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 the official capacity as Secretary of the U.S. Department of Health and Human Services; MEHMET OZ, in the official capacity as Administrator of the Centers for Medicare & Medicaid Services; and CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Maine
No. 1:25-cv-0364-LEW

BRIEF OF *AMICI CURIAE* MAINE MEDICAL ASSOCIATION, MAINE ACADEMY OF FAMILY PHYSICIANS, MAINE OSTEOPATHIC ASSOCIATION, AND THE MAINE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS IN SUPPORT OF PLAINTIFF-APPELLANT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(a)(4)(A) of the Federal Rules of Appellate Procedure, amici curiae Maine Medical Association ("MMA"), Maine Academy of Family Physicians ("MAFP"), Maine Osteopathic Association ("MOA"), and the Maine Chapter of the American Academy of Pediatrics ("MAAP") by their undersigned counsel, states that all amici are a non-profit, tax-exempt organizations that have issued no stock and have no parent corporation, and that no publicly held company has 10% or greater ownership in them.

Dated: October 29, 2025

/s/ Janice Mac Avoy
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STATEMENT OF INTEREST[1]

Amici curiae MMA, MAFP, MOA, and MAAP are professional medical associations for Maine physicians,[2] and they respectfully submit this brief in support of Plaintiff-Appellee Maine Family Planning ("MFP").

MMA, founded in 1853, is a professional association of more than 4,300 physicians, whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Mainers. MMA is one of fifty state medical organizations affiliated with the Federation of the American Medical Association and is Maine's largest physician professional organization. MMA's physicians work across medical specialties and practices, providing essential care in virtually every corner of the state, working to ensure that even Maine's most rural communities have access to high-quality healthcare. United by a shared commitment to patient care and professional integrity, MMA believes that we cannot resolve American healthcare system problems without ensuring adequate health insurance coverage for all residents, including those on Medicaid.

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[1] Pursuant to Fed. R. App. 29(a)(4)(E), all amici state that no party's counsel authored this brief in whole or in part, and no party or party's counsel contributed money intended to fund preparing or submitting this brief. No person, other than amici, their members, and their counsel contributed money intended to fund preparing or submitting the brief. All parties have consented to the filing of this brief.

[2] This brief is written on behalf amici's member physicians, but the arguments detailed herein will apply to all healthcare clinicians throughout Maine, each of whom plays an important role in patient care.

MAFP represents over 700 family physicians in Maine caring for patients through all stages of life including pregnancy, childhood, and adulthood. Many MAFP members live and provide medical care in rural Maine. MAFP supports the work of MFP to help keep Maine's communities healthy.

MOA, a division of the American Osteopathic Association, is a professional membership organization for board-certified doctors of osteopathic medicine who practice all medical specialties. MOA members provide patient-centered primary care to underserved patients across Maine. MFP is a key provider of these services, and often the only provider of these services in parts of rural Maine. MOA believes withholding Medicaid payments for services unrelated to reproductive health to repress reproductive health services is unconscionable.

MAAP is a professional organization of more than 300 pediatricians and pediatric subspecialists dedicated to protecting and improving the health of Maine children and adolescents. Ensuring that patients and their families have access to high quality, comprehensive healthcare is central to MAAP's mission. Many youth and families from across Maine, especially in rural communities, rely on the care that MFP provides, from reproductive healthcare to family support services. The care they provide is vital in keeping many infants, children, adolescents and their families in Maine healthy.

SUMMARY OF ARGUMENT

The healthcare crisis in America predates the One Big Beautiful Bill Act (the "Act"). Nearly 1 in 3 Americans lack access to key healthcare services, and more than 80% of U.S. counties lack adequate access to pharmacies, primary care providers, hospitals, hospital beds, trauma centers, and low-cost health centers, otherwise known as healthcare deserts.[3] Unsurprisingly, Maine, one of the most rural states in the country, has many healthcare deserts in its rural counties with infrastructure challenges that create barriers to healthcare access. Between Maine's rural and varied landscape (including extensive coastline and a heavily forested, but largely uninhabited, interior); extreme winter climate; limited transportation infrastructure; over-burdened healthcare system; housing shortages and high costs of living; and an older, low-income population that relies on Medicaid, Mainers (and particularly rural Mainers) are medically underserved.

[3] Amanda Nguyen, *Mapping Healthcare Deserts: Over 80% of the Country Still Lacks Adequate Access to Healthcare* (July 15, 2025), GoodRx, https://www.goodrx.com/healthcare-access/research/updated-healthcare-deserts?srsltid=AfmBOopSc8cqV7vc2TtC_nsH56YTRFDqd8lVOlSzMyEl71eJoSP3BrsV ("Healthcare deserts are areas that lack adequate access to and infrastructure for healthcare services."); Brandon Lozano, *Care Deserts: Healthcare Access in Maine* (May 9, 2023), https://storymaps.arcgis.com/stories/266151cd25ce4ee3abc62b4cda747262 (defining a care desert as "an area in which there are no primary care hospitals within a 30 minute drive or within 30 kilometers.").

