of the decisionmaking body, minutes of its meetings, or reports” to determine motivation behind law in equal protection challenge).

“Over the last several legislative sessions,” Congress has tried to exclude Planned Parenthood specifically from the Medicaid program. *Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, 2025 WL 2101940, at *9 (compiling statements of

representatives and describing this legislative effort). Every single one of these legislative efforts has centered on defunding Planned Parenthood specifically, rather than reproductive health care providers or even health care providers that also provide abortions more generally. *See id.*; Planned Parenthood Act of 2023, H.R. 128, 118th Cong. (2023) (seeking to defund Planned Parenthood while continuing to fund other community health center programs, including those that provide abortions); Defund Planned Parenthood Act of 2023, H.R. 371, 118th Cong. (2023) (same); Defund Planned Parenthood Act of 2025, H.R. 271, 119th Cong. (2025) (same); Defund Planned Parenthood Act, S. 203, 119th Cong. (2025) (proposing simply that “[n]otwithstanding any other provision of law, no Federal funds may be made available to Planned Parenthood Federation of America, or to any of its affiliates.”).

The Defunding Provision is the culmination of these efforts by including this prohibition in the 2025 Reconciliation Bill. *See Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, 2025 WL 2101940, at *9. Indeed, some members of Congress saw the budget reconciliation as an “opportunity to stop funding abortion purveyors like Planned Parenthood.” *See id.* at *11 (quoting statement of Rep. Smith). Although the provision does not explicitly reference Planned Parenthood, its enactment process closely mirrors prior efforts. For example, prior versions of this bill imposed a \$350 million threshold to be considered a “prohibited entity”—a criteria which

only included Planned Parenthood members and clearly targeted Planned Parenthood and its affiliates. *See id.* (describing prior proposed legislation). Although the lower threshold used in the Defunding Provision allowed Congress to overcome the Senate’s Byrd Rule, which prevents extraneous, nonbudgetary legislation from being included in budget reconciliation acts, legislative history still shows that Planned Parenthood was the law’s intended target. *See id.* at *11–12 (describing the lowering of the threshold for prohibited entities in the Defunding Provision); Senate Committee on the Budget, 115th Cong., Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff (July 21, 2017) (explaining the Byrd Rule). With the lower thresholds, MFP, too, became caught up in Congress’s defunding efforts.

The Defunding Provision’s tortuous delineations can only be understood in the context of Congress’s targeting of Planned Parenthood. The criteria for “prohibited entities” capture all Planned Parenthood affiliates—including those which do not provide abortions—and only two other providers, including MFP. *Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, 2025 WL 2101940, at *22. This is strong evidence that the criteria were intended to target Planned Parenthood. *See id.* at *24.

But “discriminatory exclusion is not a permissible means to accomplish fiscal objectives, nor is it a permissible legislative end.” *Id.*; *see also Planned Parenthood*

of Minnesota v. State of Minn., 612 F.2d 359 (8th Cir. 1980), *sum. aff'd*, 448 U.S. 901 (finding that targeting Planned Parenthood is not a rational basis for a restriction on funding for family planning). Rather, laws that draw irrational distinctions between similarly situated entities, and whose scope is “so discontinuous with the reasons offered for it” that they are “inexplicable by anything but animus toward the class it affects . . . lack[] a rational relationship to legitimate [government] interests.” *Romer*, 517 U.S. at 632 (citation modified).

The district court did not meaningfully address *Moreno* or its progeny, suggesting that these cases were inapplicable because they did not involve “the selective treatment of entities enlisted through federal funding to carry out congressional objectives.” *See* A13 (Op. 10). However, equal protection applies to corporations, *see Santa Clara Cnty. v. S. Pac. R. Co.*, 118 U.S. 394, 396 (1886), and to laws passed under Congress’s spending powers, *e.g.*, *Regan v. Tax’n With Representation of Wash.*, 461 U.S. 540 (1983). And, as the district court noted, the Supreme Court summarily affirmed the unconstitutionality of an analogous law in *Minnesota v. Planned Parenthood of Minn.*, 448 U.S. 901 (1980), which, like the Defunding Provision here, selectively targeted Planned Parenthood for differential treatment in public funding due to animus.

In discounting the summary affirmance in *Planned Parenthood of Minnesota*, the district court erred in finding that the Court’s summary affirmance cannot “bear

the weight” of *Dobbs v. Jackson’s Women’s Health Organization*, 597 U.S. 215 (2022). A14 (Op. 11). In *Planned Parenthood of Minnesota*, the Eighth Circuit expressly stated that Minnesota’s “failure to fund pre-pregnancy family planning services sponsored by Planned Parenthood does not impinge” on the right to abortion and thus did not apply heightened scrutiny. *Planned Parenthood of Minn.*, 612 F.2d at 360. Applying the rational basis standard, the court concluded that “there was no rational basis for the classification distinguishing between nonprofit organizations which are hospitals or HMOs and those which are not,” which the funding provision there imposed in order to defund Planned Parenthood specifically. *Id.* Finding that “Planned Parenthood’s unpopularity played a large role in [the legislation’s] passage,” the court concluded that the provision was unconstitutional because it did not rationally advance any legitimate state interest other than defunding Planned Parenthood specifically. *Id.* at 361–63 (citing *Moreno*, 413 U.S. at 535–36).

Instead of following this analogous precedent to find that the Defunding Provision violates equal protection, the district court relied heavily on the Supreme Court’s decision in *Rust v. Sullivan*, 500 U.S. 173 (1991)—a case with no equal protection claim—and incorrectly found that *Rust* “supplanted” “the apparent rationale of *Minnesota*.” A14 (Op. 11). In *Rust*, the Court permitted the government to condition receipt of family planning monies on those monies not being used for

abortion, which the Court held to be a permissible exercise of governmental power. But here, the Hyde Amendment already imposes such a condition on Medicaid dollars. *See* Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47, §§ 506, 507, 138 Stat. 460, 703. MFP does not challenge whether Defendants may restrict the use of federal Medicaid dollars for abortion—only whether Defendants may single out certain providers for restrictions on funding for their non-abortion care, a question not addressed by *Rust*.

Finally, rather than addressing the lengthy record of animus toward Planned Parenthood, the district court here credited Defendants’ alternative explanation that Congress’s aim was not to target Planned Parenthood specifically, but rather to defund a group of health care providers it describes as “Big Abortion,” A14–15 (Op. 11–12)—a group that is apparently only Planned Parenthood, MFP, and one other provider. *See Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, 2025 WL 2101940, at *17. But subbing the label “Big Abortion” for Planned Parenthood does not erase the clear evidence both in the congressional record and in the gerrymandered criteria that the statute uses which demonstrate that this law is targeting Planned Parenthood. *Id.*

In short, the district court erred in ignoring the lengthy congressional history of animus toward Planned Parenthood. As in *Planned Parenthood of Minnesota*, animus toward Planned Parenthood does not justify differential treatment of

similarly situated health care providers. In light of the evidence demonstrating that this was the reason for the law’s passage, as well as the absence of any other plausible justification as discussed *infra*, MFP is likely to succeed on the merits of its equal protection claim.

B. The Defunding Provision Does Not Rationally Advance Any Other Legitimate Justifications.

The district court incorrectly concluded that the Defunding Provision furthers a government interest in reducing the net number of certain abortions. A15 (Op. 12). Even assuming *arguendo* that such government interest exists, it is unclear how it is furthered by reducing funding for *non-abortion* care—including reducing access to contraception care. *Cf.* JA36–37 (Jarvis Decl. ¶ 5) (discussing threats to patients’ access to birth control due to Defunding Provision and resulting potential for unplanned pregnancies). Additionally, the district court ducked the issue of whether Congress acted arbitrarily in allowing other “providers of non-qualifying abortions” to continue to bill Medicaid while defunding this particular tiny subset. To survive under rational basis, there must be “some rationality in the nature of the class singled out” for differential treatment—a standard that the Defunding Provision here fails to meet. *Rinaldi v. Yeager*, 384 U.S. 305, 308–09 (1966).

1. The Defunding Provision does not advance an interest in reducing “subsidies” to abortion providers. Medicaid is not a subsidy—it reimburses providers for the specific costs of Medicaid-covered services. *See* 42 C.F.R. § 430.0.

Moreover, Defendants cannot plausibly argue that reimbursements for unrelated Medicaid care somehow allow MFP to perform more abortions. This “freeing-up” argument has been repeatedly rejected as a matter of law. *See Planned Parenthood of Cent. & N. Ariz. v. State of Ariz.*, 718 F.2d 938, 945 (9th Cir. 1983) (“the freeing-up theory cannot justify withdrawing all [Medicaid] funds from otherwise eligible entities merely because they engage in abortion-related activities disfavored by the [S]tate.”); *Planned Parenthood of Minn.*, 612 F.2d at 361 (rejecting “freeing-up” theory under rational basis because plaintiff “routinely receives restricted funding which is carefully controlled and monitored,” including funds prohibited from being used for abortion); *Ohio v. Becerra*, 87 F.4th 759, 790–91 (6th Cir. 2023) (Moore, J., concurring in the judgment and dissenting in part) (rejecting “freeing-up” theory). Allowing MFP to receive Medicaid reimbursements for care like contraception counseling and cancer screenings—as other similarly-situated providers offering this care may still do—would simply enable MFP to provide those services, not to provide more abortions.

To be clear, federal law already prohibits the use of federal Medicaid funding for abortions outside of very narrow exceptions, which “necessarily casts considerable doubt upon the proposition that [the Defunding Provision] could rationally have been intended to prevent those very same abuses.” *Moreno*, 413 U.S. at 536–37. Indeed, where entities “routinely receive[] restricted funding which is

carefully controlled and monitored,” cutting off such funding entirely to prevent its misuse does not survive rational basis. *Planned Parenthood of Minn.*, 612 F.2d at 361; *see also Planned Parenthood of Cent. North Carolina v. Cansler*, 804 F. Supp. 2d 482, 496 (M.D.N.C. 2011) (finding that a similar funding ban was not needed to ensure that funds are not used for abortion and that evidence showed the real justification for ban was animus).

2. Setting aside the redundancy of advancing a legislative outcome that is already in place, and the irrationality of doing so through policies that will achieve the opposite of that intended outcome, the Defunding Provision still fails rational basis. Its specific, irrational line-drawing does not further the purported goal of reducing the number of abortions. Instead, the provision impermissibly “discriminat[es] against individuals or groups” by arbitrarily classifying entities that are otherwise similarly situated along four lines: (1) “essential” and “nonessential” community providers; (2) nonprofits and for-profit entities; (3) entities primarily engaged in family planning services and reproductive health care and other entities; and (4) entities that received more or less than \$800,000 in Medicaid reimbursements in fiscal year 2023. Pub. L. No. 119-21, H.R. 1, 119th Cong., § 71113(b) (2025). As discussed below, none of these criteria plausibly furthers any legitimate legislative interest—be it to reduce abortions or government funds that go to entities that provide abortions. Instead, when taken as a whole, the criteria make

clear that Congress’s goal is not to reduce abortions but to target a specific subset of abortion providers while leaving other abortion providers alone, even when they are similarly situated to those targeted by the Defunding Provision.

Nonprofit entities. The Defunding Provision singles out nonprofit entities, without withdrawing Medicaid reimbursements from for-profit entities that are similarly situated to nonprofit entities in all other relevant ways. The district court concluded that this distinction is justified because “Congress could have rationally concluded that if an abortion group was already receiving such an implicit government subsidy (in the form of tax-exempt status), it should not also receive federal funds.” A15 (Op. 12) (quoting ECF No. 24 at 9).

Assuming that Congress wanted to defund nonprofits that perform abortions because they are already receiving governmental subsidies through their tax-exempt status, Congress could have defunded *all* nonprofits that perform abortions. But the Defunding Provision selectively defunds only *some* of these nonprofits—those who are “essential community providers primarily engaged in family planning services, reproductive health, and related medical care” and who received over \$800,000 in Medicaid reimbursements in federal fiscal year 2023. The remaining nonprofits, who are either not essential community providers, or not primarily engaged in family planning or reproductive health, or who receive less than \$800,000 in federal funding, retain the ability to bill Medicaid. In other words, if their tax-exempt status

is the relevant factor, then all those other factors are, by that logic, irrelevant—yet they control whether a nonprofit receives Medicaid reimbursements or not. This exact argument was rejected in *Planned Parenthood of Minnesota*. See 612 F.2d at 360 (holding that funding ban which withheld funding from some nonprofits who performed abortions, but continued to provide funding to nonprofit hospitals and health maintenance organizations who did the same, failed rational basis).

The \$800,000 cap. Similarly, the Defunding Provision only defunds entities that received over \$800,000 in Medicaid reimbursements in fiscal year 2023. Although the district court concluded that this distinction was plausibly justified by Congress’s desire to “focus on recipients of more substantial amounts of federal funding” because those are “likely to perform a higher proportion of abortions,” A15 (Op. 12) (quoting ECF No. 24 at 8–9), it is simply illogical to assume that the amount an entity gets reimbursed from Medicaid corresponds with the number of abortions it performs—particularly given that federal Medicaid reimbursement does not cover the cost of abortions outside of very narrow circumstances. Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47, §§ 506, 507, 138 Stat. 460, 703 (2024). Likewise, it would be illogical if Congress were to “rationally believe that these providers have the abortion reach they do in part thanks to their enjoyment of federal funding” when the “federal funding” at issue does not cover the costs of abortion. JA72 (Order on Emergency Mot. For Prelim. Inj. Pending Appeal, ECF

No. 38 at 4). Moreover, courts have consistently rejected similar arguments that Medicaid reimbursements can be used, even indirectly, to subsidize or fund services not covered by Medicaid. *See, e.g., Planned Parenthood of Cent. & N. Ariz.*, 718 F.2d 938, 945 (rejecting “freeing-up” theory).

Essential community providers. Consider next the provision’s singling out of “essential community providers,” or “providers that serve predominantly low-income, medically underserved individuals.” Pub. L. No. 119-21, § 71113(b); *see also* 45 C.F.R. § 156.235(c) (defining “essential community provider”). The district court did not identify any plausible justification for the provision’s application to essential community providers alone. *See* A11 (Op. 8 n.9) (acknowledging that this distinction must still meet rational basis where it treats similarly situated entities differently, but declining to address this factor in its analysis). Defendants fail to explain how the exclusion of similarly situated non-essential community providers furthers the government’s purported goal of reducing the number of abortions. *See Planned Parenthood Fed’n of Am., Inc. v. Kennedy*, 2025 WL 2101940, at *24 (noting “it is unclear how [defunding] only entities that are non-profits and provide medical services in underserved communities,” and defunding Planned Parenthood members that do not provide abortion, “is in any way related to reducing abortion”). Indeed, defunding essential community providers who provide services like contraception counseling to patients in medically underserved areas may instead

increase the number of abortions, as patients who rely on these essential community providers have the fewest other options for health care if they cannot obtain contraception at a local clinic. *See* JA43–44 (Kieltyka Decl. ¶ 11).

Entities primarily engaged in family planning services and reproductive health care. Nor is there any plausible basis for the provision’s distinction between entities it defines as “primarily” engaged in family planning and reproductive health care (which lose all Medicaid reimbursement) and entities that provide such services, including abortions, but not “primarily.” The district court accepted, without any elaboration, the Defendants’ proposed justification that this criterion singles out entities that are “more likely to engage with pregnant women seeking family-planning advice who are susceptible to efforts to push them towards abortion.” A15 (Op. 12) (quoting ECF No. 24 at 9). But even crediting the assumption that pregnant women are “susceptible” to any “efforts” to push them towards abortion, the Defunding Provision does not advance any governmental interest in reducing such efforts. The provision does not withdraw funding for anyone who pushes such patients towards abortion; instead, it assumes, without explaining why, that some entities are more likely to engage in such efforts—even though other similarly situated entities also provide abortions and also engage with pregnant patients.

Indeed, the assumption that entities like MFP are more likely than other providers to “push” patients toward getting an abortion is contradicted by the record,

which shows that MFP’s mission is to provide patients with the “the right to control their sexual and reproductive lives”—put differently, to support patients in making their *own* reproductive health care decisions. JA41 (Kieltyka Decl. ¶ 6). And that same assumption was rejected in *Planned Parenthood of Minnesota* as a valid basis for treating similar entities differently. *See* 612 F.2d 359, 362 (rejecting legislature’s assumption that Planned Parenthood played any role in a patient’s decision to obtain an abortion while other providers did not as “a distinction without a difference” because “[i]n every instance it is up to the woman and her doctor” what treatment she chooses to pursue).

Looking at the Defunding Provision’s “prohibited entities” criteria both individually and conjunctively, the only plausible explanation for the use of these criteria is that they were drafted to specifically target Planned Parenthood rather than to reduce the net number of abortions. *Cf. Planned Parenthood Fed’n of Am., Inc.*, 2025 WL 2101940, at *22 (noting that the provision’s “conjunctive criteria capture a small subset of abortion providers while leaving many others untouched”).

Rather than engaging with this express justification for the provision, the district court brushed the Defunding Provision’s criteria aside by explaining that the government is free to achieve its desired outcomes “incremental[ly],” even “notwithstanding resulting harm to some”—but not other—“beneficiaries of its broader Medicaid program[.]” A15 (Op. 12). The court reasoned that because

Congress could theoretically withdraw funds from all providers or from Medicaid altogether, it naturally can withhold funds from some providers and not others. *See* A18 (Op. 15). But that “lesser included” rationale misapprehends the harm the Equal Protection Clause is meant to prevent: the Constitution not only imposes limits on what Congress may do, but on *how* it may act. When Congress takes incremental steps toward achieving a government interest, there must still be a “rational basis for the classification” that incrementally advances the purported legislative goal. *Beach Commc’ns*, 508 U.S. at 313, 315–20 (upholding legislative distinction between commonly and individually owned facilities not merely because “the legislature must necessarily engage in a process of line-drawing,” but importantly because Congress had plausible bases for the specific lines it drew in that case, including cost distinctions between the two kinds of facilities and their potentially differing impacts on competition). Thus, even if Congress could eliminate the Medicaid program in its entirety without violating the Constitution, doing so in a manner that draws irrational distinctions between program participants still violates the Fifth Amendment. *See City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 447 (1985) (concluding that zoning ordinance requiring special permit for some homes, but not other similarly situated homes, was unconstitutional “in the circumstances” here); *Windsor*, 570 U.S. at 770 (striking legislation that withheld tax benefits from same-

sex couples under *Moreno*, even though the Constitution does not require Congress to provide tax benefits for married couples).

For the foregoing reasons, MFP’s Fifth Amendment challenge to the Defunding Provision is likely to succeed on the merits, and the district court’s findings to the contrary were an abuse of discretion.

II. The Remaining Factors Favor Reversal.

A. MFP Is Suffering and Will Continue to Suffer Irreparable Harm Absent an Injunction.

The district court correctly recognized that “concern over the impact of the Medicaid funding prohibition is weighty and there is a reasonable perspective that the injury to [MFP’s] practice is not fully redressable once realized.” A19–20 (Op. 16–17). The district court correctly concluded as well that MFP’s “asserted injury [is] more than mere ‘unsubstantiated fears’ of a ‘speculative injury.’” A20 (Op. 17) (citations omitted). Indeed, MFP is ending its primary care practice, laying off providers, and discharging its primary care patients from its care at the end of October. JA 64–65 (Kieltyka Suppl. Decl. ¶¶ 8–9). MFP anticipates that cuts and reductions for the family planning program will soon follow. JA65 (*Id.* ¶ 9). This sort of forced contraction in services is precisely the type of harm to an organization that courts have recognized as irreparable. *See League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 8 (D.C. Cir. 2016) (“An organization is harmed if the ‘actions taken by the defendant have “perceptibly impaired” the organization’s programs.’”)

(citation modified); *accord Dr. José S. Belaval, Inc. v. Perez-Perdomo*, 465 F.3d 33, 36 n.2 (1st Cir. 2006) (discussing “irreparable injury” to health center from government’s failure to make Medicaid payments). Discharging patients ruptures patient-provider relationships that MFP has worked decades to build and causes confusion amongst patients about whether MFP is being precluded from Medicaid because it has done something wrong. *See* JA48–53 (Kieltyka Decl. ¶¶ 22, 26, 29, 33, 36). Such “harm to goodwill, like harm to reputation, is the type of harm not readily measurable or fully compensable in damages.” *K-Mart Corp. v. Oriental Plaza, Inc.*, 875 F.2d 907, 915 (1st Cir. 1989).

MFP is suffering and will continue to suffer irreparable harm without a preliminary injunction. The district court made clear that if MFP showed a likelihood of success on the merits, it would “not withhold preliminary injunctive relief based on reservations about the existence of irreparable injury.” A20 (Op. 17).⁴

⁴ The district court’s reservations seem to be based on a belief that MFP could continue to provide care without Medicaid reimbursements and that MFP could circumvent the harms imposed by the Defunding Provision through corporate, structural, or operational changes, A20 (Op. 17). Both are incorrect. First, Medicaid is a significant portion of MFP’s budget, and MFP will have to make cuts to its services without Medicaid reimbursements. JA48–52 (Kieltyka Decl. ¶¶ 22, 24, 26, 29, 34). Second, the Defunding Provision deliberately restricts an entity’s ability to avoid its harsh consequences through corporate restructuring. By its own terms, the Defunding Provision applies not only to entities that independently meet the criteria for being prohibited entities but also to all “affiliates, subsidiaries, successors, and clinics” of prohibited entities. Pub. L. No. 119-21, H.R. 1, 119th Cong., § 71113(b)(1) (2025).

B. The Balance of the Equities and Public Interest Favor Granting Relief to MFP.

When—as here—the government is a party, the balance of equities and public interest factors merge. *Does I-6 v. Mills*, 16 F.4th 20, 37 (1st Cir. 2021) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009)). Both of these factors strongly weigh in favor of granting injunctive relief.

First, allowing MFP to continue to provide the essential care that it has provided for decades—and allowing MFP’s patients to continue to access such care—is consistent with “the purpose of a preliminary injunction,” which is “to preserve the status quo *before* the merits have been resolved.” *Francisco Sanchez v. Esso Standard Oil Co.*, 572 F.3d 1, 19 (1st Cir. 2009) (emphasis in original). MFP has been serving low-income patients for decades, and both MFP and its patients have relied on its continuing ability to do so. MFP built its patient network—and its primary care practice in particular—based on the belief that it would be able to continue to see Medicaid patients and receive Medicaid reimbursements. *See Lemon v. Kurtzman*, 411 U.S. 192, 203 (1973) (“It is well established that reliance interests weigh heavily in the shaping of an appropriate equitable remedy.”). Denying relief to MFP will inflict lasting damage on MFP’s reputation as a trusted community provider; this damage cannot be easily undone even when Medicaid reimbursements are eventually restored. Already, MFP will have to discharge patients and lay off staff from its primary care practice due to the Defunding Provision; without relief

from this Court, MFP may soon have to discharge or stop serving Medicaid-enrolled family planning patients. JA64–65 (Kieltyka Supp. Decl. ¶ 8–9).

But an injunction will impose no harm on Defendants, who will not be required to either cover services or expend funding that they would not otherwise have been willing to cover or spend. *See Marlo M. ex rel. Parris v. Cansler*, 679 F. Supp. 2d 635, 638 (E.D.N.C. 2010) (finding balance of equities favored plaintiffs where injunction would require the state “to maintain the funding [it] ha[s] provided to Plaintiffs for years”). And, though Defendants may “not wish to fund certain entities” because of the government’s opposition to abortion, A21 (Op. 18), this argument falls flat where the government has expressed a willingness to fund other abortion providers so long as they are not nonprofits, or essential community providers, or primarily engaged in family planning or related care, or received more than \$800,000 in Medicaid reimbursements in fiscal year 2023.

Second, the public interest factor also weighs in favor of granting injunctive relief. Preserving access to health care for low-income patients is in the public interest. *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 76–77 (1st Cir. 2005) (shutdown of health clinic “would adversely affect hundreds of Medicaid patients,” so public interest supported preliminary injunction); *Beverly Enters. v. Mathews*, 432 F. Supp. 1073, 1079 (D.D.C. 1976) (“both Congress and the Secretary have recognized the potential harm involved in [cutting off provider funding] and

the compelling public interest in providing timely and uninterrupted health care funding”). And, though Defendants gestured to “the interest of the public in ensuring that their representatives in Congress are able to effectuate legislation,” A21 (Op. 18), an injunction restoring Medicaid reimbursements for MFP does not interfere with any of Congress’s powers to effectuate legislation. The Defunding Provision does not decrease or increase funding for Medicaid programs or change the scope of services that Medicaid covers; therefore, an injunction does not interfere with any alleged Congressional power under the Appropriations Clause as it does not alter the money that Congress appropriated.

Nor does an injunction interfere with Congress’s legitimate policy choices. To the extent that Congress does not want to provide federal funding for abortion, an injunction allowing MFP to continue providing non-abortion care is irrelevant to these policy choices.

Moreover, the public interest in ensuring Congress can effectuate legislation is limited by the maxim that there is generally no public interest in unlawful government action. *See Somerville Pub. Sch. v. McMahon*, 139 F.4th 63, 76 (1st Cir. 2025) (rejecting federal agency’s argument that its actions were “indistinguishable” from the public interest). As explained *supra*, the Defunding Provision violates equal protection.

Accordingly, the balance of equities overwhelmingly favors MFP.

CONCLUSION

For the foregoing reasons, this Court should reverse the denial of the preliminary injunction.

Dated October 22, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 8,762 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that on October 22, 2025, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the First Circuit by using the appellate CM/ECF system, which will serve copies on registered CM/ECF users.

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ADDENDUM

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Reconciliation Act of 2025, Pub. L. No. 119-21, 139 Stat. 72

§ 71113. Federal Payments to Prohibited Entities

(a) IN GENERAL.—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.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—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 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.

(2) DIRECT SPENDING.—The term “direct spending” has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

(3) COVERED ORGANIZATION.—The term “covered organization” means a managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(1)(B))) or a prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section 1903(m)(9)(D) of such Act (42 U.S.C. 1396b(m)(9)(D))).

(4) STATE.—The term “State” has the meaning given such term in section 1101 of the Social Security Act (42 U.S.C. 1301).

(c) IMPLEMENTATION FUNDING.—For the purposes of carrying out this section, there are appropriated, out of any monies in the Treasury not otherwise appropriated, to the Administrator of the Centers for Medicare & Medicaid Services, \$1,000,000 for fiscal year 2026, to remain available until expended.

UNITED STATES DISTRICT COURT

THE FAMILY PLANNING)
ASSOCIATION OF MAINE d/b/a)
MAINE FAMILY PLANNING,)

Plaintiff)

V.)

No. 1:25-cv-00364-LEW

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN
SERVICES,

ROBERT F. KENNEDY, JR.)
in his official capacity as Secretary of)
the Department of Health and Human)
Services,)

CENTERS FOR MEDICARE
& MEDICAID SERVICES, and

MEHMET OZ, in his official capacity as)
Administrator of the Centers for)
Medicare & Medicaid Services,)

Defendants)

ORDER ON MOTION FOR PRELIMINARY INJUNCTION

Plaintiff, The Family Planning Association of Maine, seeks a judicial declaration that Defendants, a co-equal branch of government, its agency and appointed leadership, must continue to spend dollars in a way that is contrary to the will of the people as expressed by Congress. To overcome this constitutional inertia, Plaintiff presses into service the Equal Protection Clause. As explained below, Plaintiff's equal protection claim fails to hold the promise of flight due to several severe jurisprudential headwinds that I am

bound to observe, not the least of which are Congress’s power of the purse, an exceedingly deferential standard of constitutional review I inherit from binding precedent, and the absence of the thermal lift that used to be available to Plaintiff and other abortion providers when abortion was considered a constitutional right, before the Supreme Court’s opinion in *Dobbs v. Jackson’s Women’s Health Organization*, 597 U.S. 215, (2022) (removing the right to abortion from the list of fundamental rights protected by the United States Constitution). Consequently, for present purposes, Plaintiff’s Motion for Preliminary Injunction (ECF No. 5) is denied.

BACKGROUND

The recently enacted One Big Beautiful Bill Act¹ (hereafter the “BBB”), Pub. L. No. 119-21, H.R. 1, 119th Cong. (2025), in Subtitle B (Health), Chapter 1 (Medicaid), subchapter B (preventing wasteful spending), section 71113 (Federal payments to prohibited entities), withdraws all Medicaid funding from certain “prohibited entities,” which Congress has defined as those that (1) have tax-exempt status under Internal Revenue Code section 501(c)(3); (2) are “essential community providers” under 45 C.F.R. § 156.235² “primarily engaged in family planning services, reproductive health, and related medical care”; (3) provide abortions to clients other than in the case of rape or incest or a pregnancy that exposes a woman to the “danger of death”; and (4) received in excess of \$800,000 in Medicaid funding in fiscal year 2023. BBB § 71113(b)(1). In other words,

¹ Available online at <https://www.congress.gov/bill/119th-congress/house-bill/1/text> (last viewed Aug. 25, 2025).

² The Department of Health and Human Services defines essential community providers as Medicaid providers who operate in areas with a shortage of health care professionals. Two of Plaintiff’s eighteen clinics qualify as essential community providers.

Section 71113 withdraws all federal Medicaid funding from certain “prohibited entities” having specific characteristics that, in combination, members of Congress might believe are the defining characteristics of major abortion providers in the United States.

Plaintiff meets all four parts of the definition and is, therefore, prohibited from receiving federal funds under the Medicaid program “for items and services” provided for a period of one year subsequent to the passage of the Act. *Id.* § 71113(a). Congress’s prohibition against Plaintiff’s receipt of federal Medicaid funds is selective insofar as the criteria that govern the prohibition do not all apply to Medicaid providers that provide abortion services other than those permitted under Medicaid (hereafter, “non-qualifying abortions”) but operate on a for-profit basis; or that provide non-qualifying abortion services but do not qualify as essential community providers, which generally means that they operate in more economically viable areas³ in which Medicaid beneficiaries have access to a number of different potential service providers; or that provide non-qualifying abortion services but are not primarily engaged in the provision of family planning and reproductive health care.

Plaintiff alleges that the relevant portion of the BBB deprives it of equal protection of the laws in connection with its participation as a provider in the State of Maine’s Medicaid program. In combination with its Complaint (ECF No. 1), Plaintiff filed an Emergency Motion for a Temporary Restraining Order and/or Preliminary Injunction (ECF No. 5). Although filed as an emergency motion seeking an immediate restraining order, Plaintiff agreed that its motion should proceed on an expedited briefing schedule followed

³ Urban providers of Medicaid services can qualify as essential community providers. The designation is not limited to providers serving remote areas.

Approximately half of Plaintiff's patients are Medicaid recipients. Decl. of Evelyn KIELTYKA (ECF No. 5-2) ¶ 5. Plaintiff operates eighteen family planning clinics, with at least one site in twelve of Maine's sixteen counties, plus a mobile clinic. Plaintiff'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. Plaintiff also subcontracts with several other entities that in total provide access to sexual and reproductive health care in fifteen of Maine's sixteen counties. *Id.* ¶ 8.

4

Maine. Kieltyka Decl. ¶ 10.

In terms of the services provided by Plaintiff in its own clinics, using figures from 2024, 7.38% of Plaintiff's patients received abortion services. According to Plaintiff, this amounted to 645 abortion patients. *Id.* ¶ 11. According to Plaintiff, the only other publicly accessible health centers where a pregnant person can obtain abortion care in Maine are Planned Parenthood⁴ of Northern New England clinics and the Mabel Wadsworth Center in Bangor.⁵ *Id.* ¶ 13. Of these entities, only the Mabel Wadsworth Center is unaffected by the BBB's new funding prohibition. According to Plaintiff's own anecdotal account, the BBB effectively targets two of the three primary providers of non-qualifying abortion services in Maine, excluding only the one lacking geographic distribution.

A fair assessment of Plaintiff's factual contentions indicates that there is a great demand throughout rural Maine and other underserved areas for Medicaid-funded family planning and reproductive health (and other) services, and that the demand is largely met by organizations that specialize in meeting these needs. *Id.* ¶¶ 12, 17, 19, 33-35. One other entity that might fit this description other than Plaintiff or Planned Parenthood of Northern New England is Greater Portland Health, but while it is a tax-exempt non-profit it does not provide abortion services. *Id.* ¶ 15.

Plaintiff asserts that for its existing patients who rely on Medicaid to pay for family

⁴ Planned Parenthood Federation of America has launched its own challenge to the BBB, which raises distinct legal questions and a less deferential standard of review than the instant case. *See Planned Parenthood v. Kennedy*, No. 1:25-cv-11913, 2025 WL 2040123, at *12 (D. Mass, Jul. 21, 2025).

⁵ MaineHealth Maine Medical Center allegedly provides abortion care, but it is a full-service health care entity that is not primarily focused on the provision of family planning and reproductive health services. Kieltyka Decl. ¶ 16. Furthermore, the scope of its operations and its organizational health are not heavily reliant on the receipt of Medicaid funding.

planning or primary care, it will continue to see them despite the impact of the BBB, but only through October 31, 2025. Plaintiff states that this change may result in the closure of some of its clinics. *Id.* ¶¶ 22, 26.⁶

Slightly less than one-quarter of Plaintiff’s annual revenue comes from Medicaid, and roughly 62 percent of that one-quarter is federally funded.⁷ *Id.* ¶¶ 23-24. The cessation of services and/or the closure of clinics would impact many patients, including some patients in remote regions with serious chronic conditions in need of follow-up services. *Id.* ¶¶ 27-28.

ANALYSIS

Plaintiff alleges that the prohibition on its receipt of federal Medicaid funding violates the Equal Protection Clause of the Fifth Amendment of the United States Constitution because it arbitrarily and irrationally removes Plaintiff from the Medicare funding stream. Compl. ¶¶ 53-63 (ECF No. 1). Plaintiff asks this Court to declare as much and to enter a preliminary injunction that prohibits Defendants “from implementing or enforcing” what Plaintiff refers to as “the Defunding Provision.” Compl. at 25; Emergency Mot. for Temporary Restraining Order and/or Preliminary Injunction (ECF No. 5); Mem. of Law at 1-2, 20 (ECF No. 5-3).

Preliminary injunctive relief is “an extraordinary and drastic remedy that is never

⁶ With its Reply (ECF No. 25), Plaintiff has provided a Supplemental Declaration of Evelyn Kieltyka (ECF No. 25-1) that somewhat adjusts its prediction of harm. I address it in the context of the irreparable injury portion of the Analysis.

⁷ Maine’s Medicaid program, known as MaineCare, is jointly funded by the federal government and the State. The BBB does not restrict how Maine’s own financial contributions to the program are spent. Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47 § 507(c) (Mar. 23, 2024). However, more than half of the funding for MaineCare comes from the federal government. Kieltyka Decl. ¶ 23.

awarded as of right.” *Voice of the Arab World, Inc. v. MDTV Med. News Now, Inc.*, 645 F.3d 26, 32 (1st Cir. 2011) (citations and quotation marks omitted). “The default rule is that a plaintiff seeking a preliminary injunction must make a clear showing that ‘[it] is likely to succeed on the merits, that [it] is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [its] favor, and that an injunction is in the public interest.’” *Starbucks Corp. v. McKinney*, 602 U.S. 339, 346 (2024) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). The first requirement, a likelihood of success on the merits, is the “sine qua non” of the entire inquiry, and when it is not met the remaining factors lose their urgency. *Cushing v. Packard*, 30 F.4th 27, 36 (1st Cir. 2022).

A. Likelihood of Success

The Constitution gives to the Congress of the United States the power of the purse. U.S. Const. art. I, § 8, cl. 1. The very first enumerated legislative powers of Congress are the powers to raise and spend money, and this means that Congress, not the Executive Branch or the Judicial Branch, has the authority to determine how to spend, or not spend, the Nation’s dollars for the achievement of, among other things, the “general Welfare of the United States.” *Id.* This power is further informed by the Appropriations Clause, which specifies, “No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law.” U.S. Const. art. I, § 9, cl. 7.

For present purposes, the question is whether the Equal Protection Clause of the Fifth Amendment overrides the congressional will concerning the defunding of certain

abortion providers.⁸ It is well-established that spending decisions must not offend the Equal Protection Clause. *South Dakota v. Dole*, 483 U.S. 203, 207-208 (1987). However, where, as here, the classifications of a bill do not turn on a constitutional right but rather conduct or federal funding the Congress wishes to discourage, the Court’s review is exceedingly deferential.⁹ Typically in constitutional disputes like these, a great deal of energy is devoted by the parties as to which standard of review applies. Not so here, as the parties agree that I should apply the rational-basis test, the least rigorous tier of constitutional scrutiny. I agree.

Assuming that the Judicial Branch can order executive agencies or their officials to transfer money from the Treasury to entities prohibited *by Congress* to receive them, in no event could the Judicial Branch do so if there is “any reasonably conceivable state of facts that could provide a rational basis for the classification.” *FCC v. Beach Comms., Inc.*, 508

⁸ There are other recognized limitations on Congress’s spending power other than the Equal Protection Clause. Spending decisions must serve the “general welfare” and conditions imposed on states that accept federal dollars must be clear enough for the states to understand them. *South Dakota v. Dole*, 483 U.S. 203, 207-208 (1987). But the subsidization through Medicaid of the providers of non-qualifying abortions, however those providers may account for their receipt and expenditure of federal dollars, is, depending on who you ask, either a benefit or a bane to the general welfare. Consequently, a general welfare challenge would have no greater chance of success than Plaintiff’s equal protection claim. And as for the relative clarity of the BBB’s prohibited entities provision, Plaintiff itself alleges that the provision is clear enough for it to know that it no longer qualifies for Medicaid reimbursement.