Organizations like MFP, however, have spent decades grappling with these unique barriers to create an accessible statewide resource, providing family planning *and primary care* services[4] that would otherwise be inaccessible to thousands of Mainers. In fact, MFP specifically modeled its primary care practice to target and serve Medicaid patients.[5] Medicaid funding makes up approximately 20-25% of MFP's annual budget and is particularly essential for MFP's primary care services, which are critical for the 70% of MFP patients that will not see another clinician in a given year.[6]

Section 71113 of the Act ("the Defunding Provision")—which prohibits "essential healthcare providers" like MFP and Planned Parenthood from receiving Medicaid funding because they provide abortion care as one of many services—threatens to obliterate the tireless efforts of MFP and cause irreparable harm to Mainers. Without Medicaid funding, MFP will no longer be able to sustain its primary care practice. As a result, it will be forced to lay off medical staff, close clinics in rural areas, and turn away existing and new patients—causing irreparable harm to at minimum hundreds, and potentially thousands, of Mainers.[7]

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[4] Appellant Br. at 2.
[5] *Id.* at 7; Decl. of Evelyn Kieltyka in Supp. Pl.'s Mot. for a TRO and/or Prelim. Inj. ¶ 18, JA 46-47 ("Kieltyka Decl.")
[6] Appellant Br. at 4, 10-11.
[7] *Id.* at 10-11.

Indeed, MFP's forced reduction in services will cause direct, life-threatening and irreparable harm to patients, many of whom are already at particularly high risk for negative health outcomes. Many low-income and rural patients live hours away from clinics and hospitals and do not have reliable or affordable access to transportation that would allow them to seek out a replacement for MFP. In any event, Maine's already burdened healthcare system is not equipped to fill the gap left by MFP, leaving rural and low-income Mainers in need of healthcare, but without any accessible options.

ARGUMENT

Through this brief, amici provide additional context on the healthcare systems in Maine through verified research and reporting, as well as stories and quotes from the perspective of clinicians with years of expertise serving these communities.[8] Amici first address the importance of MFP to Mainers, particularly those in rural and low-income communities, as MFP's services were designed to address Maine's unique barriers to healthcare access. The brief then describes these barriers—Maine's already-existing healthcare deserts, reliance on Medicaid, and weak

[8] To capture the perspective of Maine clinicians, undersigned counsel conducted interviews and collected quotes from MMA clinicians regarding the effects of the Defunding Provision on Maine's healthcare system. The medical opinions expressed herein are the doctors' own and not necessarily shared by the institution(s) with which they are affiliated. To promote candid testimony and to protect the legal and privacy interests of these clinicians and their patients, the clinicians' identities are anonymized.

transportation infrastructure—which the Defunding Provision will only exacerbate because MFP will be one less medical provider equipped to address them. Amici then provide the clinician perspective on the serious consequences of disrupting the patient-clinician relationship and continuity of care that will flow from the Defunding Provision's effect on MFP. Accordingly, the Defunding Provision will cause irreparable harm to Maine's communities, warranting a preliminary injunction in MFP's favor.

I. MFP PROVIDES CRITICAL MEDICAL SERVICES IN RURAL MAINE

As detailed in MFP's papers, which amici incorporate by reference, MFP is a non-profit organization that provides affordable healthcare to Maine's underserved communities, offering reproductive healthcare, family planning, and, critically, primary care services, such as annual wellness exams, wound care and treatment for acute and chronic illnesses.[9] MFP has spent decades grappling with the unique challenges that Maine faces as one of the most rural states in the country to create an accessible statewide resource for consistent family planning and primary care services. As such, MFP is a trusted community provider, serving 8,735 patients in

[9] Compl. ¶¶ 17, 20, JA 13-14; Appellant Br. at 4-6.

2024 (and 28,000 patients through its larger network of subcontractors[10]), the majority of whom did not see another clinician that year.[11]

Despite MFP's importance to Maine communities, the Defunding Provision seeks to dismantle MFP's efforts to promote a healthier Maine by eliminating MFP's Medicaid funding. Amici know that defunding MFP will deepen Maine's healthcare crisis; for example, MFP will be forced to close its clinics and cut subcontracts to the 44 additional sites it partners with to bring care to underserved populations.[12] MFP's rural patients will be forced to travel for hours to access new care, which many Mainers are unwilling or unable to do because of financial constraints, Medicaid reliance, distrust of unknown medical institutions, and/or poor transit infrastructure. And even if MFP's former patients were able to travel, Maine's already-strained healthcare system cannot support a new influx of displaced patients. The reality of defunding MFP is therefore a harsh one: people will be left without medical care and without the ability to seek out new clinicians, leading to long-term negative (and life-threatening) health outcomes from delayed or nonexistent care.

[10] Kieltyka Decl. ¶ 11, JA 43.
[11] Appellant Br. at 5.
[12] Kieltyka Decl. ¶ 19, JA 47.

Even the government agrees that community-based healthcare in rural, underserved counties in Maine is "essential."[13] But the Defunding Provision nonetheless undermines these essential medical services and gambles with the health and lives of MFP's thousands of Medicaid patients.