⁹ There is no authority supporting the notion that either tax-exempt essential community providers who meet the BBB’s definition of “prohibited entity” or the patients who depend on their services constitute suspect classifications for purposes of equal protection analysis. There is also some question whether Plaintiff is in fact similarly situated to the other, non-prohibited providers of non-qualifying abortion care, given that Congress employed four factors in Section 71113 to distinguish Plaintiff from other such providers. See Opp’n at 7. Potentially, this imposes yet another hurdle for Plaintiff, but I have chosen instead to focus on the plausible rationality of the disqualifying factors in relation to the task of identifying the major providers of non-qualifying abortions. While, as a general proposition, an equal protection plaintiff has the burden to demonstrate that it was singled out unfairly for disadvantageous treatment as compared against a similarly situated comparator, that is not always a requirement of an equal protection claim. *Wadsworth v. Nguyen*, 129 F.4th 38, 54, 73 n.20 (1st Cir. 2025). In any event, here the similarly situated inquiry and the rational basis inquiry basically dovetail.

Id. Undoubtedly, most of the public that is outraged by Congress’s defunding of “prohibited entities” will feel as they do because they find the provision unwise, unfair, and illogical. In fact, much of Plaintiff’s argument turns on a public policy critique of the prohibited entities portion of the BBB. However unwise is the prohibition of Medicaid funding to providers best positioned to deliver Medicaid services to underserved rural populations, the Judicial Branch, despite much generated confusion on this basic point, does not serve as an omnibus super-legislature to sit in final judgment as to which policy outcomes it prefers. That judgment rests with the people.

Beyond critiquing the wisdom of the BBB, Plaintiff contends that it has been targeted by Congress for disfavored treatment merely as part of a congressional effort to deny Medicaid funding to Planned Parenthood, a separate entity that is disfavored by many members of Congress. In fact, the Supreme Court has held that a “bare congressional desire to harm a politically unpopular group” does not amount to a rational basis that would justify discriminatory lawmaking. *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 534 (1973). But the written Supreme Court opinions in this line all appear to involve profound irrationalities that target individuals for disfavored treatment rather than the selective treatment of entities enlisted through federal funding to carry out congressional objectives.¹⁰ Still, there is one case in this line in which the Supreme Court upheld, without providing a written opinion, the partial invalidation of a state-funded welfare program that targeted non-profit abortion providers for exclusion but excepted from such treatment hospitals and health maintenance organizations. *Planned Parenthood of Minn. v. Minnesota*, 612 F.2d 359 (8th Cir. 1980), *sum. aff’d*, 448 U.S. 901 (1980). But the Supreme Court’s summary affirmance in *Minnesota* occurred within the context of a precedential landscape in which abortion was considered a constitutional right and in which, consequently, the right of abortion providers and their patients to be protected against legislative disadvantage was at its apex under *Roe v. Wade*, 410 U.S. 113 (1973), *overruled by Dobbs v. Jackson Women’s Health Org.*, 597

¹⁰ See *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (finding irrational the purposeful “intrusion into the personal and private life of the individual” in relation to consensual, adult intimacies); *Romer v. Evans*, 517 U.S. 620, 627, 632-33 (1996) (involving a “sweeping and comprehensive” “change in legal status” for a class of individuals); *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 450 (1985) (setting aside legislation informed only by an “irrational prejudice” against individuals with intellectual disabilities); *Moreno*, 413 U.S. at 534 (finding it irrational to deny food stamps to all low-income occupants of a household if some occupants are not related by blood).

U.S. 215 (2022). Furthermore, the apparent rationale of *Minnesota* has since been supplanted by Supreme Court holdings that the Government may impose requirements on the receipt of federal funding, including mandatory organizational disassociation, out of concern that federal subsidies extend the reach of other, disfavored organizational objectives by, for example, keeping the lights on and paying for operational overhead. *Rust v. Sullivan*, 500 U.S. 173 (1991) (affirming the Executive Branch’s power to construe a congressional prohibition on the expenditure of Title X monies on abortion by conditioning such providers’ participation in the Title X program on the operation of family planning projects that do not share space, personnel, or accounting with abortion providers). I am not persuaded, for these reasons, that the Supreme Court’s summary affirmation of the Eighth Circuit’s rational-basis takedown of the state program at issue in *Minnesota* can bear the weight of Plaintiff’s post-*Rust*, post-*Dobbs* challenge to the wisdom of the BBB.

Furthermore, in terms of likelihood of success on the merits, Plaintiff’s importuning of congressional irrationality and its allegation of presumed, monolithic malice toward Planned Parenthood overlooks the more plausible likelihood that the members of Congress who voted for the BBB’s prohibited entities provision most likely hold a variety of serious and sincerely held perspectives on the issue, including a rational desire to withhold a Medicaid subsidy from the primary providers of non-qualifying abortions. On this point, in opposition to Plaintiff’s narrative, Defendants have offered a competing narrative that the challenged provision is an incremental step taken by Congress to gradually remove non-qualifying abortion providers from the Medicaid program, describing Plaintiff, Planned Parenthood, and other affected providers as “Big Abortion.” Defs.’ Opp’n (ECF

¹¹ Plaintiffs would offer the rejoinder that reducing access to family planning services for their patients will more likely result in unplanned pregnancies, some portion of which could end in non-qualifying abortions, as though that observation exposed the irrationality of Congress's choice. Pl. Supp. Br. (ECF No. 29) at 6-7. But that reasoning is only convincing if access to family planning services via federal subsidy has succeeded access to abortion as a fundamental right. Plaintiff has not offered any precedent to that effect. Furthermore, the rank ordering of policy choices related to the family planning program is a matter for Congress rather than the courts.

Were I to enjoin Defendants against obeying Congress’s funding instructions I cannot say that I would be acting on any basis other than a difference of opinion as to “the wisdom, fairness, or logic of legislative choices,” which I have no authority to do. *Beach Comms.*, 508 U.S. at 313. Recall, too, that while the allegation of malice is plausible, in the context of rational-basis equal protection claims, plausibilities favor Defendants rather than Plaintiff. *Beach Comms.*, 508 U.S. at 313-14 (“Where there are ‘plausible reasons’ for Congress’ action, ‘our inquiry is at an end.’” (quoting *United States Railroad Retirement Bd. v. Fritz*, 449 U.S. 166, 179 (1980))). Only if Plaintiff can establish as a factual matter that malice was the essential cause for § 71113 of the BBB (assuming it is otherwise constitutional) will it be able to succeed in this case.¹²

Ultimately, Plaintiff has failed with its opening salvo to convincingly negate any reasonable state of facts that would rationalize the prohibition against its receipt of federal Medicaid funds. It should come as no surprise to anyone even moderately attuned to national politics that Congress has long debated the propriety of giving federal funding to health care providers who perform non-qualifying abortions. If it had the votes, no doubt

¹² As Chief Justice Earl Warren once wrote for a unanimous Supreme Court, quoting in part Justice Edward Douglass White: “The decisions of this court from the beginning lend no support whatever to the assumption that the judiciary may restrain the exercise of lawful power on the assumption that a wrongful purpose or motive has caused the power to be exerted.” *U. S. v. O’Brien*, 391 U.S. 367, 383 (1968) (quoting *McCray v. United States*, 195 U.S. 27, 56 (1904)). Furthermore:

Inquiries into congressional motives or purposes are a hazardous matter. . . . What motivates one legislator to make a speech about a statute is not necessarily what motivates scores of others to enact it, and the stakes are sufficiently high for us to eschew guesswork. We decline to void essentially on the ground that it is unwise legislation which Congress had the undoubted power to enact and which could be reenacted in its exact form if the same or another legislator made a ‘wiser’ speech about it.

Id. at 383–84 (overturning First Circuit opinion declaring unconstitutional on First Amendment grounds a criminal sanction imposed by Congress for the destruction of a selective service registration card).

Congress could disqualify all such providers from participation in the Medicaid program. *Cf. Rust*, 500 U.S. at 192-93 (“[T]he government may ‘make a value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds.’” (quoting *Maher v. Roe*, 432 U.S. 464, 474 (1977))). As it happens, a majority of the members of Congress will not vote, as yet, to go so far. But a coalition of House and Senate members have agreed in sufficient numbers, along with Vice President JD Vance,¹³ to withdraw Medicaid funding from a subset¹⁴ of abortion providers, thereby reducing the number of abortion providers who participate in Medicaid (potentially for only a one-year period) rather than eliminating them altogether. I cannot simply brush this all aside as constitutionally infirm because it only achieves a legislative end in part rather than in whole. Incrementalism is the byword for most of what Congress achieves these days and it is “virtually unreviewable, since the legislature must be allowed leeway to approach a perceived problem incrementally.” *Beach Comms.*, 508 U.S. at 316.

¹³ The BBB passed in the Senate due to the tie-breaking vote of Vice President Vance. Plaintiffs impugn the bona fides of the BBB because it was passed only with the aid of parliamentary maneuvers in the context of budget reconciliation. I do not understand why a budgetary act should be deemed irrational based on, exclusively, the failure to observe, for example, Senate filibuster and cloture process, and I therefore bypass further discussion of that theory because it does not strike me as one that is likely to succeed. *See, generally*, Mot. Mem. of Law at 4-5, 11-12; Defs.’ Opp’n at 10. I also do not discuss outside of this footnote Plaintiff’s contention that the irrationality of the BBB is demonstrated by the fact that the State of Maine is entitled as a separate sovereign to avoid this kind of federal funding change because it is responsible for administration of the Medicaid program in Maine and wants to foster non-qualifying abortion services through its network of Medicaid providers. Mot. Mem. at 12; Opp’n at 11. The challenged provision of the BBB does not prevent Maine from fostering a non-qualifying abortion network with its own funds.

¹⁴ The subset includes Planned Parenthood, the most well-known provider of abortion services nationwide. Also impacted are abortion providers such as Maine Family Planning. The record does not provide any information concerning the number of non-qualifying abortions performed annually by all such organizations or what percentage of all non-qualifying abortions performed in the United States are provided by them. However, presumably senators and representatives are informed on the topic. Under our equal protection jurisprudence the burden is not on Defendants to supply a justification for the votes of members of Congress. The burden is on Plaintiff to negate any reasonable rationale. *Bd. of Trustees of Univ. of Alabama*, 531 U.S. at 367.

Plaintiff also contends that Section 71113 of the BBB is irrational because it does not serve its purported end, describing that end as preventing Medicaid dollars from being used to fund non-qualifying abortions. It points to the Hyde Amendment, a rider placed on the Department of Health and Human Services’ annual appropriations, that already prohibits the expenditure of federal funds on non-qualifying abortions. *See, e.g.*, Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47 §§ 506, 507 (Mar. 23, 2024). Plaintiff protests that despite its receipt of Medicaid funding for many years, it has never been found to have violated the Hyde Amendment, an assertion that posits the need for some prior misstep to justify disqualification from the Medicaid program. But a prohibition on the manner in which federal dollars are expended once received is not the same as a prohibition on the receipt of federal funds in the first instance. Because it is not constitutionally irrational for Congress to reduce the number of non-qualifying abortion-provider participants in the Medicaid program—since it could with the requisite votes eliminate such providers from the program altogether—the Hyde Amendment is not the high-water mark of funding measures that Congress can employ to disassociate federal Medicaid expenditures from abortion services.

For the foregoing reasons, the denial of Plaintiff’s request for a preliminary injunction is proper. The first requirement for entry of a preliminary injunction is a likelihood of success on the merits, which serves as the “sine qua non” of the entire inquiry, and when it is not met, the remaining factors lose urgency. *Cushing v. Packard*, 30 F.4th 27, 36 (1st Cir. 2022).

B. Irreparable Injury

The irreparable injury standard seeks to determine whether, in the absence of

preliminary injunctive relief, the movant would suffer the kind of harm that cannot be remedied after the fact, such as through an award of damages or later-issued permanent injunction. *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 76 (1st Cir. 2005). The standard asks not whether such an injury is possible, but whether it is likely. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008).

Plaintiff expresses concern that it may have to close some clinics and that the disruption of patient care will harm its patients. However, upon presentation of its Motion for Preliminary Injunction, Plaintiff feared that it would also lose federal family planning funding under the Public Health Service Act, Title X. It has since learned that that is not the case. Suppl. Kieltyka Decl. ¶ 4 (ECF No. 25-1). Still, Plaintiff anticipates harm that will chiefly impact services to patients seeking primary care under Medicaid and those seeking family planning services under Medicaid who are not eligible for Title X benefits. *Id.* ¶¶ 6-7. Also, without access to Medicaid reimbursement for its qualifying patients, Plaintiff claims that its primary care practice is not “self-sustaining.” *Id.* ¶ 7. Furthermore, “[w]ithout court intervention, unless [it] can identify a new funding source, [Plaintiff] will have to look at [its] limited reserve funding to continue providing family planning care to Medicaid patients.” *Id.* ¶ 8. Plaintiff does “not know for how long” it can continue to provide that care. *Id.* Plaintiff says that these consequences will not only harm its “mission of ensuring that all people have access to high-quality, culturally relevant and affordable health care services,” *id.* ¶ 9, but also will harm its reputation as a trusted community provider,” *id.* ¶ 10, and its “ability to provide comprehensive care.” Reply Mem. at 5 (ECF No. 25).

Plaintiff’s concern over the impact of the Medicaid funding prohibition is weighty

and there is a reasonable perspective that the injury to its practice is not fully redressable once realized. I also consider the asserted injury to be more than mere “unsubstantiated fears” of a “speculative injury.” Opp’n at 13 (quoting *Charlesbank Equity Fund II v. Blinds To Go, Inc.*, 370 F.3d 151, 162 (1st Cir. 2004), and *Narragansett Indian Tribe v. Guilbert*, 934 F.2d 4, 6-7 (1st Cir. 1991), respectively). However, I am not convinced that Plaintiff’s interest in insuring that it can fulfill its mission of providing comprehensive care across its network to all patients desiring its services is unassailable in the context of a federal legislative initiative to withdraw one tranche of federal funding. It also appears likely that Plaintiff could avoid repeat exposure to congressional legislation of the kind at issue by means of corporate and other structural and operational changes, and might well do so in light of the fact that the political pendulum has repeatedly brought Plaintiff and others to federal court to combat similar legislation, the type of which has become even more clearly foreseeable in the wake of *Dobbs*.

Despite this observation, if Plaintiff's prospect of success on the merits of its equal protection claim was strong, I would not withhold preliminary injunctive relief based on reservations about the existence of irreparable injury, since a strong showing of a constitutional injury would tend to expand the degree or nature of the injury Plaintiff would sustain. But as it is, because I find the likelihood of success showing to be weak rather than strong, and because I do not consider the showing of irreparable injury to be powerful enough to warrant a sliding scale (i.e., lower standard) in regard to the merits inquiry, Plaintiff's irreparable injury showing does not turn the outcome in its favor.

C. Balance of Equities and Public Interest

When legislation or other government initiatives are challenged, the balance of

equities and the public interest factors fold into one. *See Does 1-6 v. Mills*, 16 F.4th 20, 37 (1st Cir. 2021) (citing *Nken v. Holder*, 556 U.S. 418, 435 (2009) (“These factors merge when the Government is the opposing party.”)). Plaintiff emphasizes that its continued provision of care, particularly to low-income patients, is the paramount interest and that the passage of time and resulting reliance on its participation in the Medicaid program outweigh the more recent shift in the Capitol that informs the defunding provision. Mot. Mem. at 18-19. Defendants disagree with this weighing and argue that they are in the better position due to a presumption of constitutionality as well as the interest of the public in ensuring that their representatives in Congress are able to effectuate legislation. Opp’n at 18-19. Defendants have the better argument. They observe:

That is particularly true here, where Congress has made a judgment about which entities it wishes to benefit from public funds, in a policy context of substantial human, moral, and political significance. An order displacing Congress’s assessment that it does not wish to fund certain entities unless they cease providing abortions would work grave irreparable injury on the democratically elected branches. And it would countermand the traditional rule that a congressional enactment “is in itself a declaration of public interest and policy which should be persuasive in inducing courts to give relief.” *Virginian Ry. Co. v. Sys. Fed’n No. 40*, 300 U.S. 515, 552 (1937).

Id. at 19.

Plaintiff’s predicament is complicated by a long-standing cultural battle over the availability of abortion spanning the nearly 50 years it was considered a constitutional right. However, three years ago the Supreme Court held that abortion is not a right protected by any constitutional provision and as such, “the permissibility of abortion, and the limitations upon it, are to be resolved like most important questions in our democracy: by citizens trying to persuade one another and then voting.” *Dobbs*, 597 U.S. at 232 (quoting *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 979 (1992))

(Scalia, J., concurring in judgment in part and dissenting in part)). That is precisely the type of democratic exercise that produced the BBB. It would be a special kind of judicial hubris to declare that the public interest has been undermined by the public. Over the years, political winds have shifted and Plaintiff can only be understood as voluntarily standing its ground, from a corporate governance standpoint, despite the dramatically increased likelihood of defunding after *Dobbs*. Fair enough, but while its adherents may celebrate the firmness of its convictions, those convictions are not equal to the task of enjoining congressional will in this arena.

CONCLUSION

Because Plaintiff has failed to make a strong showing that its equal protection challenge to Section 71113 of the One Big Beautiful Bill Act has merit, and because Plaintiff's showing on the remaining preliminary injunction factors does not demonstrate that all of the preliminary injunction factors are met, Plaintiff's Emergency Motion for Temporary Restraining Order and/or Preliminary Injunction (ECF No. 5) is DENIED.

SO ORDERED.

Dated this 25th day of August, 2025.

/s/ Lance E. Walker
CHIEF U.S. DISTRICT JUDGE

No. 25-1829

IN THE
United States Court of Appeals for the First Circuit

THE FAMILY PLANNING ASSOCIATION OF MAINE,
D/B/A MAINE FAMILY PLANNING,

Plaintiff-Appellant

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;
ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health &
Human Services; CENTERS FOR MEDICARE & MEDICAID SERVICES;
MEHMET OZ, in his official capacity as the Administrator of the Centers for
Medicare & Medicaid Services; *Defendants-Appellees.*

On Appeal from the United States District Court
for the District of Maine

No. 1:25-cv-00364-LEW, Hon. Lance E. Walker

JOINT APPENDIX

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APPEAL,STANDARD

**U.S. District Court
District of Maine (Bangor)
CIVIL DOCKET FOR CASE #: 1:25-cv-00364-LEW**

THE FAMILY PLANNING ASSOCIATION OF MAINE v.
UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES et al
Assigned to: JUDGE LANCE E. WALKER
Referred to: MAGISTRATE JUDGE KAREN FRINK WOLF
Case in other court: First Circuit Court of Appeals, 25-01829
Cause: 28:2201 Constitutionality of State Statute(s)

Date Filed: 07/16/2025
Jury Demand: None
Nature of Suit: 950 Constitutional – State
Statute
Jurisdiction: U.S. Government Defendant

Plaintiff

**THE FAMILY PLANNING
ASSOCIATION OF MAINE**
doing business as
MAINE FAMILY PLANNING

represented by **ASTRID MARISELA ACKERMAN**
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Defendant

ROBERT F KENNEDY, JR
*In his official capacity as Secretary of
Health and Human Services*

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Defendant

MEHMET OZ
*in his official capacity as the
Administrator of the Centers for
Medicare & Medicaid Services*

represented by **EMILY MARGARET HALL**
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ATTORNEY TO BE NOTICED

Defendant

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MEDICAID SERVICES**

represented by **EMILY MARGARET HALL**
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Date Filed	#	Docket Text
07/16/2025	<u>1</u>	COMPLAINT against CENTERS FOR MEDICARE AND MEDICAID SERVICES, ROBERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PAYMENT OF FILING FEE DUE WITHIN 48 HOURS. IF FILING FEE IS BEING PAID WITH A CREDIT CARD COUNSEL ARE INSTRUCTED TO LOGIN TO CMECF AND DOCKET Case Opening Filing Fee Paid FOUND IN THE Complaints and Other Initiating Documents CATEGORY. CHECK PAYMENTS DUE WITHIN 48 HOURS. , filed by THE FAMILY PLANNING ASSOCIATION OF MAINE. (Service of Process Deadline 10/14/2025) Fee due by 7/18/2025.(lcb) Modified on 7/16/2025 to correct party name (lcb). (Entered: 07/16/2025)
07/16/2025	<u>2</u>	CIVIL COVER SHEET. (lcb) (Entered: 07/16/2025)
07/16/2025	<u>3</u>	RULE 7.1 DISCLOSURE STATEMENT by THE FAMILY PLANNING ASSOCIATION OF MAINE. (lcb) (Entered: 07/16/2025)
07/16/2025	<u>4</u>	Summons Issued as to CENTERS FOR MEDICARE AND MEDICAID SERVICES, ROBERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. Counsel shall print the embossed summons and effect service in the manner in accordance with Fed.R.Civ.P.4.

		Note—If you are using Version 6 of Adobe Acrobat, be sure the PRINT WHAT field is set to DOCUMENTS AND COMMENTS (Click File, then Print to check this setting). (Attachments: # <u>1</u> Summons for United States Department of Health and Human Services, # <u>2</u> Summons for Robert F Kennedy Jr., # <u>3</u> Summons for Mehmet Oz)(lcb) Modified on 7/16/2025 to correct party name(lcb). (Entered: 07/16/2025)
07/16/2025	<u>5</u>	MOTION for Temporary Restraining Order, MOTION for Preliminary Injunction by THE FAMILY PLANNING ASSOCIATION OF MAINE Responses due by 8/6/2025. (Attachments: # <u>1</u> Declaration of Cassidy Jarvis, # <u>2</u> Declaration of Evelyn Kieltyka, # <u>3</u> Plaintiff Maine Family Planning's Memorandum of Law in Support of its Motion)(lcb) (Entered: 07/16/2025)
07/16/2025		Filing Fee Paid via Credit Card (Filing fee \$ 405 receipt number AMEDC-3138804.), filed by THE FAMILY PLANNING ASSOCIATION OF MAINE.(ASEN, TAYLOR) (Entered: 07/16/2025)
07/17/2025	<u>6</u>	CERTIFICATION for Admission Pro Hac Vice of Meetra Mehdizadeh, Esq. filed by TAYLOR ANDREW ASEN on behalf of THE FAMILY PLANNING ASSOCIATION OF MAINE (Total admission fee \$ 200 receipt number AMEDC-3139525.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (ASEN, TAYLOR) (Entered: 07/17/2025)
07/17/2025	<u>7</u>	CERTIFICATION for Admission Pro Hac Vice of Astrid Ackerman, Esq. filed by TAYLOR ANDREW ASEN on behalf of THE FAMILY PLANNING ASSOCIATION OF MAINE (Total admission fee \$ 200 receipt number AMEDC-3139527.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (ASEN, TAYLOR) (Entered: 07/17/2025)
07/17/2025	8	NOTICE of APPROVAL by Clerk's Office re <u>7</u> Certification for Admission Pro Hac Vice,, <u>6</u> Certification for Admission Pro Hac Vice,, Attorney MEETRA MEHDIZADEH,ASTRID MARISELA ACKERMAN for THE FAMILY PLANNING ASSOCIATION OF MAINE added to this specific case only. Maine has transitioned to the NextGen ECF filing system; therefore, to complete the admissions process, Attorney Mehdizadeh and Ackerman must register for a PACER account and/or request the appropriate e-filing rights in the District of Maine via PACER at www.pacer.uscourts.gov by 7/24/2025. NOTE: Counsel appearing Pro Hac Vice MUST click on the PRO HAC VICE link when requesting e-filing rights via PACER. For more details on NextGen/PACER go to our website at www.med.uscourts.gov. (lrt) (Entered: 07/17/2025)
07/21/2025	<u>9</u>	MOTION for Oral Argument/Hearing re <u>5</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction by THE FAMILY PLANNING ASSOCIATION OF MAINE Responses due by 8/11/2025. (MEHDIZADEH, MEETRA) (Entered: 07/21/2025)
07/22/2025	10	ORDER granting <u>9</u> Motion for Oral Argument/Hearing By JUDGE LANCE E. WALKER. (clp) (Entered: 07/22/2025)
07/22/2025	<u>11</u>	NOTICE of Appearance by ROSALIE B.C. WENNBURG on behalf of THE FAMILY PLANNING ASSOCIATION OF MAINE (WENNBURG, ROSALIE) (Entered: 07/22/2025)
07/22/2025	12	NOTICE of Hearing on Motion <u>5</u> MOTION for Temporary Restraining Order, MOTION for Preliminary Injunction : Motion Hearing set for 8/14/2025 at 01:00 PM in Portland Courtroom 1 before JUDGE LANCE E. WALKER. (clp) (Entered: 07/22/2025)

07/23/2025	<u>13</u>	NOTICE/CORRESPONDENCE Re: Joint Motion for Briefing Schedule <i>on Plaintiff's Motion for a TRO and/or Preliminary Injunction</i> by THE FAMILY PLANNING ASSOCIATION OF MAINE (MEHDIZADEH, MEETRA) (Entered: 07/23/2025)
07/24/2025		Reset Deadlines as to <u>5</u> MOTION for Temporary Restraining Order, MOTION for Preliminary Injunction per directive of Chief U.S. District Judge Lance E. Walker: Responses due by 8/1/2025. Reply due by 8/8/2025. (clp) (Entered: 07/24/2025)
07/29/2025	<u>14</u>	CERTIFICATION for Admission Pro Hac Vice of Faith Gay, Esq. filed by TAYLOR ANDREW ASEN on behalf of THE FAMILY PLANNING ASSOCIATION OF MAINE (Total admission fee \$ 200 receipt number AMEDC-3145709.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (ASEN, TAYLOR) (Entered: 07/29/2025)
07/29/2025	<u>15</u>	CERTIFICATION for Admission Pro Hac Vice of Joshua Margolin, Esq. filed by TAYLOR ANDREW ASEN on behalf of THE FAMILY PLANNING ASSOCIATION OF MAINE (Total admission fee \$ 200 receipt number AMEDC-3145722.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (ASEN, TAYLOR) (Entered: 07/29/2025)
07/29/2025	16	NOTICE of APPROVAL by Clerk's Office re <u>15</u> Certification for Admission Pro Hac Vice,, <u>14</u> Certification for Admission Pro Hac Vice,, Attorney FAITH GAY,JOSHUA MARGOLIN for THE FAMILY PLANNING ASSOCIATION OF MAINE added to this specific case only. Maine has transitioned to the NextGen ECF filing system; therefore, to complete the admissions process, Attorney Gay and Margolin must register for a PACER account and/or request the appropriate e-filing rights in the District of Maine via PACER at www.pacer.uscourts.gov by 8/5/2025. NOTE: Counsel appearing Pro Hac Vice MUST click on the PRO HAC VICE link when requesting e-filing rights via PACER. For more details on NextGen/PACER go to our website at www.med.uscourts.gov . (lrt) Modified on 7/29/2025 to clarify docket text(lrt). (Entered: 07/29/2025)
07/29/2025	<u>17</u>	CERTIFICATION for Admission Pro Hac Vice of Olivia F. Summers filed by STEPHEN C. WHITING on behalf of American Center for Law and Justice (Total admission fee \$ 200 receipt number AMEDC-3146108.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (WHITING, STEPHEN) (Entered: 07/29/2025)
07/29/2025	<u>18</u>	CERTIFICATION for Admission Pro Hac Vice of Nathan Moelker filed by STEPHEN C. WHITING on behalf of American Center for Law and Justice (Total admission fee \$ 200 receipt number AMEDC-3146118.) The District of Maine is a CM/ECF NextGen Court. If PHV counsel has not previously been granted electronic filing rights with the District of Maine, PHV counsel will now need to submit a PRO HAC VICE request in this District via PACER at www.pacer.uscourts.gov (Attachments: # <u>1</u> Supplement List of Court Admissions)(WHITING, STEPHEN) Modified on 7/30/2025 to insert name of Pro Hac Attorney (lrt). (Entered: 07/29/2025)
07/30/2025	19	NOTICE of APPROVAL by Clerk's Office re <u>18</u> Certification for Admission Pro Hac Vice,, <u>17</u> Certification for Admission Pro Hac Vice,, Attorney OLIVIA FRANCES SUMMERS,NATHAN JEREMIAH MOELKER for American Center for Law and Justice added to this specific case only. Maine has transitioned to the NextGen ECF filing system; therefore, to complete the admissions process, Attorney Summers must register for a PACER account and/or request the appropriate e-filing rights in the District of Maine via PACER at www.pacer.uscourts.gov by 8/6/2025. NOTE: Counsel appearing Pro Hac Vice MUST click on the PRO HAC VICE link when requesting e-filing rights via PACER. For more details on NextGen/PACER go to our website at www.med.uscourts.gov . (lrt) (Entered: 07/30/2025)

07/31/2025	<u>20</u>	NOTICE of Appearance by ELISABETH NEYLAN on behalf of All Defendants (NEYLAN, ELISABETH) (Entered: 07/31/2025)
08/01/2025	<u>21</u>	Consent MOTION for Leave to File <i>Amicus Brief in Opposition to Plaintiff's Motion for a Preliminary injunction</i> by AMERICAN CENTER FOR LAW AND JUSTICE Responses due by 8/22/2025. (Attachments: # <u>1</u> Exhibit Proposed Amicus Brief in Opposition to Plaintiff's Motion for a Preliminary injunction,)(MOELKER, NATHAN) (Entered: 08/01/2025)
08/01/2025	22	ORDER granting <u>21</u> Motion for Leave to File Amicus Brief in Opposition to Plaintiff's Motion for a Preliminary Injunction By JUDGE LANCE E. WALKER. (clp) (Entered: 08/01/2025)
08/01/2025	<u>23</u>	BRIEF <i>Amicus Brief in Opposition to Plaintiff's Motion for a Preliminary injunction</i> by AMERICAN CENTER FOR LAW AND JUSTICE. (MOELKER, NATHAN) (Entered: 08/01/2025)
08/01/2025	<u>24</u>	RESPONSE in Opposition re <u>5</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction filed by CENTERS FOR MEDICARE AND MEDICAID SERVICES, ROBERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. Reply due by 8/15/2025. (Attachments: # <u>1</u> Affidavit Declaration of Anne Marie Costello)(NEYLAN, ELISABETH) (Entered: 08/01/2025)
08/04/2025		Reset Deadlines as to <u>5</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction per directive of Chief U.S. District Judge Lance E. Walker: Reply due by 8/8/2025. (clp) (Entered: 08/04/2025)
08/08/2025	<u>25</u>	REPLY to Response to Motion re <u>5</u> MOTION for Temporary Restraining Order MOTION for Preliminary Injunction filed by THE FAMILY PLANNING ASSOCIATION OF MAINE. (Attachments: # <u>1</u> Supplemental Declaration of Evelyn Kieltyka)(MEHDIZADEH, MEETRA) (Entered: 08/08/2025)
08/12/2025	<u>26</u>	NOTICE of Appearance by EMILY MARGARET HALL on behalf of All Defendants (HALL, EMILY) (Entered: 08/12/2025)
08/14/2025	27	Minute Entry for proceedings held before JUDGE LANCE E. WALKER: Oral Argument held re <u>5</u> MOTION for Temporary Restraining Order, MOTION for Preliminary Injunction filed by THE FAMILY PLANNING ASSOCIATION OF MAINE. Matter taken under advisement. Decision to enter. (Court Reporter: Lori Dunbar) (clp) (Entered: 08/14/2025)
08/14/2025	<u>28</u>	ORDER. (Set Deadlines: Briefs due by no later than 5:00PM on 8/15/2025. No responses permitted.) By JUDGE LANCE E. WALKER. (clp) (Entered: 08/14/2025)
08/15/2025	<u>29</u>	BRIEF re <u>28</u> Order by THE FAMILY PLANNING ASSOCIATION OF MAINE. (MEHDIZADEH, MEETRA) Modified on 8/18/2025 to clean up text (clp). (Entered: 08/15/2025)
08/15/2025	<u>30</u>	BRIEF re <u>28</u> Order, Set Deadlines BERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. (Attachments: # <u>1</u> Exhibit Minnesota Jurisdictional Statement, # <u>2</u> Exhibit Minnesota Motion to Affirm)(NEYLAN, ELISABETH) Modified on 8/18/2025 to clean up text (clp). (Entered: 08/15/2025)
08/25/2025	<u>31</u>	ORDER ON MOTION FOR PRELIMINARY INJUNCTION denying <u>5</u> Motion for TRO/Motion for Preliminary Injunction By JUDGE LANCE E. WALKER. (clp) (Entered: 08/25/2025)
08/29/2025	<u>32</u>	NOTICE OF APPEAL as to <u>31</u> Order on Motion for TRO, Order on Motion for Preliminary Injunction by THE FAMILY PLANNING ASSOCIATION OF MAINE . (Filing fee \$ 605 receipt number AMEDC-3161832.) NOTICE TO FILER: A transcript Report/Order form <u>MUST</u> be completed and submitted to the First Circuit Court of Appeals. The form can be found under the Forms & Fees section on their website at https://www.ca1.uscourts.gov .

		NOTICE TO COUNSEL: Counsel should register for a First Circuit CM/ECF Appellate Filer Account at https://pacer.psc.uscourts.gov . Counsel should also review the First Circuit requirements for electronic filing by visiting the CM/ECF Information section at https://www.ca1.uscourts.gov/cmecf (MEHDIZADEH, MEETRA) (Entered: 08/29/2025)
08/29/2025	<u>33</u>	Emergency MOTION for Preliminary Injunction <i>Pending Appeal</i> by THE FAMILY PLANNING ASSOCIATION OF MAINE Responses due by 9/19/2025. (Attachments: # <u>1</u> Memorandum of Law in Support of Plaintiff Maine Family Planning's Motion for An Injunction Pending Appeal)(MEHDIZADEH, MEETRA) (Entered: 08/29/2025)
08/29/2025	<u>34</u>	APPEAL COVER SHEET Re: <u>32</u> Notice of Appeal (jlm) (Entered: 08/29/2025)
08/29/2025	<u>35</u>	CLERK'S CERTIFICATE Re: <u>32</u> Notice of Appeal, Documents sent to the U.S. Court of Appeals. (jlm) (Entered: 08/29/2025)
08/29/2025		Reset Deadlines as to <u>33</u> Emergency MOTION for Preliminary Injunction <i>Pending Appeal</i> per directive of Chief U.S. District Judge Lance E. Walker: Responses due by 9/5/2025. Reply due by 9/8/2025. (clp) (Entered: 08/29/2025)
09/02/2025	36	USCA Case Number 25-1829 for <u>32</u> Notice of Appeal. (clp) (Entered: 09/02/2025)
09/05/2025	<u>37</u>	RESPONSE in Opposition re <u>33</u> Emergency MOTION for Preliminary Injunction <i>Pending Appeal</i> filed by CENTERS FOR MEDICARE AND MEDICAID SERVICES, ROBERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. Reply due by 9/19/2025. (HALL, EMILY) (Entered: 09/05/2025)
09/08/2025		Reset Deadlines as to <u>33</u> Emergency MOTION for Preliminary Injunction <i>Pending Appeal</i> per directive of Chief U.S. District Judge Lance E. Walker: Reply due by 9/8/2025. (clp) (Entered: 09/08/2025)
09/08/2025	<u>38</u>	ORDER ON MOTION FOR INJUNCTION PENDING APPEAL denying <u>33</u> Emergency Motion for Preliminary Injunction Pending Appeal By JUDGE LANCE E. WALKER. (clp) (Entered: 09/08/2025)
09/09/2025	<u>39</u>	CLERK'S FIRST SUPPLEMENTAL CERTIFICATE Re: <u>32</u> Notice of Appeal, Documents Sent to U.S. Court of Appeals (jlm) (Entered: 09/09/2025)
09/09/2025		Supplemental Record on Appeal transmitted to US Court of Appeals re <u>32</u> Notice of Appeal (jlm) (Entered: 09/09/2025)
09/10/2025	<u>40</u>	NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Proceedings Oral Argument held on August 14, 2025, before Judge Lance E. Walker. Court of Appeals Docket Number 25-1829. Court Reporter/Transcriber: Lori Dunbar, Telephone Number: (207) 749-4072. NOTICE RE REDACTION OF TRANSCRIPTS: The parties have seven (7) calendar days to file with the Court a Notice of Intent to Request Redaction of this transcript. If no such Notice is filed, the transcript will be made remotely electronically available to the public without redaction after 90 calendar days. The policy is located on our website at www.med.uscourts.gov. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. Release of Transcript Restriction set for 12/9/2025. (DUNBAR, LORI) (Entered: 09/10/2025)
09/12/2025	<u>41</u>	Consent MOTION to Stay <i>Further District Court Proceedings Pending Resolution of Plaintiff's Motion for an Injunction Pending Appeal</i> by CENTERS FOR MEDICARE AND MEDICAID SERVICES, ROBERT F KENNEDY, JR, MEHMET OZ, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Responses due by 10/3/2025. (NEYLAN, ELISABETH) (Entered: 09/12/2025)
09/16/2025	42	ORDER granting <u>41</u> Motion to Stay Further District Court Proceedings Pending Resolution of Plaintiff's Motion for an Injunction Pending Appeal By JUDGE LANCE E. WALKER. (clp) (Entered: 09/16/2025)

**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. _____

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

REQUEST FOR IMMEDIATE RELIEF

Plaintiff Family Planning Association of Maine d/b/a Maine Family Planning (“MFP”), through its attorneys, brings this Complaint for Declaratory and Injunctive Relief against the United States Department of Health and Human Services (“HHS”), Robert F. Kennedy, Jr., in his official capacity as Secretary of HHS, the Centers for Medicare & Medicaid Services (“CMS”), and Mehmet Oz in his official capacity as the Administrator of CMS, and alleges as follows:

INTRODUCTION

1. “[A]ffordable, confidential care”—“no matter who you are or where you live.”¹

True to its motto, Maine Family Planning has spent decades providing award-winning, essential health care and serves thousands of Mainers each year. Its services include contraception counseling, gynecological exams and check-ups, preventive care, cancer screenings, sexually transmitted infections (“STI”) testing, well-person exams, and treatment of common acute and chronic conditions like strep throat, asthma, and diabetes.