II. MAINE'S FRAGILE MEDICAL SYSTEM IS ON THE VERGE OF CRISIS

Maine's rural nature creates a unique set of barriers to healthcare access for many of its citizens, ultimately leading to worse overall health outcomes.[14] Specifically, rural communities face (1) limited transportation infrastructure; (2) overwhelming reliance on Medicaid; and (3) an already-strained healthcare system (even without funding cuts). Rural Mainers face higher poverty rates, are less likely to have insurance, and have far less access to healthcare providers than their urban counterparts.[15] Rural adults in general experience "higher rates of mortality from

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[13] *See* 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 Oct. 24, 2025).

[14] Rural Health, State of Maine Dept. of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/healthy-living/rural-health (last visited Oct. 28, 2025); William B. Weeks et al., *Rural-urban disparities in health outcomes, clinical care, health behaviors, and social determinants of health and an action-oriented, dynamic tool for visualizing them*, 3(10) PLOS Glob. Public Health 1, 2 (Oct. 2023).

[15] 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 Oct. 24, 2025) (13 of Maine's 16 counties contain primary care health professional shortages); 13 Primary Care Health Professional Shortage Areas (HPSAs), Kaiser Fam. Found. (Dec. 31, 2024), https://www.kff.org/other/state-

heart disease, cancer, unintentional injury, and stroke" relative to their urban counterparts.[16] MFP has spent decades tailoring its services to overcome these exact barriers. But the Defunding Provision will force MFP to decrease its services by closing clinics and cancelling primary care, making these healthcare barriers harder to overcome.[17]

A. Maine Is Already a Healthcare Desert Hotspot

Maine's existing healthcare system is already overburdened and fragile. This largely is attributed to the geographic and demographic makeup of the state. Around 40% of Maine's population, which is older and lower-income than many states in the country, lives in one of its 11 rural counties.[18] Unsurprisingly, these communities have far less access to healthcare providers than their urban counterparts.[19] In many parts of Maine, towns and cities, and their corresponding

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indicator/primary-care-health-professional-shortage-areas (85,155 Maine residents live in healthcare professional shortage areas).

[16] Paula Chatterjee, *Causes and Consequences of Rural Hospital Closures*, 17 J. of Hosp. Med. 938, 938 (2022), https://doi.org/10.1002/jhm.12973.

[17] Rural Health, State of Maine Dept. of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/healthy-living/rural-health (last visited Oct. 28, 2025).

[18] *Id.*

[19] 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 Oct. 24, 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.

doctor's offices, hospitals,[20] and other healthcare providers, are few and far between: the very definition of a healthcare desert.[21]

These healthcare deserts, combined with limited resources, housing shortages, and high cost of living, also make it difficult to attract clinicians to Maine.[22] Maintaining a stable clinician population in the state is difficult and expensive, with the turnover of a single physician representing the loss of $200,000 for an organization.[23] The costs associated with running Maine's healthcare infrastructure

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[20] Rural Health, State of Maine Dept. of Health and Human Servs., https://www.maine.gov/dhhs/mecdc/healthy-living/rural-health (last visited Oct. 28, 2025); Maine State Office of Rural Health Strategic Plan 2021 at 4, https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/MaineRural%20Health%20and%20Primary%20Care%20Strategic%20Plan2021.pdf (50% of Maine's land is completely uninhabited; Maine is the least densely populated state east of the Mississippi River at 41.3 people per square mile); Sean McCarthy et al., *Impact of Rural Hospital Closures on Health-Care Access,* 258 J. Surgical Rsch. 170, 175 (Feb. 2021) (at least 11,300 Mainers are unable to reach a hospital in 45 minutes or less).

[21] Adrienne Washington, *Maine's public transportation options are limited. Lawmakers would like to change that*., Portland Press Herald (May 18, 2025), https://www.pressherald.com/2025/05/18/maines-public-transportation-options-are-limited-lawmakers-would-like-to-change-that/ ("a fifth of Mainers live in places where they need to travel at least 30 miles to see a doctor."); Amanda Blanco and Jay Lindsay, *What stops the bleeding? Heath care gets harder to find in northern New England*, Fed. Rsrv. Bank of Bos. (June 11, 2025), https://www.bostonfed.org/news-and-events/news/2025/06/health-care-access-health-care-deserts-primary-care-doctor-shortage-northern-new-england.aspx; *Mapping Healthcare Deserts: Over 80% of the Country Still Lacks Adequate Access to Healthcare*, *supra* note 3; Lozano, *supra* note 3.

[22] Blanco & Lindsay, *supra* note 21.

[23] *Maine State Office of Rural Health Strategic Plan 2021*, *supra* note 20.

have already led to hospital and clinic closures, especially in rural locations.[24] One of the state's largest health care providers, Northern Light Health, closed a hospital in Waterville and a clinic in Bangor in May, and cut its work force by 300 last month.[25] Nearly half of Maine's 24 rural hospitals are considered at risk of closing, including Aroostook Medical Center in Presque Isle, Northern Light Maine Coast Hospital in Ellsworth, Cary Medical Center in Caribou, and Calais Community Hospital.[26] Hospital closures will lead to longer wait times, and an overall increase in health care costs, including for people not on Medicaid.[27]

MFP is one provider attempting to fill the gaps in Maine's healthcare system. As one MMA clinician observed, "due to the shortage of primary care providers in