2. MFP has continuously sought to improve and expand its services to meet the needs of Maine’s most underserved populations, including lower-income, rural, and unhoused patients. Many of these Mainers could not access health care without MFP. Indeed, for approximately 70% of its patients, MFP is the only health care provider that they will see in a given year.² Because of the population MFP serves, almost half of MFP’s patients who receive care other than abortion rely on Medicaid, and Medicaid funding comprises nearly one-quarter of MFP’s budget.

3. After decades of providing a broad range of quality care to its Medicaid patients, on July 4, 2025, MFP was stripped of its ability to receive federal Medicaid reimbursements for all of its services—solely because MFP provides abortions in addition to its numerous other health care services. But existing federal law, known as the Hyde Amendment, already prohibits the use of federal Medicaid funding for abortions outside of extremely limited circumstances.³ MFP strictly abides by this restriction on the use of federal Medicaid funding, and has never been found to have improperly used Medicaid funding for abortions.

¹ Me. Fam. Plan., Home Page, <https://mainefamilyplanning.org/> (last visited July 11, 2025).

² Chantelle Lee, *Abortion Is Legal in Maine, but Trump’s ‘Big Beautiful Bill’ Could Gut Much of the State’s Reproductive Health Care Access*, TIME (July 2, 2025, 14:49 PT), <https://time.com/7299743/trump-big-beautiful-bill-reproductive-health-care-maine/>.

³ Departments of Labor and Health, Education, and Welfare Appropriation Act of 1977, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976); Further Consolidated Appropriations Act of 2024, Pub. L. No. 118-47 §§ 506, 507, 138 Stat. 460, 703 (2024).

4. On July 4, 2025, Section 71113⁴ (the “Defunding Provision”) was signed into law as part of President Trump’s “big beautiful bill.” The Defunding Provision is the culmination of a years-long campaign to “defund” Planned Parenthood. The provision’s parameters were designed to create plausible deniability that its sole target was Planned Parenthood; as a result, MFP got caught in its net.

5. The Defunding Provision bars federal Medicaid funding for *all* health care services, including preventive care and family planning services, for a *tiny subset* of American health care providers—including MFP—that, as of October 1, 2025, (1) are non-profit, (2) “essential community providers . . . primarily engaged in family planning services, reproductive health, and related medical care”—providers who, by definition, “serve[] predominantly low-income, medically underserved individuals,” (3) received more than \$800,000 in federal and state Medicaid reimbursements in fiscal year 2023 (FY23), and (4) provide abortions that fall outside of the narrow exceptions in the Hyde Amendment.⁵

6. In stark contrast, the Defunding Provision does not apply to other entities providing the exact same Medicaid-reimbursable health care as MFP. Non-profit clinics providing family planning services but not abortion that receive a similar amount of Medicaid funding as MFP are not affected by the Defunding Provision. Non-profit clinics providing family planning and abortion services that received less than \$800,000 in Medicaid reimbursements in FY23 are not affected by the Defunding Provision. Non-profit clinics providing family planning services and abortion that receive a similar amount of Medicaid funding but do not “primarily” engage in providing reproductive health care or family planning are not affected by the Defunding Provision. For-profit

⁴ One Big Beautiful Bill Act, H.R.1, 119th Cong. § 71113 (2025) (as enrolled).

⁵ H.R. 1, § 71113(b).

entities providing family planning services and abortion care are not affected by the Defunding Provision.

7. The Defunding Provision thus deprives MFP of the same Medicaid funding available to other health care providers throughout the United States. Targeting health care providers who serve the populations with the fewest resources, and doing it by withholding funding simply because they also provide abortion care, is completely opposed to the goal of the Medicaid program—to ensure that adults and children with limited resources can access health care.

8. By irrationally including MFP to disguise its true purpose of targeting Planned Parenthood while allowing similarly situated entities to continue to bill Medicaid, the Defunding Provision violates the Fifth Amendment’s guarantee of equal protection and endangers the health of thousands of Mainers, particularly those who are low-income, live in rural areas, and are women. Without federal Medicaid reimbursements, MFP’s ability to provide comprehensive health care to Medicaid-eligible patients is at grave risk. The result is significant and irreparable harm to MFP and its patients, many of whom have nowhere else to turn for time-sensitive health care such as cancer screenings and STI testing.

PARTIES

I. Plaintiff Maine Family Planning

9. Plaintiff MFP is a 501(c)(3) non-profit incorporated in Maine with its principal place of business in Augusta, Maine. Its mission is to ensure that all Mainers have access to high-quality and affordable sexual and reproductive health care. MFP offers a range of family planning, reproductive health, and primary care services, including abortion care. MFP directly operates eighteen health care centers throughout Maine and provides funding through subcontracts that support forty-four additional sites. Plaintiff MFP sues on its own behalf.

II. Defendants

10. Defendant the United States Department of Health and Human Services (“HHS”) is an executive department of the United States.

11. Defendant Robert F. Kennedy, Jr., is the Secretary of HHS and is sued in his official capacity. Secretary Kennedy has overall responsibility for implementation of the Medicaid program, including for the Defunding Provision.

12. Defendant Centers for Medicare & Medicaid Services (“CMS”) is a subdivision of HHS.

13. Defendant Mehmet Oz is the Administrator of CMS and is sued in his official capacity. Administrator Oz is responsible for implementing the Medicaid program in a manner consistent with federal law, including the Defunding Provision.

JURISDICTION AND VENUE

14. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331, as this action arises under the Constitution and laws of the United States. This Court has jurisdiction to render declaratory and injunctive relief under 28 U.S.C. §§ 2201 and 2202, Federal Rules of Civil Procedure 57 and 65, and the inherent equitable powers of this Court.

15. Venue is proper in this district under 28 U.S.C. §§ 1391(b)(2) and (e)(1). MFP is located in this judicial district and has its principal place of business in this judicial district. A substantial part of the events or omissions giving rise to these claims occurred or is occurring in this judicial district. Defendants are United States departments and agencies and United States officials sued in their official capacities.

FACTUAL BACKGROUND

I. MFP Provides Critical Family Planning, Reproductive Health, and Primary Care.

16. MFP operates eighteen family planning clinics located in Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Thomaston, Rumford, Skowhegan, and Waterville—at least one site in twelve out of Maine’s sixteen counties. MFP also has a mobile health clinic.

17. At its clinics, 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; endometrial and vulvar biopsy; 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 moms, and their families. MFP offers procedural abortions at its Augusta clinic and medication abortions at all eighteen clinics.

18. 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 (the “ECP List”).⁶ By definition, essential community providers serve “predominantly low-income, medically underserved individuals.” 45 C.F.R. § 156.235(c).

⁶ *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*].

19. MFP also provides funding through subcontracts that support forty-four additional sites. The sixty-two family planning centers in its network are located across the state, providing access in fifteen out of Maine's sixteen counties. In calendar year 2024, the network served approximately 28,000 patients across the state. MFP clinics served over 8,000 patients, including 645 abortion patients (7.4 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 10,000 visits and primary care patients had over 2,000 visits.

20. MFP offers primary care at three of its clinic locations: Ellsworth, Houlton and Presque Isle. The primary care services include wellness and preventive care; diagnosis and treatment of common acute and chronic conditions; menopause management for mid-life women; adolescent health services; and geriatric health services. MFP began offering this care in Ellsworth in 2015 and in Houlton and Presque Isle in 2022 after realizing the dearth of health care providers in these regions. Even for patients who are not coming to MFP for primary care, MFP providers address patients' overall health, including identifying potential chronic illnesses, because MFP is often the only health care provider that its patients see in a given year.

21. As one MFP patient explained, "Maine Family Planning in Augusta is my Primary Care Physician. In the last four years I've received care there, not once did I have an abortion. I have however, had access to STD/STI testing, thyroid testing, blood panels, Pap smears, breast examinations, referrals for mammograms, [and] a Premenstrual Dysphoric Disorder diagnosis. The last two saved my life. Not only was I able to find a space and practitioner that felt safe enough to advocate for myself, they took my concerns seriously and they provided me care that would not

otherwise be accessible to me.”⁷ And according to another patient: “Many of us count on our local MFP for a wide variety of basic, essential health care that often we can’t otherwise access. Mainers are facing innumerable barriers to accessing health care, from insurance coverage fights to providers not accepting new patients, from transportation barriers to federal attacks on Medicaid funding.”⁸

22. To better serve populations with difficulty accessing health care, MFP established an outreach program called the Reproductive Empowerment Project for people with opioid addiction that includes contraceptive consultation, harm reduction, STI screening, pregnancy testing, and options counseling.

23. In late 2024, MFP also launched “Health on Wheels,” a mobile health care facility that travels across the state to serve populations with difficulty accessing health care, such as people with opioid addiction or people who are unhoused. Health on Wheels provides services like primary, wound, and reproductive health care including birth control, Pap smears, HIV prevention, and STI testing.⁹ The mobile clinic travels “up to 100 miles in any direction” from where it is housed, providing care at locations including syringe service programs, encampments, soup kitchens, and places with known HIV clusters.¹⁰ These services are critical given ongoing increases

⁷*An Act to Improve Women’s Health and Economic Security by Funding Family Planning Services: Hearing on L.D. 143 Before the J. Standing Comm. on Health & Human Servs.*, 132nd Leg., 1st Spec. Sess. (Me. 2025) (testimony of Ashley Smith).

⁸ Kelsey Linnell, *Family Planning Health Centers Are a Crucial Safety*, Bangor Daily News (June 16, 2025), <https://www.bangordailynews.com/2025/06/16/opinion/opinion-contributor/family-planning-health-centers-safety-net-joam40zk0w/>.

⁹ Brianna Bush, *Health on Wheels Brings Care Services to Mainers Who Have Limited Access*, News Ctr. Me. (Dec. 17, 2024, 21:02 EST), <https://www.newscentermaine.com/article/news/health/health-on-wheels-accessible-healthcare-maine-west-gardiner-maine-family-planning/97-5e88683c-b613-4c29-846c-614681ad97ec>; Joe Charpentier, *Maine Family Planning Tours Lewiston with Mobile Medical Unit*, Sun J. (Nov. 20, 2024), <https://www.sunjournal.com/2024/11/20/maine-family-planning-tours-lewiston-with-mobile-medical-unit/>.

¹⁰ Bush, *supra* note 9; Charpentier, *supra* note 9.

in HIV and STI cases in Maine, particularly among these underserved populations.¹¹ If MFP could not reach this patient population, most of these individuals would otherwise not be able to receive care.

24. The care MFP provides is crucial because Maine already faces a shortage of health care providers. Thirteen of Maine's sixteen counties contain health professional shortage areas for primary care,¹² and 85,155 Maine residents live in these areas.¹³ In some regions of the state, MFP is the only clinic where patients can obtain long-acting reversible contraception ("LARCs"), such as IUDs or implants, without having to schedule around limited provider availability and facing extensive wait times.

25. Further compounding the provider shortage, factors such as geography, poverty, and low population density can make health care even more difficult to access in Maine. Maine is one of the most rural states in the country, and 40% of its population lives in Maine's rural counties.¹⁴ Indeed, in eleven of the twelve counties where MFP operates clinics, more than 50% of the population lives in a rural area.¹⁵ Many patients live long distances from Maine's cities, and transportation and excessive travel times are major obstacles to accessing health care, especially with limited public transportation outside of Maine's one large city, Portland. The remote and rural areas with low population densities have fewer health care choices compared with Maine's more

¹¹ Div. of Disease Surveill., Me. Ctr. for Disease Control & Prevention, *Infectious Disease Prevention Program*, Me. Dep't of Health & Human Servs. <https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/> (last visited July 11, 2025).

¹² *Health Professional Shortage Areas: Primary Care, by County, April 2025 - Maine*, Rural Health Info. Hub, <https://www.ruralhealthinfo.org/charts/5?state=ME> (last visited July 11, 2025).

¹³ *Primary Care Health Professional Shortage Areas (HPSAs)*, Kaiser Fam. Found. (Dec. 31, 2024), <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁴ 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).

¹⁵ 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).

heavily populated southern counties. Transportation within and between remote counties is also limited. Interstate 95 is the sole north-south highway; in winter weather, it is usually reduced to one lane north of Orono and is occasionally closed. There are no east-west interstates, and travel along Route 2, which goes from Bangor to the New Hampshire border, can be very slow in some parts of the state.

26. With travel posing such a hurdle to accessing care, local clinics in rural areas are a crucial part of the health care system. As one Mainer explained, “At the current funding level, many of Maine’s rural health centers are open 1-2 days a week. . . . In my reproductive years I was fortunate to have Family Planning nestled in my Waterville neighborhood. In fact, services remain within walking distance for many consumers. We have many in our low-moderate income neighborhood who depend on affordable Family Planning. Waterville is a service center for many in Somerset County, one of the poorest counties in Maine.”¹⁶

27. MFP’s confidential, nonjudgmental, quality care has gained the trust of Mainers over decades of providing care throughout the state, and many MFP patients continue to return for care. Particularly in rural areas, patients worry about anonymity when visiting a health center. Many patients may feel more comfortable—and less stigmatized—discussing sensitive topics related to reproductive health care at MFP, where they know they will receive confidential care from clinicians who specialize in reproductive health. As one MFP patient explained: “When I began to need family planning services, I was uncomfortable going to the same primary care provider I’d had since childhood . . . My experience at a family planning provider was the first time I ever received kind, comprehensive, non-coercive information about birth control My

¹⁶ *An Act to Improve Women’s Health and Economic Security by Funding Family Planning Services: Hearing on L.D. 143 Before the J. Standing Comm. on Health & Human Servs.*, 132nd Leg., 1st Spec. Sess. (Me. 2025) (testimony of Kimberly Hallee), <https://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=10035608>.

family planning providers were and continue to be compassionate, knowledgeable and truly nonjudgmental.”¹⁷

28. MFP has won several awards for its dedication to providing 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. Medicaid Is Essential for Mainers Seeking Health Care, Including at MFP.

29. Medicaid is a government program that provides crucial health care services to adults and children with limited resources. First established in 1965, the purpose of Medicaid is to allow states “to furnish . . . medical assistance” to patients “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1. The provision of medical services must be administered in a

¹⁷ Jake Richards, *Advocates and Lawmakers Push for increased funding for Maine Planned Parenthood*, News Ctr. Me. (Mar. 7, 2025), <https://www.newscentermaine.com/article/news/health/push-for-increased-maine-planned-parenthood-funding/97-cd57cd5c-0d4f-4e99-bd15-1b628bd93294>.

manner consistent with “simplicity of administration and the best interests of the recipients.” 42 U.S.C. § 1396a(a)(19).

30. The Medicaid program is funded by both state and federal funding. 42 C.F.R. § 430.0. State governments have latitude to determine coverage and management of each state’s Medicaid program, within broad guidelines set by the federal government. 42 U.S.C. §§ 1396a, 1396b; *Atkins v. Rivera*, 477 U.S. 154, 156–57 (1986).

31. MaineCare is the state of Maine’s Medicaid program. MaineCare covers medically necessary services, including primary care visits, family planning services, prescription medications, and behavioral health.¹⁸ MaineCare plays a critically important role in ensuring that rural Mainers have access to care. Adults and children living in rural areas, including most of Maine, are more likely to rely on MaineCare or CHIP (the Children’s Health Insurance Program) than adults and children who live in urban areas.¹⁹ Indeed, more than half of Medicaid enrollees in Maine live in rural areas,²⁰ and more than 20% of non-elderly adults in Maine who live outside of urban areas are covered by Medicaid.²¹ In some rural counties like Aroostook County, Washington County, and Somerset County, where five MFP clinics are located, the number of Mainers who rely on MaineCare is as high as 40%.²²

32. Almost half of MFP’s patients who receive care other than abortion rely on Medicaid. Between July 1, 2022 and June 30, 2023, 41% of MFP family planning network’s patients had public insurance, and 82% fell below 250% of the federal poverty level and, as a

¹⁸ Off. MaineCare Servs., Me. Dep’t Health & Human Servs., *MaineCare Member Handbook*, at 8-9 (2024), <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/mainecare-member-handbook.pdf>.

¹⁹ Joan Alker et al., *Medicaid’s Role in Small Towns and Rural Areas*, Geo. Univ. Ctr. Child. & Fams. (Jan. 15, 2025), <https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/>.

²⁰ *Medicaid in Maine*, Kaiser Fam. Found. (May 2025), <https://files.kff.org/attachment/fact-sheet-medicare-state-ME> (52% of Medicaid enrollees in Maine live in a rural area).

²¹ Alker et al., *supra* note 19.

²² 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.

result, qualified for free or reduced services.²³ And in calendar year 2024, 49.8% of patients who received services other than abortion care at MFP were enrolled in MaineCare. Without MaineCare, many of these patients could not afford to see a health care provider and might postpone or forgo care altogether.

33. Medicaid funding is essential to MFP and allows MFP to serve low-income patients. Prior to the passage of the Defunding Provision, MFP billed MaineCare when it provided covered services to patients on MaineCare and would then be reimbursed for the cost of the specific service provided. Reimbursements for Medicaid funding are a significant part of MFP's annual budget—approximately 20 to 25%, or roughly \$1.9 million. Thus, in FY23, MFP received more than \$800,000 from Medicaid reimbursements.

34. Unlike MFP, many health care providers in private practice do not accept Medicaid because the reimbursement rates are often lower than private insurance.²⁴ As a result, Medicaid patients have fewer options when finding a health care provider.²⁵ These patients may face long waitlists when scheduling care,²⁶ or have to travel longer distances to find a provider who is able to see them in a timely manner. Even if other health care providers accept Medicaid, MFP makes intentional efforts to reach particularly underserved patient populations, including through the Reproductive Empowerment Project and Health on Wheels—programs that other health care providers are unlikely to replicate.

²³ Me. Fam. Plan., *Annual Report 2023*, at 4, <https://mainefamilyplanning.org/wp-content/uploads/MFP2023AnnualReport.pdf> (last visited July 14, 2025).

²⁴ FamilyCare Health, *The Medicaid Payment Crisis: Why Many Doctors Are No Longer Accepting Patients* (March 14, 2025), <https://familycare.health/resources/the-medicaid-payment-crisis/>.

²⁵ Suzanne Blake, *Medicaid Patients Are Losing Their Doctors Because of Costs*, Newsweek (July 19, 2024), <https://www.newsweek.com/medicaid-patients-are-losing-doctors-because-costs-1927849>; Walter R Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis*, 56 *Inquiry: J. Health Care Org, Provision, & Fin.* 1, 6 (2019).

²⁶ Evelyn G. Gotlieb et al., *Disparities in Primary Care Wait Times in Medicaid versus Commercial Insurance*, 34 *J. Am. Bd. of Fam Med.* 3 (2021).