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[24] WGME Staff, *Medicaid cuts lead to rural Maine hospital closures and service reductions*, WGME (July 4, 2025), https://wgme.com/news/local/medicaid-cuts-lead-to-rural-maine-hospital-closures-and-service-reductions (four hospitals have closed in the last decade, and just this year, one hospital has closed, two hospitals closed their labor and delivery units, and one hospital closed their obstetrics unit).
[25] Jenna Russell & Anna Griffin, *A Freeze on Medicaid Payments Is Forcing Cuts to Rural Health Care*, N.Y. Times (Oct. 4, 2025), https://www.nytimes.com/2025/10/04/us/medicaid-cuts-trump-maine-clinics.html.
[26] Channa Steinmetz, *Mainers warn of rural hospital closures under GOP cuts*, Me. Beacon (Oct. 8, 2025), https://mainebeacon.com/mainers-warn-of-rural-hospital-closures-under-gop-cuts/; Eesha Pendharkar, *Report warns hospitals in Aroostook, Ellsworth face imminent risk of closure due to Medicaid cuts*, Me. Morning Star (Aug. 22, 2025), https://mainemorningstar.com/2025/08/22/report-warns-hospitals-in-aroostook-and-ellsworth-face-imminent-risk-of-closure-due-to-medicaid-cuts/.
[27] Eesha Pendharkar, *Report warns hospitals in Aroostook, Ellsworth face imminent risk of closure due to Medicaid cuts*, Me. Morning Star (Aug. 22, 2025), https://mainemorningstar.com/2025/08/22/report-warns-hospitals-in-aroostook-and-ellsworth-face-imminent-risk-of-closure-due-to-medicaid-cuts/.

rural Maine, there are times during the week when I am unable to offer same-day or urgent visits. In these cases, [MFP] serves as an important resource, offering quicker access to care—especially for infections or other concerns that require timely antibiotic treatment." Defunding MFP will cause significant and irreversible harm to Maine's fragile healthcare system, decreasing the already limited options available to rural Mainers.

B. Rural Mainers Rely on Medicaid for Healthcare, Limiting Healthcare Access

Further compounding the issue of Maine's healthcare deserts is the fact that rural Mainers heavily rely on Medicaid and other forms of public insurance.[28] Maine's rural counties in particular have high poverty rates, with Piscataquis, Somerset, and Washington facing poverty rates of 16.5%, 18.3%, and 19.6%, respectively.[29] Low-income residents must also confront escalating living costs in Maine, with the value of a single-family house rising by 63.7% between 2020 and 2025.[30]

More than half of Medicaid enrollees in Maine live in rural areas, including more than 20% of non-elderly adults.[31] In some rural counties like Aroostook,

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[28] Blanco & Lindsay, *supra* note 21.
[29] *See Maine State Office of Rural Health Strategic Plan 2021*, *supra* note 20, at 14.
[30] Blanco & Lindsay, *supra* note 21.
[31] *Medicaid in Maine*, Kaiser Fam. Found. (May 2025), https://files.kff.org/attachment/fact-sheet-medicaid-state-ME; Joan Alker et al., *Medicaid's Role in Small Towns and Rural Areas*, Geo. Univ. Ctr. Child. & Fams.

Washington, and Somerset, the percentage of Mainers relying on Medicaid is as high as 40%.[32] An MMA member and Bangor family medicine physician observed that 30-40% of his patients, many of whom are from the rural areas surrounding Bangor, rely on Medicaid.

Rural Mainers relying on Medicaid face a further roadblock to receiving care because they can only access clinicians that accept their insurance, of which there are few (and MFP is one of them).[33] Many clinicians that would otherwise be accessible to rural Mainers do not accept Medicaid, reducing the already limited options. As one MMA clinician warned, these patients "have to settle for low cost/no cost alternatives that I am able to obtain from relief organizations. These are often less effective and places them at higher risk of complication." One MMA member family medicine physician even described how many rural clinicians prefer to institute a non-insurance-based subscription model for payment that most low-income residents cannot afford. The Defunding Provision will only make things

(Jan. 15, 2025), https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

[32] 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.

[33] Appellant Br. at 5–6; *see also* Rose Lundy, *A 1950s medical model grows in Maine*, The Me. Monitor (July 3, 2025), https://themainemonitor.org/1950s-medical-model-grows/ (a growing number of primary care providers take no insurance whatsoever).

worse because MFP will be forced to cut one of the few accessible primary care practices.

C. The Lack of Transportation Infrastructure in Maine's Rural Communities Is a Large Barrier to Healthcare Access

The existence of rural healthcare deserts, coupled with the limited availability of clinicians who accept Medicaid, requires rural, low-income Mainers to travel long distances in order to receive medical care. One MMA clinician in Skowhegan explained that he provides care to patients from northern Maine, where "travel times are often between one to two hours, making it extremely difficult to attend routine office appointments." An MMA family medicine physician in Bangor sees that "some patients travel two, three, or four hours for basic care."