35. Medicaid coverage is crucial for access to essential reproductive health services, including birth control, screenings for breast and cervical cancer, and STI testing and treatment.²⁷ Medicaid is the largest source of public funding for family planning services, accounting for 75% of all public family planning expenditures.²⁸ It also covers prenatal and postpartum care and provides funding for 41% of all births in the United States, including 39% of births in Maine in 2023.²⁹ Studies consistently show that Medicaid enrollees have substantially better access to care than people who are uninsured, and thus they are less likely to postpone or go without care due to cost.³⁰ Research demonstrates that access to Medicaid is associated not only with increased access to care, but with lower mortality rates for conditions such as cancer and cardiovascular disease, and decreased maternal mortality.³¹

36. Federal Medicaid funding does not cover abortions outside of limited exceptions. Since 1977, a federal law—commonly known as the Hyde Amendment—has prohibited the use of

²⁷ 42 U.S.C. § 1396d; 42 C.F.R. § 441.20; CMS, *Mandatory & Optional Medicaid Benefits*, <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits> (last visited July 11, 2025); Jennifer J. Frost et al., Guttmacher Inst., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, at 19 (2019), https://www.guttmacher.org/sites/default/files/report_pdf/publicly-supported-fp-services-us-2016.pdf (without access to publicly funded family planning services, in 2016, “an estimated 1.3 million women would have foregone or postponed cervical cancer testing” and “6.7 million women would have foregone screening” for STIs).

²⁸ Usha Ranji et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, Kaiser Fam. Found. (Feb. 17, 2022), <https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey>; Am. Coll. of Obstetricians & Gynecologists, *Medicaid*, <https://www.acog.org/practice-management/payment-resources/payer-policies/Medicaid> (last visited July 11, 2025).

²⁹ Nat’l Ctr. for Health Stats., Ctrs. for Disease Control & Prevention, *Birth Data* (June 13, 2025), <https://www.cdc.gov/nchs/nvss/births.htm>; Usha Ranji et al., *5 Key Facts About Medicaid and Pregnancy*, Kaiser Fam. Found. (May 29, 2025), <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-pregnancy>.

³⁰ Alice Burns et al., *10 Things to Know About Medicaid*, Kaiser Fam. Found. (Feb. 18, 2025), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid>; see also Benjamin Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1501, 1507-08 (2016); Steven C. Hill & Salam Abdus, *The Effects of Medicaid on Access to Care and Adherence to Recommended Preventive Services*, 56 Health Servs. Res. 84, 89-92 (2020).

³¹ Burns et al., *supra* note 30; see also Julia Paradise & Rachel Garfield, *What Is Medicaid’s Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*, Kaiser Fam. Found. (Aug. 2, 2013), <https://www.kff.org/report-section/what-is-medicaid-s-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief>.

federal Medicaid dollars to pay for abortions, except in extremely limited circumstances.³² Today, the Hyde Amendment prohibits the use of federal Medicaid funds to pay for abortions except when (1) the pregnancy is the result of rape or incest; or (2) a pregnant person “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 [pregnant person] in danger of death unless an abortion is performed.”³³

37. Consistent with these restrictions, MFP does not use federal Medicaid funding for abortion services outside of these limited exceptions. Indeed, MFP has been a recipient of federal funding for over 50 years, has always adhered to the abortion-related restrictions placed on such funds, and has never been found to have improperly used federal funds for abortion services.

III. MFP Is Ensnared In Congress’s Latest Attempt to Exploit the Budget Process to Strip Medicaid Funding from Planned Parenthood.

38. The Defunding Provision is the culmination of a years-long attempt to exclude Planned Parenthood from receiving federal funding for any health care services. Although legislative history indicates that Planned Parenthood was the intended target of the legislation, to circumvent procedural barriers, Congress drafted the Defunding Provision to include *some* additional entity other than Planned Parenthood. MFP got caught in Congress’ net.

39. Indeed, Congress has previously tried to pass defunding prohibitions that mirrored the current Defunding Provision in all respects other than the amount of Medicaid reimbursements that an entity had received to be a “prohibited entity.” During a previous attempt to defund Planned Parenthood using the budget reconciliation process, the House of Representatives passed a bill with a provision to prohibit Medicaid funding for “prohibited entit[ies]” that met criteria

³² See, e.g., Fabiola De Liban et al., *Abortion Coverage Under Medicaid*, Nat’l Health Law Program (2025), <https://healthlaw.org/wp-content/uploads/2022/04/2025-Abortion-Coverage-Under-Medicaid.pdf>.

³³ Further Consolidated Appropriations Act, 2024, Pub. L. No. 118-47, §§ 506, 507, 138 Stat.460, 703 (2024).

substantively identical to the Defunding Provision, but with a much higher threshold of \$350,000,000 in Medicaid payments.³⁴ This attempt failed when the Senate Parliamentarian determined that “prohibit[ing] only Planned Parenthood from receiving Medicaid funds for one year” violates the Byrd Rule,³⁵ a procedural rule that prevents inclusion of “extraneous” non-budgetary provisions in budget reconciliation legislation, and therefore requires 60 votes in the Senate to waive (rather than the ordinary 51 votes for budget reconciliation legislation).³⁶ Anti-abortion politicians in the Senate responded by reducing the threshold for “prohibited entities” from \$350 million to \$1 million.³⁷ The Parliamentarian allowed the bill to proceed with the \$1 million threshold, though the bill ultimately failed to pass.

40. Learning from its prior efforts to defund Planned Parenthood, Congress used a lower threshold for Medicaid reimbursements in the Defunding Provision to avoid targeting only Planned Parenthood and thus implicating the Byrd Rule.³⁸ As passed, the Defunding Provision provides that “[n]o 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”³⁹ A “prohibited entity” is defined as any entity that meets the following criteria as of “the first day of the first quarter beginning after the date of enactment” of the Defunding Provision: (1) is organized as a 501(c)(3) and exempt from

³⁴ American Health Care Act of 2017, H.R. 1628, 115th Cong. § 103 (2017).

³⁵ S. Comm. on the Budget, 115th Cong., *Background on the Byrd Rule Decisions from the Senate Budget Committee Minority Staff* (2017), https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20Decisions_7.21%5B1%5D.pdf; Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong., § 123 (2017) (July 20, 2017 discussion draft), <https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf>.

³⁶ Bill Heniff Jr., Cong. Rsch. Serv., RL30862, *The Budget Reconciliation Process: The Senate’s “Byrd Rule”* 3-5 (2022), <https://www.congress.gov/crs-product/RL30862>.

³⁷ See S. Amend. 267 to H.R. 1628, 115th Cong. § 106 (2017).

³⁸ H.R. 1, § 71113.

³⁹ *Id.*

tax under 501(a) of the Internal Revenue Code of 1986; (2) is an essential community provider under 45 C.F.R. § 156.235 and “primarily engaged in family planning services, reproductive health, and related medical care”; (3) provides abortions for reasons other than to terminate pregnancies caused by rape or incest or where the patient is at risk of death without an abortion; and (4) received more than \$800,000 in federal and state expenditures under Medicaid in FY23.⁴⁰

41. Upon information and belief, the Defunding Provision was drafted to ensure that, while exempting hospitals from Medicaid cuts, it would also ensnare *at least one other health care entity in addition to Planned Parenthood* and thus avoid an unfavorable ruling by the Senate Parliamentarian similar to the ruling in 2017.

42. The bill was signed into law on July 4, 2025. Though the Defunding Provision defines “prohibited entity” based on the entity’s activities as of the first day of the next quarter following enactment, or October 1, 2025, the Defunding Provision states that it takes effect immediately, prior to the determination of whether an organization qualifies. Thus, though an entity may not know for certain whether it would be a “prohibited entity” until October 1, it would nonetheless be prohibited from receiving Medicaid funding for all of its services as of July 4.

43. The Defunding Provision does not purport to be a cost-saving measure. Rather, because the Defunding Provision targets a small number of specific health care entities rather than eliminating services or reducing patient eligibility, it leaves open the possibility that patients could access care from other Medicaid providers who would bill for reimbursement from the federal government—in which case, the federal government would still be covering the cost of their care and would not be saving on costs (though in practice, many of MFP’s patients will struggle to find alternative providers if they cannot go to MFP). Moreover, the Congressional Budget Office

⁴⁰ *Id.*

(“CBO”) estimates that the Defunding Provision will cost taxpayers \$52 million over the next 10 years, and an additional \$1 million has been appropriated just for implementation costs in FY26 alone.⁴¹ And, as CBO noted during a prior attempt to enact a similar provision, prohibitions like the Defunding Provision will result in individuals losing health care access, including “services that help women avert pregnancies,” especially in “areas without other health care clinics or medical practitioners who serve low-income populations.”⁴²

IV. The Defunding Provision Discriminates Against Abortion Providers Like MFP and Will Have a Devastating Impact on MFP and its Patients.

44. Along with Planned Parenthood, MFP falls within the Defunding Provision’s criteria for “prohibited entities.”⁴³

45. The Defunding Provision does not prohibit family planning providers that are similarly situated to MFP from receiving federal Medicaid reimbursements. For example, at least three other providers in Maine are not impacted by the Defunding Provision even though they provide similar family planning and primary care services and serve similar patient populations as MFP:

⁴¹ Cong. Budget Off., *Estimated Budgetary Effects of an Amendment in the Nature of a Substitute to H.R. 1, the One Big Beautiful Bill Act* (June 29, 2025), <https://shorturl.at/0Qp6c> (“Title VII” tab, Section 71115 “Federal Payments to Prohibited Entities”); H.R.1, § 71113(c).

⁴² Cong. Budget Off., *Cost Estimate, American Health Care Act 23* (Mar. 13, 2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

⁴³ Planned Parenthood filed suit on July 7, 2025. *Planned Parenthood Fed’n of Am. v. Kennedy*, No. 1:25-cv-11913 (D. Mass. filed July 7, 2025), ECF No. 1. The court issued a temporary restraining order the same day, enjoining defendants from “enforcing, retroactively enforcing, or otherwise applying the provisions of Section 71113 of ‘An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14,’” against Planned Parenthood and requiring defendants to “take all steps necessary to ensure that Medicaid funding continues to be disbursed in the customary manner and timeframes” to Planned Parenthood. TRO, *Planned Parenthood Fed’n of Am. v. Kennedy*, No. 1:25-cv-11913 (D. Mass. July 7, 2025), ECF No. 18; Am. TRO, *Planned Parenthood Fed’n of Am. v. Kennedy*, No. 1:25-cv-11913 (D. Mass. July 11, 2025), ECF No. 46.

- a. The Mabel Wadsworth Center (“Mabel’s”)⁴⁴ is a 501(c)(3) organization which, like MFP, has a clinic in Bangor.⁴⁵ 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.⁴⁶ Mabel’s also provides medication and procedural abortion.⁴⁷ Nearly half of Mabel’s patients rely on MaineCare.⁴⁸ Upon information and belief, Mabel’s is not impacted by the Defunding Provision.
- b. Greater Portland Health (“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.⁴⁹ 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.⁵⁰ Like MFP, GPH has clinics within the Greater Portland

⁴⁴ *AbortionFinder*, https://www.abortionfinder.org/results?location=maine&age=18%20or%20older&Impepoch=unsure&telehealth=physical_only&page=1 (last visited July 11, 2025).

⁴⁵ Mabel Wadsworth Ctr., *Donate*, <https://www.mabelwadsworth.org/donate> (last visited July 11, 2025).

⁴⁶ Mabel Wadsworth Ctr., *Health Services*, <https://www.mabelwadsworth.org/services> (last visited July 11, 2025).

⁴⁷ Mabel Wadsworth Ctr., *Abortion Care*, <https://www.mabelwadsworth.org/services/pregnancy-care/abortion-services> (last visited July 11, 2025).

⁴⁸ 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>.

⁴⁹ Greater Portland Health, *Services*, <https://www.greaterportlandhealth.org/services#newpatients> (last visited July 11, 2025); Greater Portland Health, *Our Story*, <https://www.greaterportlandhealth.org/about/our-story> (last visited July 11, 2025); Greater Portland Health, *School-Based Health Centers*, <https://www.greaterportlandhealth.org/services/school-based-health-centers> (last visited July 11, 2025).

⁵⁰ *Services*, *supra* note 49.

metropolitan area⁵¹ and appears on the ECP List as a family planning provider.⁵²

GPH accepts MaineCare, and in 2023 and 2024, approximately 51% of GPH's patients were enrolled in Medicaid.⁵³ GPH does not provide abortions. Upon information and belief, GPH is not impacted by the Defunding Provision.

- c. 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, vaginal, and sexually transmitted infections; biopsies for gynecological issues; and miscarriage care.⁵⁴ MMC also provides a range of other medical and behavioral health services, like primary care, urgent and inpatient care, and other specialized care.⁵⁵ MMC

⁵¹ Greater Portland Health, *Hours & Locations*, <https://www.greaterportlandhealth.org/locations> (last visited July 11, 2025).

⁵² *ECP List*, *supra* note 6.

⁵³ Greater Portland Health, *Payments & Insurance*, <https://www.greaterportlandhealth.org/for-patients/payment-and-insurance> (last visited July 11, 2025); Greater Portland Health, *Annual Report 2023*, at 14 (2023), <https://files.aptuitivcdn.com/eGVOpZw261-1791/docs/2023-Annual-Report-1.pdf>; Greater Portland Health, *Annual Report 2024*, at 14 (2024), <https://files.aptuitivcdn.com/eGVOpZw261-1791/docs/2024-Annual-Report.pdf>.

⁵⁴ MaineHealth, *About MaineHealth*, <https://www.mainehealth.org/about-mainehealth> (last visited July 11, 2025); MaineHealth, *Obstetrics & Gynecology*, <https://www.mainehealth.org/care-services/obstetrics-gynecology-obgyn> (last visited July 11, 2025); MaineHealth, *Sexually Transmitted Diseases*, <https://www.mainehealth.org/care-services/infectious-disease-care-travel-medicine/sexually-transmitted-disease-std> (last visited July 11, 2025); MaineHealth, *Uterine Cancer/Endometrial Cancer*, <https://www.mainehealth.org/mainehhealth-cancer-care/cancer-conditions-services/uterine-cancer-endometrial-cancer> (last visited July 11, 2025); MaineHealth, *Miscarriage Testing & Treatment*, <https://www.mainehealth.org/care-services/prenatal-care-and-childbirth/miscarriage-testing-treatment> (last visited July 11, 2025).

⁵⁵ MaineHealth, *Care & Services*, <https://www.mainehealth.org/care-services> (last visited July 11, 2025); MaineHealth, *Cervical Cancer*, <https://www.mainehealth.org/mainehhealth-cancer-care/cancer-conditions-services/cervical-cancer> (last visited July 11, 2025); MaineHealth, *Vaginal Cancer*, <https://www.mainehealth.org/mainehhealth-cancer-care/cancer-conditions-services/vaginal-cancer> (last visited July 11, 2025); MaineHealth, *Prenatal Testing*, <https://www.mainehealth.org/care-services/prenatal-care-and-childbirth/prenatal-testing-pregnancy-screening> (last visited July 11, 2025); MaineHealth, *Obstetrics & Gynecology*, *MaineHealth Franklin Hospital*, <https://www.mainehealth.org/mainehhealth-franklin-hospital/care-services/obstetrics-gynecology-mainehealth-franklin-hospital> (last visited July 11, 2025).

provides abortions, including in cases of lethal fetal conditions.⁵⁶ MMC accepts MaineCare, and its Portland location appears on the ECP List.⁵⁷ Upon information and belief, MMC is not impacted by the Defunding Provision.

46. The Defunding Provision provides no rationale for its differential treatment of MFP and these similarly situated providers. Nor does the Defunding Provision provide any rationale for summarily excluding MFP from Medicaid solely because it is a non-profit essential community provider that provides family planning and abortions when other similarly situated health care providers would be guaranteed process before they are excluded from Medicaid—including those entities who have been convicted of serious criminal offenses like fraud or patient neglect/abuse.⁵⁸

47. Because the Defunding Provision states that it is effective immediately, MFP has stopped billing for Medicaid-covered services effective July 5, 2025.

48. Almost half of MFP's patients who receive care other than abortion rely on Medicaid, and, if MFP no longer receives federal Medicaid funding, these patients will likely lose their only accessible health care provider and be forced to forgo essential family planning, reproductive health, and primary care services, including wellness and preventative care, wound care, cancer screenings, STI and HIV testing and treatment, contraceptive care, and treatment of common acute and chronic conditions like diabetes. For example, almost all of the patients that MFP sees through the Health on Wheels program are enrolled in Medicaid, and MFP is the only

⁵⁶ Yves-Yvette Young et al., *Expanding Access to Later Abortion Care in Maine: Improving In-State Clinic Referral Systems*, 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>.

⁵⁷ *ECP List*, *supra* note 6; MaineHealth, *Billing & Financial Services*, <https://www.mainehealth.org/patients-visitors/billing-and-financial-services> (last visited July 11, 2025); MaineHealth, *Health Insurance Coverage*, <https://www.mainehealth.org/patients-visitors/billing-and-financial-services/mainehealth-access-care/health-insurance-coverage> (last visited July 11, 2025).

⁵⁸ See, e.g., 42 C.F.R. pt. 1001, subparts E-F; *id.* pt. 1003 subpart O; MaineCare Benefits Manual ch. I, § 1.23-1 (codified at 10-144 Me. Code R. ch. 101, § 1.23-1).

health care provider that many of these patients see in a given year. If not enjoined, the Defunding Provision would strip these already underserved individuals of health care services altogether.

49. Even patients who may be able to access health care elsewhere will face significant delays due to the overstretched health care system in Maine. There is already a shortage of providers who accept Medicaid because of its lower reimbursement rates, and it will be difficult if not impossible for the thousands of patients MFP sees each year to find new practices willing to take on additional Medicaid recipients. Those practices may also lack MFP's geographic reach, particularly in more rural areas. Many patients will be forced to travel further distances and incur additional expenses to access care. These additional burdens will fall on patients who, by definition, already face significant hurdles in accessing care in the first place.

50. MFP has already had to stop taking new patients enrolled in MaineCare who are seeking primary care. For existing patients, the Defunding Provision has disrupted MFP's ability to continue providing care for longer than a few more months. MFP cannot abruptly discharge patients from its care, as its patients rely on MFP to treat a variety of medical conditions, including ones that require recurring medical appointments and follow-ups, such as individuals who tested positive for chlamydia, patients who have had colposcopies (examination of the cervix), or patients with abnormal cervical cancer screenings. MFP's practice is to provide patients with 30 days' notice prior to discharging them from MFP. MFP has determined that, without injunctive relief, it will have to notify its MaineCare family planning and primary care patients by September 30, 2025, that it is discharging them from care, effective October 31, 2025.

51. Without federal Medicaid reimbursements, MFP cannot cover the costs of services to the nearly half of its patients who receive care other than abortion who are enrolled in MaineCare. Already, Medicaid reimburses clinics at a lower rate than private insurance; as a result,

MFP already faces significant cost deficits. MFP's health centers in Rumford, Damariscotta, and Dexter only operate one or two days per week due to these current funding deficits. Without Medicaid funding, these clinics and others would have to make up for the shortfall and will be forced to limit or end the services that they currently provide.

52. MFP and its patients have become collateral damage to the Defunding Provision's intent to defund Planned Parenthood. In so doing, the Defunding Provision decimates access to critical health care in some of Maine's most underserved areas.