Traveling for hours to attend a doctor's appointment on a regular basis is just not feasible. Patients not only have to grapple with long travel times, but also high travel costs and limited infrastructure. Indeed, "[s]econd only to poverty, transportation…[is] one of the highest health factor challenges to overcome in Maine."[34]

[34] Maine State Office of Rural Health Strategic Plan 2021, *supra* note 20, at 19, https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/MaineRural%20Health%20and%20Primary%20Care%20Strategic%20Plan2021.pdf, 19, 23 ("Groups of Medicaid enrollees, low-income adults and low-income adults 65 and over cited lack of transportation as the number one non-cost reason for delaying medical care therefore confirming transportation as a factor in access to health care.").

First, public transportation options in Maine are severely lacking, particularly in rural areas.[35] Without reliable public transportation, rural Mainers are forced to make the hours-long journey for healthcare by car, which comes with its own challenges. 40,000 Maine households have no access to a vehicle,[36] and Franklin, Aroostook, and Penobscot counties (all rural counties) have some of the highest percentages of zero-car households in Maine, making travel for medical care difficult, or even impossible.[37]

Second, even if a patient does have access to a car, Maine's limited rural road network, which is made up of narrow, winding, poorly-lit roads that often lead

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[35] Sean Murphy, *Report*: *Maine needs more public transit,* Spectrum News (Mar. 27, 2025), https://spectrumlocalnews.com/me/maine/traffic_and_transit/2025/03/27/report--maine-needs-more-public-transit ("[E]xisting public transit satisfies just 11% of the estimated needs").

[36] Moving Maine Network, *Try to Imagine it's You: How Transportation Barriers are Hurting Maine and How We Move Forward* 8 (2025), https://static1.squarespace.com/static/65b16bd6dac3ca0970776cf8/t/68014503f5b23411f27694d6/1744913691672/MMN_BarriersReport_2025_Final.pdf.

[37] John T. Gorman Foundation, *Moving Towards Solutions: Addressing the Transportation Challenges of Maine Families* 4, 7 (2025), https://www.jtgfoundation.org/2025/04/new-report-addressing-the-transportation-challenges-of-maine-families/.

through areas with low cell service, makes travel difficult or dangerous.[38] This is especially true in winter, when these roads are covered by snow and ice.[39]

Third, and even more limiting, the high poverty rates in rural Maine often make long-distance travel (and therefore healthcare) simply unaffordable. One MMA family medicine physician has witnessed that patients "often do not seek medical care because they cannot fill up their car with gas." Similarly, an April 2025 study addressing transportation challenges for Maine families confirmed that "[e]ven a small setback—a flat tire, a misaligned bus schedule, or a canceled ride—can be enough to prevent or threaten the progress of families who are living on razor-thin margins."[40]

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[38] TRIP, *Maine's Rural Roads & Bridges Have Significant Deficiencies; Backlog of Needed Repairs & Improvements to U.S. Rural Roads & Bridges Totals $198 Billion* 4 (Sep. 19, 2024), https://tripnet.org/reports/rural-connections-maine-news-release-09-19-2024/ ("Rural roads are more likely" to have "narrow lanes, limited shoulders, sharp curves, exposed hazards, pavement drop-offs, steep slopes and limited clear zones along roadsides."); TRIP, *Keeping Maine Mobile: Providing a Modern, Sustainable Transportation System in the Pine Tree State* 3 (Oct. 2024), https://tripnet.org/wp-content/uploads/2024/09/TRIP_Keeping_Maine_Mobile_Report_October_2024.pdf (79 percent of Maine's traffic fatalities occur on "rural, non-interstate roads"); *Highway Corridor Priorities*, https://www.maine.gov/dot/sites/maine.gov.dot/files/docs/maps/docs/2020/Highway_Corridor_Priorities.pdf (last visited October 28, 2025).

[39] *See, e.g.*, Gillian Graham, *Cars slide off icy roads across southern Maine on Friday*, Portland Press Herald (Jan, 27, 2024), https://www.pressherald.com/2024/01/26/cars-slide-off-icy-roads-across-southern-maine/.

[40] John T. Gorman Foundation, *supra* note 37, at 1.

As a result, rural Mainers go to the doctor infrequently, or wait to go to the doctor until their symptoms worsen or become life-threatening, which can have disastrous and heartbreaking results. There are many tragic stories that illustrate this point, and amici provide one here. An MMA family medicine physician recalled one patient in their late fifties who was completely dependent on others for transportation, even though the physician's primary care practice was only a few miles away from the patient's home. The patient was sometimes able to get rides to the physician's office, but when the patient presented with symptoms indicative of some form of carcinoma, the additional distance that the patient would be required to travel to the hospital was too great a barrier to overcome. The patient did not go to the hospital for further testing or treatment. Years later, the patient presented to the emergency room in distress and was diagnosed with an inoperable tumor. The patient entered hospice care and passed away shortly after. The physician lamented that this tragedy would have been avoidable had the patient been able to access the hospital; the cancer was completely curable had it been timely diagnosed and treated.

This patient story is just one example of the transportation struggles faced by rural Mainers trying to access healthcare. Another patient, a 68-year-old woman from Winslow, Maine, reported that she receives diabetes care in Bangor, drives to Pittsfield for cardiology and foot appointments, sees a primary care clinician in

Unity, and is on a two-year waitlist for her dermatologist in Brunswick.[41] She had triple bypass surgery, and is supposed to get a check-up for clogged arteries every six months, but she was unable to get an appointment until eight months past her last check-up.[42] Doctors she has seen for years are booked out until next year.[43] As she explained, "[i]t's a very bad situation, because I'm elderly …. [a]s we get older, we don't like to drive after dark and we don't like to go distances."[44]

* * *

The combination of Maine's healthcare deserts, Medicaid reliance, and transportation insecurity creates huge barriers to medical care, ultimately resulting in lapses or deprivation of care. MFP closures and reductions in services, resulting from the Defunding Provision, will only further exacerbate these barriers for rural, low-income patients. As one MMA clinician starkly observed, "where we don't have adequate access, people just don't go for healthcare . . . we see that people will get sicker and die sooner." Another MMA clinician cautioned that "patients who

[41] Hannah Kaufman, *Health care options in central Maine dwindle after recent closures*, CentralMaine.com (Oct. 10, 2025), https://www.centralmaine.com/2025/10/10/health-care-options-in-central-maine-dwindle-after-recent-closures/ (describing wait times of multiple months to over a year).
[42] *Id.*
[43] *Id.*
[44] *Id.*

become ill enough will have no option but to go to an emergency room where the cost of their care will be absorbed by our already strained local-hospitals."

Even more alarming, the patients that are willing and able to seek out new care will likely be left with very few (if any) viable alternatives because Maine's other Medicaid-accepting healthcare options are already operating at capacity. An MMA family medicine physician predicts that as a result of defunding MFP, "we will be getting phone calls asking if we're accepting new patients from practices that are closing. We already have long waitlists as it is. It's already taking four to six months before people can see a primary care provider for their first visit, and those wait times will get even longer. Patients will miss important events such as timely cancer screenings, timely screenings for diabetes, and then treatment for those disorders. It is more than probable that people will end up in life-threatening situations."

III. THE DEFUNDING PROVISION WILL SEVER LONG-STANDING CLINICIAN-PATIENT RELATIONSHIPS, LEADING TO EVEN WORSE HEALTH OUTCOMES FOR RURAL MAINERS

From a clinician perspective, one of the biggest harms of the Defunding Provision is the severing of the clinician-patient relationship—an essential component of quality medical care. [45] When the Defunding Provision forces MFP

[45] Jamey J. Lister & Paul J. Joudrey, *Rural Mistrust of Public Health Interventions in The United States: A Call for Taking the Long View to Improve Adoption*, 39(1) J. Rural Health 18, 18 (2022).

to close clinics and reduce primary care services, rural Medicaid patients will experience a disruption in continuity of care, leading to decreased trust in the healthcare system, lapses in preventative care, and worse health outcomes overall. Even non-MFP patient-clinician relationships will not be immune from the Defunding Provision and will likewise be harmed by longer wait times and increased strain on resources.[46]

A. The Defunding Provision Interrupts Continuity of Care for Rural Mainers

The clinician-patient relationship is essential to achieving optimal health outcomes. It "has been and remains a keystone of care."[47]

An important aspect of the clinician-patient relationship is continuity of care, defined as when the patient sees the same clinician or members of the same practice consistently over time.[48] A focus on continuity of care in healthcare has been linked to "reduced mortality, fewer hospitalizations, lower healthcare expenses, improved medication compliance, and higher patient satisfaction" for patients with chronic

[46] *See* Fallon E. Chipidza, Rachel S. Wallwork & Theodore A. Stern, *Impact of the Doctor-Patient Relationship*, 17(5) The Primary Care Companion for CNS Disorders (2015).
[47] Susan Dorr Gold & Mack Lipkin Jr., *The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. Gen. Internal Med. S26. S26 (1999).
[48] Kam-Suen Chan et al., Effects of Continuity of Care on Health Outcomes Among Patients with Diabetes Mellitus and/or Hypertension: A Systematic Review, 22(145) BMC FAM. PRAC. 1, 2 (2021).

conditions.[49] High physician continuity is also associated with lower emergency department use and results in fewer hospitalizations for medically complex patients.[50] "The best healthcare outcomes (measured by [emergency department] visits and hospitalizations) are associated with consistently seeing one's own primary family physician or seeing a clinic partner when that physician is unavailable."[51]

Patients suffer when they lose a primary care clinician, and often decline to seek out a new primary care clinician afterward.[52] Only 23% of patients who lose their primary care clinician will visit a new primary care clinician, and 27% of patients never visit a primary care clinician ever again, choosing instead to visit specialists when persistent issues arise.[53] Moreover, when a patient loses the relationship with their primary care clinician, they are 4% "more likely to die," 4% "more likely to have an emergency department visit," and 3% "more likely to be admitted to the hospital."[54] Patients are also 4% "more likely to be admitted to a

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[49] *Id.* at 2.

[50] Terrence McDonald et al., *The Impact of Primary Care Clinic and Family Physician Continuity on Patient Health Outcomes: A Retrospective Analysis from Al berta, Canada*, 22(3) The Annals of Fam. Med. 223, 223 (May 2024).

[51] *Id.* at 223.

[52] *See generally* Adrienne Sabety, *The Value of Relationships in Healthcare*, 225 J. Pub. Econ. 1, 11 (Sept. 2023).

[53] *Id.* at 15.