CLAIM FOR RELIEF

DENIAL OF EQUAL PROTECTION

53. The foregoing allegations in paragraphs 1 through 52 are re-alleged and incorporated by reference as if fully restated herein.

54. The Due Process Clause of the Fifth Amendment prohibits the United States from denying MFP equal protection under law.

55. The Defunding Provision prohibits MFP from receiving federal Medicaid reimbursements while allowing thousands of similarly situated health care entities throughout the United States to continue to receive federal Medicaid reimbursements for the same critical health care services that MFP provides.

56. Defendants have not and cannot proffer any rationale—let alone a constitutionally legitimate justification—as to why MFP should be subject to the Defunding Provision while thousands of similarly situated health care entities throughout the United States are not. The Defunding Provision will not save the government money, and in fact will cost the government millions of dollars more than simply allowing patients to continue to seek care from providers like MFP.

57. To the extent that the Defunding Provision is motivated by a desire to ensure that federal funds are not used for abortion, that is duplicative of existing legislation, and such duplication “necessarily casts considerable doubt upon the proposition that the [law] could rationally have been intended to prevent those very same abuses.” *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 537 (1973).

58. The legislative record indicates that the only purpose of the Defunding Provision is a “bare congressional desire to harm a politically unpopular group,” namely Planned Parenthood. *Id.* at 534. Ensnaring MFP to cloak its targeting of Planned Parenthood in a veil of plausible deniability cannot transform that bare desire to harm into anything remotely resembling a “legitimate governmental interest.” *Id.*

59. Targeting a tiny subset of the myriad of providers throughout the United States who provide abortions outside of the Hyde Amendment exceptions is arbitrary and does not serve any legitimate government interest.

60. Targeting a tiny subset of the essential community providers throughout the United States who are “primarily engaged in family planning services, reproductive health, and related medical care” is arbitrary and does not serve any legitimate government interest.

61. Targeting a tiny subset 501(c)(3) nonprofit organizations throughout the United States is arbitrary and does not serve any legitimate government interest.

62. The \$800,000 threshold is devoid of explanation or record support, is entirely arbitrary, and does not serve any legitimate government interest.

63. Absent declaratory and injunctive relief, the Defendants’ violations will continue to cause devastating and ongoing harm to the Plaintiff and its low-income, rural, and female patients in particular.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that the Court:

- a. Issue a declaratory judgment that the Defunding Provision violates the Fifth Amendment of the United States Constitution on its face and/or as applied to MFP;
- b. Enter a preliminary and permanent injunction prohibiting Defendants from implementing or enforcing the Defunding Provision as to MFP and/or vacating the Defunding Provision in its entirety;
- c. Award MFP attorneys' fees and costs, as provided by applicable statute or regulation or the inherent powers of the Court; and
- d. Grant all further and additional relief that the Court deems just and proper.

Dated: July 16, 2025

Respectfully submitted,

/s/ Taylor Asen

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** Application for admission pro hac vice
forthcoming*

**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 CASSIDY JARVIS IN SUPPORT OF PLAINTIFF’S MOTION FOR
TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION**

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

1. I have been a Site Administrative Coordinator at Maine Family Planning’s (“MFP”) Fort Kent and Presque Isle clinics in Aroostook County for the past ten years. In my role as a Site Administrative Coordinator, I work at the front desk, check patients in and out, field any calls from patients to the clinic, and triage patients who come to the clinic to pick up birth control pills. For

the last five years or so, I have also worked as a Certified Medical Assistant (“CMA”) at these two clinics. In my role as a CMA, I assist with patient care, including rooming patients; taking patients’ medical, social, and family history; collecting urine samples; and helping with procedures like colposcopies, endometrial biopsies, and insertion and removal of long-acting reversible contraception (“LARC”) like Nexplanon and IUDs.

2. I am familiar with section 71113 of the One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025) (the “Defunding Provision”) and the impact it has had and will continue to have on MFP’s Fort Kent and Presque Isle clinics. 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.

3. Our Fort Kent and Presque Isle clinics provide essential care in a rural and remote part of Maine. In many parts of Aroostook County, health care is hard to access: some patients may not have access to cars, not many providers are within walking distance, and there is not a lot of public transportation. Even if patients can access care elsewhere, many prefer to get their care at MFP. Many hospitals in the area use locum doctors (temporary or traveling doctors) who stay for only short periods of time, so their providers are constantly changing. In contrast, we have had the same providers at our Fort Kent and Presque Isle clinics for the last ten years, who have built trust with our patients and community over that time. As a result, our patients feel comfortable sharing intimate details about their sexual and reproductive health, including details that may be difficult to discuss, with our providers. Many of our female patients also feel more comfortable receiving care like pelvic exams at MFP because our providers are female, while many of the health care providers in the surrounding area are male. Finally, our patients trust us to provide confidential care. Because the community in this area is small, many patients prefer to get their

sexual and reproductive health care at MFP clinics rather than at hospitals, where there is a higher chance of running into someone they know. Because we have spent time and effort building these trusting relationships with our patients, many of them continue to come back to MFP for care; they do not want to go elsewhere for care, especially when going to a new provider would mean having to again tell someone else intimate and potentially difficult-to-discuss details about their sexual and reproductive health.

4. The Defunding Provision has had a devastating impact on our ability to keep providing essential care to our patients. Since the Defunding Provision was signed into law on July 4, 2025, we have been forced to stop accepting new primary care patients who are on Medicaid, even though we have people coming in almost daily who want to sign up as new primary care patients. If we cannot take Medicaid, I worry these patients will not be able to get primary care elsewhere, particularly because some primary care offices in the area are not accepting new patients at this time.

5. Our existing Medicaid patients are scared and confused about what the Defunding Provision means for their ability to keep getting care. We have continued to see Medicaid patients at the Fort Kent and Presque Isle clinics because we know our patients rely on us for care. But we have been forced to stop submitting Medicaid reimbursements. In the short time the Defunding Provision has been in effect, our patients—including those who have traveled significant distances to receive care at our clinics—have expressed concerns about their ability to pay out of pocket for birth control and other care. Necessities like heating and electricity are expensive in Aroostook County, and paying out of pocket for one pack of birth control pills costs \$25 per month, so if we cannot accept Medicaid, many patients will be forced to make tough decisions about whether they can afford to pay for birth control out of pocket given the high cost of other necessities. I have also

7. The Defunding Provision has also had an impact on MFP staff like me. We all have bills to pay and families to take care of, and I am personally afraid of what the Defunding Provision means for MFP clinics and for my job. I love working at MFP. I feel like I belong here and that I am part of a family here. I love connecting with our patients and witnessing how providing care for them is often a source of relief and self-affirmation. It is incredibly hard to deal with the uncertainty that the Defunding Provision has created for the clinics and our staff while trying to continue providing quality care to our patients and reassuring them that we are going to be here for them for as long as we can.

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

Executed this 15 day of July, 2025 at Fort Kent, Maine.


Cassidy Jarvis

**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.

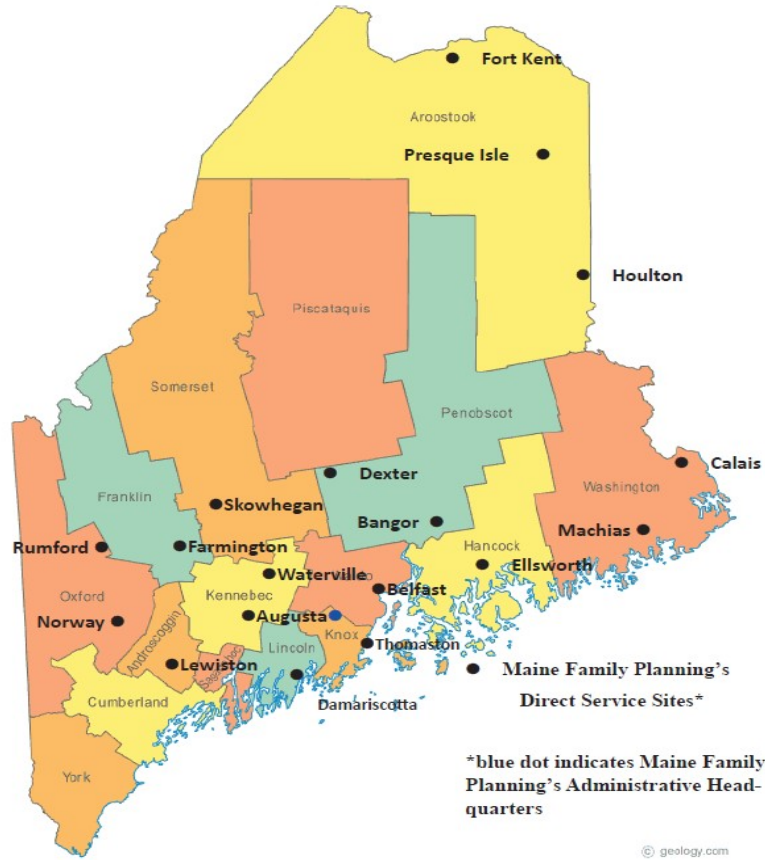
I. Maine Family Planning Provides Essential Health Care.

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

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

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.aptnitvcdn.com/eGVOpZw261-1791/docs/2023-Annual-Report-1.pdf> (last visited July 14, 2025); Greater Portland Health, *2024 Annual Report*, at 14, <https://files.aptnitvcdn.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

<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/mainehhealth-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/mainehhealth-cancer-care/cancer-conditions-services/cervical-cancer> (last visited July 14, 2025); MaineHealth, *Vaginal Cancer*, <https://www.mainehealth.org/mainehhealth-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/mainehhealth-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/mainehhealth-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.

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.

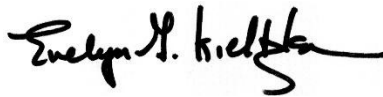
35. Even patients who may be able to access health care elsewhere will face significant delays from the already overstretched health care system in Maine. There is already a shortage of providers who accept Medicaid, and it will be difficult if not impossible for the thousands of

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 this 15th day of July 2025 at Augusta, Maine.



Evelyn Kieltyka

IN THE 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, *et al.*,

Defendants.

No. 1:25-cv-00364-LEW

DECLARATION OF ANNE MARIE COSTELLO

I, Anne Marie Costello, declare as follows:

1. I am employed by the Department of Health and Human Services (HHS) in the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS), located at 7500 Security Boulevard, Baltimore, MD 21244. I am a Deputy Director for CMCS. I have held this position since January 2020. Before that, I served as the Director of the Children and Adults Health Programs Group within CMCS. I have been employed at CMS since 2010. In my role as a Deputy Director of CMCS, I manage a team of professional and administrative staff with a variety of advanced degrees in fields including economics, law, medicine, public health, public policy, finance, and business operations. My team is responsible for policy development, management, oversight, budget, and performance issues related to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP) on behalf of CMS. My team and I regularly interact with representatives from states and other stakeholders.

2. Medicaid is a joint state/federal partnership. States are responsible for providing care to Medicaid beneficiaries and do so through both fee-for-service (FFS) and managed care delivery systems. States design their Medicaid programs including determining which delivery system(s) to utilize for providing care to Medicaid beneficiaries and which benefits are offered in each delivery system. The federal government outlines Medicaid program requirements and reviews and approves many components of a state's Medicaid program, such as underlying authorities for benefits, eligibility, FFS provider reimbursement rates, managed care, and managed care contracts and rates.

3. The federal government also contributes federal financial participation (FFP) towards the Medicaid program. Federal law and regulations require that CMS issue advanced funding (through "initial grant awards") to states at the beginning of each quarter based on CMS-reviewed state expenditure estimates.

4. Once the advanced funding request is approved, the state can draw down the federal advance for the allotted amount as costs are incurred. 42 C.F.R. § 430.30(d)(3). The state draws down federal funds through a subaccount operated through the Payment Management System (PMS) application within HHS' Program Support Center (PSC). Section 430.30(d)(3), 42 C.F.R., provides that the grant award "authorizes the State to draw Federal funds as needed to pay the Federal share of disbursements." The state's quarterly federal Medicaid award is only to be used to reimburse Medicaid providers for actual payments. 42 C.F.R. § 430.30 and 45 C.F.R. § 95.13.

5. Those initial awards are reconciled to actual state expenditures following a finalization process that includes quarterly CMS reviews of state-submitted, actual expenditures and state draw-downs from its PMS subaccount. The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement that

each state Medicaid agency submits each quarter to CMS to claim FFP for its Medicaid expenditures.

6. The Form CMS-64 is a summary of actual expenditures derived from source documents including invoices, payment vouchers, governmental funds transfers, expenditure certifications, cost reports and settlements, and eligibility records. It does not include claim-level information.

7. Medicaid provider payment occurs at the state level; CMS does not directly pay providers. In the FFS delivery system, the state Medicaid agency must conduct prepayment review for all claims received.¹ Additionally, in both the FFS and managed care delivery systems, the state or the health plan respectively, must generally pay 90 percent of clean claims (i.e., claims that can be processed without obtaining additional information) within 30 days of the date of receipt.² Although CMS is not involved in the process, CMS therefore understands that a Medicaid provider in any given state can generally expect to receive payment from the state within 30 days of submitting a claim for service rendered to a Medicaid beneficiary.

8. Family planning services and supplies are a mandatory Medicaid benefit in accordance with Section 1905(a)(4)(C) of the Social Security Act. Family planning services must also be provided to individuals receiving Medicaid services through an Alternative Benefit Plan, as described in Section 1937(b)(7) of the Act. This benefit can be provided in both the FFS and managed care delivery systems.

¹ 42 C.F.R. § 447.45(f)

² 42 C.F.R. § 447.45(d)(2); 42 C.F.R. § 447.46(c). In a managed care delivery system, this requirement applies only to managed care organizations (MCOs), and the MCO and its providers may, by mutual agreement, establish an alternative payment schedule.

State Expenditure Reporting and Claims for FFP

9. To claim FFP, each state submits its aggregate expenditures on a quarterly basis to CMS electronically via the Medicaid Budget and Expenditure System (MBES) using the Form CMS-64. The state submits this form electronically to CMS 30 days after the end of each quarter (January 30, April 30, July 30, and October 30).

10. When submitting its quarterly expenditures, each state certifies that its expenditures are allowable under federal requirements. The Form CMS-64 consists of a series of forms that separate expenditures based on certain categories of services (typically aligned with statutorily defined benefit categories such as inpatient hospital services, nursing facility services, etc., though managed care expenditures are separate reporting line(s)). The Form CMS-64 is CMS's official accounting record of Medicaid expenditures.

11. CMS must assure that state expenditures claimed for federal matching funds under Medicaid are programmatically reasonable, allowable, and allocable in accordance with existing federal laws, regulations, and policy guidance. To achieve this, CMS relies primarily upon quarterly reviews of the Form CMS-64 performed by CMCS financial management staff across the country. The quarterly expenditure review process is complex, with up to 225 individual reporting lines for each state, which can result in over 1,000 pages of detailed expenditures each quarter. For each quarter, CMS Medicaid financial staff has 60 days to complete their review, including verifying the accuracy of reported expenditures; determining whether the expenditures are properly supported; verifying the authority for FFP in the expenditures; and verifying the federal match rate.

12. CMS has a standard National CMS-64 Review Guide which is used by staff to ensure consistency of the reviews. The Review Guide targets specific areas on which to focus the review, based on risk, while also providing flexibility for staff and managers to use their

professional discretion to expand or curtail the review based on the complexity of the state's program and issues identified during the review process.

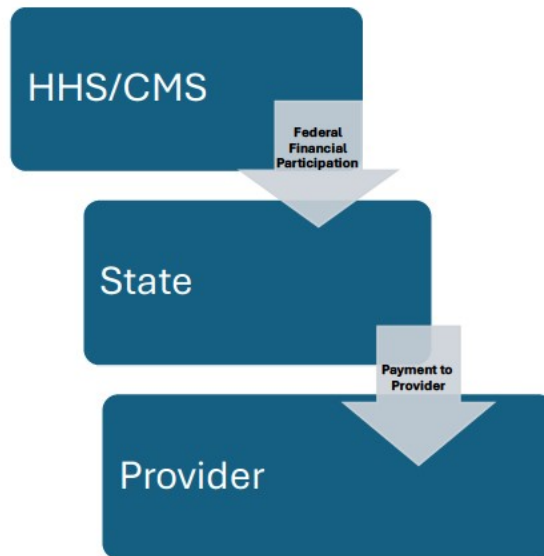
13. Although review times may vary, it typically takes CMS up to 6 months from the date of submission of Form CMS-64 to pay any additional FFP requested by the state.

14. Section 1132(a) of the Social Security Act requires states to claim FFP for Medicaid and CHIP expenditures within two years of the date of the expenditure. Implementing regulations at 45 C.F.R. 95 Subpart A specify FFP will be available only if the state files a claim within two years after the calendar quarter in which the expenditures were made. Under certain limited circumstances, the Medicaid statute and regulations provide for exceptions to the two-year time limit. Section 1132(a) of the Act and regulations at 45 C.F.R. 95.19 specify that time limit does not apply for any claims that: (a) are an adjustment to prior year costs (this is limited to interim payments reconciled to actual cost); (b) result from an audit exception; (c) result from a court-ordered retroactive payment; or (d) for which the Secretary determines there was good cause for the failure by the state to file the claim within the time period.

Medicaid Fee-for-Service (FFS)

15. In an FFS delivery system, the state directly reimburses providers for each service delivered to Medicaid beneficiaries. States claim FFP for these costs from CMS.

16. The graphic below illustrates the payment relationship in an FFS delivery system at a high level:



Medicaid Managed Care

17. Managed care is the predominant delivery system for most Medicaid beneficiaries. In a managed care delivery system, the state contracts with risk-based health plans³ to provide services to Medicaid beneficiaries who are enrolled in the plan (known as enrollees). The state executes a contract with one or more health plans, and this contract outlines the contractual responsibilities of the plan. The state pays health plans capitation payments for taking on these contractual obligations. The state claims FFP for capitation payments.

18. A capitation payment is a periodic payment (generally monthly), that a state makes to a health plan on behalf of each beneficiary enrolled under a contract, similar to a health insurance

³ 42 C.F.R. § 438.2. There are three types of risk-based health plans (often referred to as managed care plans): (1) MCOs; (2) prepaid inpatient health plans (PIHPs); and prepaid ambulatory health plans (PAHPs). Generally, MCOs are comprehensive health plans while PIHPs and PAHPs are limited benefit plans.

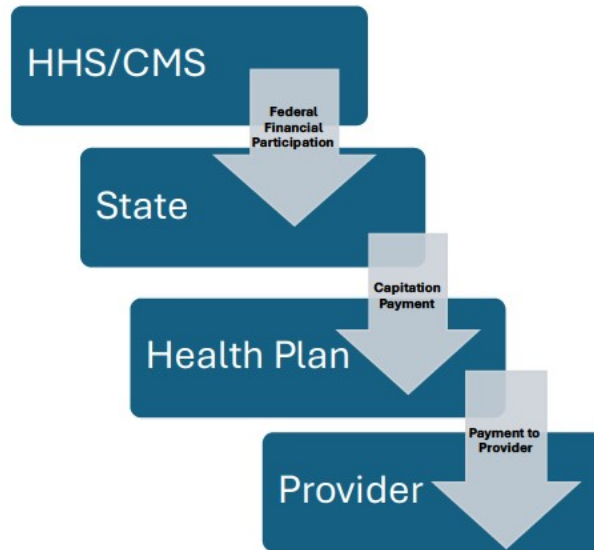
premium paid in employer-sponsored insurance.⁴ The state makes this payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

19. The health plan is responsible for contracting with a provider network, negotiating provider payment rates, and paying providers for covered services. Health plans are responsible for maintaining a sufficient provider network to meet the needs of the anticipated number of enrollees. In managed care, enrollees are generally restricted to only utilize the provider network of a health plan (i.e., network providers) with some exceptions for out-of-network providers. A network provider has a provider agreement with a health plan or subcontractor of that plan.⁵ Network and out-of-network providers submit claims to the health plans for payment and health plans pay both network and out-of-network providers.

20. The graphic below illustrates the Medicaid managed care payment relationship at a high level:

⁴ 42 C.F.R. § 438.2.

⁵ Definition of network provider in 42 C.F.R. § 438.2.



21. With respect to family planning specifically, Sections 1902(a)(23)(B) and 1915(b) of the Social Security Act allow Medicaid managed care enrollees to obtain family planning services and supplies from providers of their choice, including those out-of-network. Thus, in practice, when family planning services and supplies are included in managed care, enrollees receive family planning services from network providers and out-of-network providers, and both provider types are paid by the health plans.

* * *

I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct, to the best of my knowledge and belief.

Dated: August 1, 2025

ANNE MARIE COSTELLO

**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. 1:25-cv-00364

**SUPPLEMENTAL 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”). As I stated in my first declaration dated July 15, 2025 (“July Declaration”), among other responsibilities, I oversee clinical services to ensure MFP is meeting our revenue and expense targets. This includes helping to manage our five-year Title X grant.

2. Title X is a federal grant program administered by the Office of Population Affairs within the Department of Health and Human Services (“HHS”). Title X provides funding for family planning services, including contraception, screening for sexually transmitted infections, and cancer screenings for low-income families. Title X funding is not used for abortion. I have the overall responsibility of managing the performance of our family planning subgrantees, communicating with subgrantees, and applying every year for the renewal of MFP’s Title X grant. I submit this supplemental 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.

3. Since my July Declaration, there have been updates to MFP’s status as a Title X grantee. In 2022, MFP was awarded a five-year non-competitive Title X grant with a project period of April 1, 2022 through March 31, 2027. During each year of the five-year project period, MFP has to apply for a continuation award. Until this year, the grant was renewed annually during the non-competitive yearly application process. Without any prior notice, on March 31, 2025, MFP received a letter from HHS stating that our Title X grant was temporarily withheld. But on July 23, 2025, MFP received another letter from HHS notifying us that our Title X grant would be restored, and on August 6, 2025, MFP received the Notice of Award, which includes the amount of the grant and the grant’s terms and conditions.

4. At the time of my July Declaration, MFP had not received any notice regarding the restoration of Title X funds. Our calculation that we would have to discharge all Medicaid patients was thus based on an understanding that MFP would not have *any* Title X funding, which is no longer true.

5. MFP's reinstated Title X grant totals approximately \$1.78 million for the funding period from April 1, 2025, through March 31, 2026. As the sole Title X grantee for the state of Maine, MFP distributes a portion of this funding to subgrantees and does not use all the funding at MFP clinics. For this grant cycle, approximately \$1.08 million of the total funding received will be used by MFP, though some of that funding will be used for grant monitoring and program management. Approximately \$880,000 of the total Title X grant will be available for use at MFP clinics.

6. Title X requires grantees to prioritize serving patients from low-income families while Title X funds are available. For us to comply with this program requirement—while Title X funds are available—we cannot discharge Medicaid patients from our family planning practice, as many of them qualify as low-income families under Title X regulations. We are also required to continue accepting new Medicaid patients for family planning services.

7. But MFP's share of Title X funding does not allow us to continue to serve *all* Medicaid patients. Specifically, because Title X funding is for family planning services, we cannot use those funds to provide primary care services unrelated to family planning care. We currently provide primary care at our clinics in Presque Isle, Houlton, and Ellsworth. We started offering primary care in these areas because there are provider shortages, and patients faced long wait times to see a provider. Our primary care practice has been modeled to serve Medicaid patients, and without Medicaid funding, our primary care practice is not self-sustaining.

8. As I stated in my July Declaration, we have already stopped taking new primary care patients enrolled in Medicaid. Since my July Declaration, we have determined that we cannot continue the primary care practice if we cannot serve Medicaid patients. No later than September 30, we will notify all existing primary care patients that, regardless of insurance status, we will no longer be able to provide them with primary care unrelated to family planning services past the

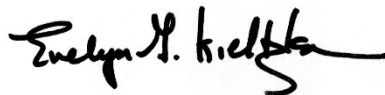
end of October 2025. Additionally, while we plan to continue serving family planning patients for as long as we can, once Title X funds run out, we will need to discharge or stop serving family planning patients enrolled in Medicaid. We expect the grant funds will run out around September 2025. Without court intervention, unless we can identify a new funding source, we will have to look at our limited reserve funding to continue providing family planning care to Medicaid patients. We do not know for how long we will be able to provide that care before we have to close clinics or discharge patients.

9. As I stated in my July Declaration, discharging our patients will interfere with our ability to carry on our mission of ensuring that all people have access to high-quality, culturally relevant and affordable health care services. Our primary care clinics in Houlton and Presque Isle are located in Aroostook County, and our Ellsworth clinic is in Hancock County. Both counties face a significant shortage of healthcare providers. Patients in these areas rely on MFP's clinics for primary care, often traveling considerable distances to access services. If we are forced to discharge patients, there will be few—if any—local providers available to meet their needs. Additionally, ending our primary care practice would require us to terminate two providers who currently provide primary care; without these providers, it would be challenging reestablish a primary care practice in the future.

10. Turning away vulnerable patients will also damage MFP's reputation as a trusted community provider. Even if Medicaid funding is later restored, I worry that patients who have been discharged from MFP because of the Defunding Provision may feel like they cannot come back, or cannot trust that we will not have to discharge them from care again.

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

Executed this 8 day of August 2025 at Augusta, Maine.

A handwritten signature in black ink, appearing to read "Evelyn M. Kieltyka". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Evelyn Kieltyka

**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. 1:25-cv-00364

NOTICE OF APPEAL

Please take notice that Plaintiff Family Planning Association of Maine d/b/a Maine Family Planning hereby appeals to the United States Court of Appeals for the First Circuit from this Court's August 25, 2025 Order on Motion for Preliminary Injunction, ECF No. 31.

Dated: August 29, 2025

Respectfully submitted,

/s/ Meetra Mehdizadeh

Meetra Mehdizadeh*

Astrid Marisela Ackerman*

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Attorneys for Plaintiff

**Admitted pro hac vice*

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

THE FAMILY PLANNING)
 ASSOCIATION OF MAINE d/b/a)
 MAINE FAMILY PLANNING,)
)
 Plaintiff)

v.)

No. 1:25-cv-00364-LEW

UNITED STATES DEPARTMENT)
 OF HEALTH AND HUMAN)
 SERVICES,)
)

ROBERT F. KENNEDY, JR.)
 in his official capacity as Secretary of)
 the Department 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)

ORDER ON MOTION FOR INJUNCTION PENDING APPEAL

Plaintiff The Family Planning Association of Maine d/b/a Maine Family Planning seeks an injunction pending appeal. Pl.’s Emergency Mot. for Injunction Pending Appeal (ECF No. 33). On August 25, 2025, I issued an Order on Motion for Preliminary Injunction (ECF No. 31), in which I denied Plaintiff’s request that the Court enjoin Defendants from

compliance with certain federal spending legislation pending the resolution of this litigation. The Rules require that I address Plaintiff's request for an injunction pending appeal in the first instance. *See* Fed. R. App. P. 8(a)(1)(C). The following discussion assumes the reader is familiar with the August 25 Order.

To secure from a district court injunctive relief pending appeal, "the moving party need not persuade the court that it is likely to be reversed on appeal." *Canterbury Liquors & Pantry v. Sullivan*, 999 F. Supp. 144, 150 (D. Mass. 1998). However, "more than a mere possibility of relief is required." *Nken v. Holder*, 556 U.S. 418, 434 (2009) (internal quotation marks omitted). The provision of a stay pending appeal is a discretionary matter attuned to the circumstance of the case at hand. *Id.* at 433. The exercise of that discretion is guided by the moving party's ability to convincingly demonstrate the following: (1) likelihood of success on appeal; (2) irreparable harm absent injunctive relief; (3) a lack of substantial injury to others having an interest in the decision under appeal; and (4) service of the public interest. *Id.* at 434; *Arborjet, Inc. v. Rainbow Treecare Sci. Advancements, Inc.*, 794 F.3d 168, 171 (1st Cir. 2015). Of these elements, the "first two factors are the most critical," *Respect Maine PAC v. McKee*, 622 F.3d 13, 15 (1st Cir. 2010), but failure to "show a strong likelihood of success" on appeal is an independent basis for denial of an injunction pending appeal, *id.*; *Acevedo-Garcia v. Vera-Monroig*, 296 F.3d 13, 16 (1st Cir. 2002) (per curiam); *In re Elias*, 182 Fed. App'x 3 (1st Cir. 2006) (per curiam).

Plaintiff argues that my previous assessment of the merits was misguided because each of the factors set forth in section 71113 of the One Big Beautiful Bill Act (hereafter

“BBB”)¹ that disqualifies certain entities from receiving Medicaid reimbursement lacks a rational basis. According to Plaintiff, the individual factors do not “advance” any governmental justification, Pl.’s Mem. of Law (ECF No. 33-1) at 7-10, and, consequently, are exposed as a naked act of discriminatory animus toward Planned Parenthood, *id.* at 4-7.

As indicated in the August 25 Order, Plaintiff’s arguments against each of the several factors are well reasoned but amount to, in the end, a valorous debate performance on matters that are ultimately assigned to Congress. The relief Plaintiff seeks is not available so long as there exists “any reasonably conceivable state of facts that could provide a rational basis for the classification.” *FCC v. Beach Comms., Inc.*, 508 U.S. 307, 313 (1993). The Equal Protection Clause “is not a license for courts to judge the wisdom, fairness, or logic of legislative choices.” *Id.* “The Constitution presumes that, absent some reason to infer antipathy, even improvident decisions will eventually be rectified by the democratic process and that judicial intervention is generally unwarranted no matter how unwisely we may think a political branch has acted.” *Vance v. Bradley*, 440 U.S. 93, 97 (1979) (footnote omitted). Consequently, even though Plaintiff’s challenges are well reasoned and may persuade a large cross section of the public, Plaintiff still cannot win a mere rational basis contest where the light of reason shines on the choices made by Congress. Unlike other legal contexts, persuading a judge that your reasoning is better

¹ Pub. L. No. 119-21, H.R. 1, 119th Cong. (2025).

does not ensure a victory in a rational basis regime. *Beach Comms.*, 508 U.S. at 313; *Vance v. Bradley*, 440 U.S. at 97.

Furthermore, while Plaintiff aims to kick each of the four legs out from under the disqualification provision, Plaintiff overlooks the fact that those factors, in combination, serve to identify the larger providers of non-qualifying abortion services in the United States, according to Congress, and Congress could rationally believe that these providers have the abortion reach they do in part thanks to their enjoyment of federal funding and tax-exempt status. In fact, Plaintiff appears to concede that the disqualification provision is meant to have precisely this targeting effect. And although Plaintiff observes that any targeting must not be the product of animus, unconstitutional animus is different than the generalized disfavor members of Congress may harbor based on deeply held views about controversial conduct coupled with a desire to reduce subsidies to or programmatic dependence on the major providers of non-qualifying abortion products and services. In fact, it is plausible that Congress means to advance the latter, permissible objective, even if certain members of Congress have in the past voiced some manner of political grudge against Planned Parenthood. Because the permissible course is plausible, my inquiry is supposed to be at an end. *United States v. Skrametti*, 605 U.S. ---, 145 S. Ct. 1816, 1835 (2025).

“The rational basis inquiry ‘employs a relatively relaxed standard reflecting the Court’s awareness that the drawing of lines that create distinctions is peculiarly a legislative task and an unavoidable one.’” *Id.* (quoting *Massachusetts Bd. of Ret. v. Murgia*, 427 U.S. 307, 314 (1976)). “Perfection in making the necessary classifications is neither possible

nor necessary.” *Massachusetts Bd. of Ret.*, 427 U.S. at 314. With section 71113 of the BBB, Congress appears to be doing with Medicaid spending what it routinely does in any number of other pieces of legislation, *i.e.*, drawing lines between preferred and disfavored conduct, based on a combination of factors.

Plaintiff also offers supplemental arguments concerning the precedential weight of *Planned Parenthood of Minnesota v. Minnesota*, 612 F.2d 359 (8th Cir. 1980), *sum. aff’d*, 448 U.S. 901 (1980). Plaintiff argues that because the analysis there was not based on the constitutionality of abortion, the recent issuance of *Dobbs v. Jackson Women’s Health Organization*, 597 U.S. 215 (2022), has no importance or relevance to the merits of their equal protection challenge. But that is like saying that a challenge to a firearm regulation would be stronger in the *absence* of the Second Amendment. The fundamental nature of the right in question animates the deliberative process whether it is expressly acknowledged as causative to the outcome or not. When a fundamental right is removed from the equation, normative (*i.e.*, policy) considerations are permitted and positive assessments about what is “most” rational are not supposed to dictate outcomes in a judicial venue. *Pers. Adm’r of Massachusetts v. Feeney*, 442 U.S. 256, 272 (1979) (“The calculus of effects, the manner in which a particular law reverberates in a society, is a legislative and not a judicial responsibility.”).

Additionally, *Planned Parenthood of Minnesota* was decided in 1980, not long after the Supreme Court decided *Roe v. Wade*, 410 U.S. 113 (1973). The prohibition in *Minnesota* applied to any non-profit other than a hospital or health maintenance organization that performed any abortions at all, regardless of any distinction between what

are, for purposes of federal law, qualifying and non-qualifying abortions. 612 F.2d at 360. The current legislation draws a distinction between the two. Furthermore, the current legislation is drawn in the context of what members of Congress could fairly characterize as a steady outgrowth and increase of non-qualifying abortion provision over the course of 45 years due, in part, to a steady stream of federal subsidies under Medicaid and Title X—though neither statutory scheme is meant to compensate non-qualifying abortion care. In that time, certain providers—plausibly, those who meet all four of the criteria for prohibition—have come to be regarded within their respective regions as “Big Abortion,” at least by members of Congress. That historical development modifies the factual controversy in this case sufficiently, for purposes of a rational basis inquiry, to step outside the precedential impact of the Supreme Court’s unwritten summary affirmance in *Minnesota*. The District Court Judge who engaged in fact finding in *Minnesota* would not have anticipated that steady development any more than the Circuit Court judges and Supreme Court justices who reviewed the decision would have. *Allen v. Wright*, 468 U.S. 737, 764 (1984), *abrogated by Lexmark Int’l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118 (2014) (observing that a prior summary affirmance “could hardly establish principles contrary to those set out in opinions issued after full briefing and argument” (citing *Fusari v. Steinberg*, 419 U.S. 379, 392 (1975) (Burger, C. J., concurring))); *Fusari*, 419 U.S. at 391-92 (“When we summarily affirm, without opinion, . . . we affirm the judgment but not necessarily the reasoning by which it was reached. An unexplicated summary affirmance settles the issues for the parties, and is not to be read as a renunciation by this Court of doctrines previously announced in our opinions after full argument.”

(Footnote omitted)); *Cent. Maine Power Co. v. Maine Comm’n on Gov’tal Ethics & Election Practices*, 144 F.4th 9, 23 n.5 (1st Cir. 2025) (citing *Anderson v. Celebrezze*, 460 U.S. 780, 784 n.5 (1983) (same)).

Plaintiff also critiques the significance of *Rust v. Sullivan*, 500 U.S. 173 (1991), on which I relied in part, because it involved challenges based on the First Amendment and the then, substantive due process right to abortion. The significance of *Rust* is in its relation to congressional leeway when it comes to imposing conditions in the context of a similar federal spending program (Title X) and the Court’s decision to uphold conditions on the receipt of funding despite challenges based on fundamental rights, whereas the current case involves only non-suspect classifications.²

For the reasons articulated in the August 25 Order, I disagree with Plaintiff that, absent judicial policy ranking, it is likely to achieve a court ruling that Congress is

² Plaintiff suggests in a footnote that the August 25 Order asserted that corporations are not entitled to equal protection of the law. Pl.’s Emergency Mot. for Inj. Pending Appeal at 7, n.1. That is not an accurate interpretation of the Order. The reference to corporate entities was clearly modified to identify those serving congressional objectives in the context of a federal program, not to suggest that corporations are not protected by the Equal Protection Clause. *See* August 25 Order at 10 (“[T]he written Supreme Court opinions in this line all appear to involve profound irrationalities that target individuals for disfavored treatment rather than the selective treatment of entities enlisted through federal funding to carry out congressional objectives.”). Plaintiff also suggests in the same footnote that I did not understand that the Equal Protection Clause could restrain congressional spending activities, but I quite clearly stated: “It is well-established that spending decisions must not offend the Equal Protection Clause.” August 25 Order at 8. To the extent my language suggested reticence, that is simply because Plaintiff does not ask the Court to enjoin an Executive Branch’s refusal to honor a spending bill enacted by the Legislative Branch, but rather to enjoin members of the Executive Branch to disregard a spending bill enacted by the Legislative Branch. Finally, Plaintiff’s citation of *Regan v. Taxation With Representation of Washington*, 461 U.S. 540 (1983), only tends to reinforce my prediction on the merits of this case. *See id.* at 549 (observing that Congress can condition access to “largesse” in the nature of appropriations and tax exemptions as it will).

constitutionally barred from charting a new legislative course—in the context of a federal spending program—that separates, incrementally, providers from the Medicaid funding stream based in part on concerns over the scope of such entities’ reach when it comes to the provision of non-qualifying abortions or presumptions about the number of non-qualifying abortions they provide. Because I find that Plaintiff is not likely to succeed on the merits, I conclude that an injunction pending appeal is not warranted.

The Emergency Motion for Preliminary Injunction pending appeal (ECF No. 33) is DENIED.

SO ORDERED.

Dated this 8th day of September, 2025.

/s/ Lance E. Walker
Chief U.S. District Judge

CERTIFICATE OF SERVICE

I hereby certify that on October 22, 2025, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the First Circuit by using the appellate CM/ECF system, which will serve copies on registered CM/ECF users.

CENTER FOR REPRODUCTIVE RIGHTS

/s/ Meetra Mehdizadeh

Meetra Mehdizadeh

Counsel for Plaintiff-Appellant