[54] *Id.* at 2.

skilled nursing facility," and 9% "more likely to initiate hospice care."[55] These outcomes are even higher for certain vulnerable groups, such as rural populations.[56]

In fact, rural populations in America tend to have shorter lifespans than their urban counterparts, and are more likely to be uninsured, unvaccinated, food-insecure, obese, tobacco users, and physically inactive.[57] Rural counties in the America "overwhelmingly had worse measures of health and [social determinants of health]", and the gap between rural and urban health outcomes continues to widen.[58] Rural populations already operate at a disadvantage when it comes to social determinants of health and access to quality healthcare, and should the Defunding Provision be upheld, it will only exacerbate this health disparity.

Patients and clinicians alike recognize the value of continuity of care. A 2001 study found that maintaining a general practitioner is "very important" or "extremely important" in general by 64% of patients and 69% of general practitioners.[59] Physicians similarly agree that continuity of care allows for a deeper understanding of each individual patient, resulting in more accurate diagnosis and more personalized treatment plans. For example, in one MMA family medicine

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[55] *Id.* at 2.
[56] *See id.* at 46; Weeks et al., *supra* note 14, at 2.
[57] *Id.* at 6.
[58] *Id.* at 13.
[59] Karen E. Kearley, George K. Freeman & Anthony Heath, *An Exploration of the Value of the Personal Doctor-Patient Relationship in General Practice*, 51(470) The Brit. J. of Gen. Prac.: The J. of The Royal Coll. of Gen. Prac. 712, 715 (2001).

physician's practice, continuity of care has meant he found and diagnosed things that he would not have if the care he provided was merely episodic. But the longer patient relationship meant he knew his patient's baseline health and behavior well enough to spot issues. This continuity of care has enabled MMA physicians to create more informed treatment plans by considering the patient's home life and distance to the medical center. For instance, one MMA clinician recently discharged a patient to their home instead of a rehabilitation facility because he knew the patient had a strong family support system who could assist with exercises and course of treatment. Continuity of care can also combat distrust of clinicians and healthcare institutions—a distrust that many rural Mainers have.[60]

The Defunding Provision will interrupt continuity of care for hundreds, and potentially thousands, of Mainers who rely on MFP's primary care services, requiring them to find new clinicians.[61] Unfortunately, many people will not be able to find new clinicians, given the influx of patients for the often-limited healthcare options in rural Maine, while others may simply just give up on seeking a new clinician at all. But the result for all rural Mainers that rely on MFP will be the same: lack of access to medical care and worse health outcomes.

[60] *See infra* Section III(B).
[61] Appellant Br. at 5, 33.

Further, the Defunding Provision will damage even clinician-patient relationships that were *not* severed by the Defunding Provision when the remaining Medicaid clinicians receive an influx of new patients. This type of stressor on the medical system will further undermine the clinician-patient relationship by placing time constraints on care visits, increasing patient-clinician ratios, and increasing costs.[62] The vital patient-clinician relationship will suffer as a result.

B. The Defunding Provision Hinders the Development of Trust in Medical Institutions in Maine's Rural Areas

Along with disrupting continuity of care, the Defunding Provision will damage carefully built trust between clinicians and their patients—something that MFP has spent decades cultivating in Maine's rural communities.[63] Patients in rural areas are more likely to mistrust medical institutions, healthcare organizations, and clinicians. "Research has identified higher mistrust of government and institutions among rural communities of the United States, mistrust of health services among racial and ethnic minority populations in rural areas, and examined the role mistrust of scientific information plays in adoption of public health guidance among the politically conservative."[64]

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[62] Fallon E. Chipidza, Rachel S. Wallwork & Theodore A. Stern, *Impact of the Doctor-Patient Relationship*, 17(5) The Primary Care Companion for CNS Disorders (2015).
[63] Appellant Br. at 33, 34.
[64] Lister & Joudrey, *supra* note 45, at, 18.

Violations of trust affect the willingness of the affected group to seek care from the institutions that have harmed them in the past.[65] It follows that the trust built over time by organizations like MFP is difficult to replicate, and patients may be reluctant to seek alternative avenues of care if these organizations are shuttered by the Defunding Provision. Moreover, distrust of medical institutions, healthcare organizations, and clinicians has increased since the COVID-19 pandemic—making trust an even more precious commodity today. A study of adults found that the proportion reporting a lot of trust for physicians and hospitals fell from 71.5% in April 2020 to 40.1% in January 2024.[66] And rural participants were even less likely than suburban or urban participants to trust physicians and hospitals.[67] One MMA clinician in Maine expressed concern that some of the vulnerable groups MFP serves, including rural populations without other ready access to healthcare, will be unable to access care and unwilling to seek out new clinicians if the Defunding Provision is upheld:

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[65] Carly Parnitzke Smith, *First, do no harm: institutional betrayal and trust in healthcare organizations*, J. of Multidisciplinary Healthcare 133, 140 (2017) ("[b]etrayal appears to be a contributor to patient behaviors that undermine treatment effectiveness, including not seeking medical care when it is necessary and not complying with treatment recommendations.").

[66] Roy H. Perlis et al., *Trust in Physicians and Hospitals During the COVID-19 Pandemic in a 50-State Survey of U.S. Adults*, JAMA Network Open 1, 4 (Jul. 31, 2024).

[67] *Id.* at 7.

> Part of my work is providing free care to people who are unhoused. This population already has a hard time accessing care. The mobile unit in the Augusta area through Maine Family Planning has been essential to bridging the gap of gynecologic care, reproductive healthcare, wound care, and HIV testing in central Maine. The mobile unit has earned this population's hard-earned trust but I fear that withdrawing it now would irreversibly damage their willingness to utilize such resources.

Given high levels of healthcare mistrust in rural areas, strong clinician-patient relationships are especially important. Having a trusted clinician, who patients can speak to without fear of judgment, improves healthcare outcomes. MMA clinicians' patients have expressed heartbreak and feelings of abandonment, in addition to worsened health outcomes, as the result of losing access to a primary care clinician. Patients may feel uncomfortable asking intimate questions (such as questions about sensitive topics like birth control or vaccines) to a clinician they have not visited before. Some patients may forgo these questions altogether. And it is not only MMA patients who feel this way; research shows that many people abandon routine care altogether when they can no longer see their primary care clinician.[68]

IV. THE DEFUNDING PROVISION IRREPARABLY HARMS MAINERS

As set forth above, there is extensive evidence establishing that the Defunding Provision's effect on MFP would cause irreparable harm to Maine's citizens. Courts grant preliminary injunctions where a plaintiff is likely (1) to succeed on the merits

[68] *E.g.,* Adrienne Sabety, *The Value of Relationships in Healthcare*, 225 J. PUB. ECON. 1, 11 (Sept. 2023).

of its claim, (2) to suffer irreparable harm absent preliminary relief, (3) the balance of equities tips in its favor, and (4) the injunction is in the public interest.[69] The first two factors weigh heaviest in the analysis.[70] They "are measured on a sliding scale[,] such that when there is a strong showing as to irreparable harm, a preliminary injunction may be warranted even if the showing as to likelihood of success on the merits is relatively weak."[71] If the potential for irreparable harm is high, "a preliminary injunction may issue if the plaintiffs' claims present fair grounds for further litigation."[72]

Here, the irreparable harm of the Defunding Provision cannot be overstated. MFP serves thousands of Mainers each year, and its clinics serve counties with some of the highest Medicaid enrollment in the state.[73] As detailed above, for many rural Medicaid patients, MFP is the only viable avenue for primary care, but without

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[69] *Starbucks Corp. v. McKinney*, 602 U.S. 339, 346 (2024).
[70] *Braintree Labs., Inc. v. Citigroup Glob. Mkts. Inc.*, 622 F.3d 36, 41 (1st Cir. 2010).
[71] *Cosel v. Tr. of Wendt Fam. Tr.*, No. 22-CV-30113 (MGM), 2022 WL 22915206, at *2 (D. Mass. Nov. 1, 2022) (citing *Braintree*, 622 F.3d at 42–43); *see also Ross-Simons of Warwick, Inc. v. Baccarat, Inc.*, 102 F.3d 12, 19 (1st Cir. 1996) ("the predicted harm and the likelihood of success on the merits must be juxtaposed and weighed in tandem"); *Pub. Serv. Co. of N.H. v. Patch*, 167 F.3d 15, 26-27 (1st Cir. 1998); *Hamilton Watch Co. v. Benrus Watch Co.*, 206 F.2d 738, 740 (2d Cir. 1953) ("[I]f ... the balance of hardships tips decidedly toward plaintiff[,] it will ordinarily be enough [to justify a preliminary injunction] that the plaintiff has raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberate investigation.").
[72] *Concord Hosp., Inc. v. NH Dep't of Health & Hum. Servs.*, 743 F. Supp. 3d 325, 362 (D.N.H. 2024) (internal quotation marks omitted).
[73] Appellant Br. at 5.

Medicaid funding, MFP will be forced to turn away hundreds, and potentially thousands, of patients by the end of October.[74] In addition, the Defunding Provision will sever some clinician-patient relationships, worsen others, and sow more distrust in healthcare institutions.[75] In short, the Defunding Provision will tip the scales in what is already a massive healthcare shortage in Maine.[76]

The inarguable irreparable harm of the Defunding Provision coupled with, at a minimum, fair grounds for further litigation on the merits (as articulated by MFP's briefing) entitles MFP to a preliminary injunction.

CONCLUSION

For the reasons articulated above, this Court should reverse the district court's decision and grant MFP a preliminary injunction halting the Defunding Provision's as applied to it.

[74] *Id.* at 5, 33; *see supra* Section I.
[75] *See supra* Section III.
[76] *See supra* Section II.

Dated: October 29, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

As required by Fed. R. App. P. 29(a)(4)(G) and 32(g)(1), I certify that this Brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because this Brief contains 6,419 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

I further certify that this Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this Brief has been prepared in a proportionally spaced typeface using Word 2019 in 14-point Times New Roman. I certify that the information on this form is true and correct to the best of my knowledge and belief formed after a reasonable inquiry.

Dated: October 29, 2025

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed via the Court's electronic filing system on October 29, 2025, to be served by operation of the electronic filing system on all ECF-registered counsel of record.

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