Nos. 23-726 & 23-727

In the Supreme Court of the United States

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

Petitioners,

v.

UNITED STATES,

Respondent.

STATE OF IDAHO,

Petitioner,

v.

UNITED STATES,

Respondent.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR FORMER HHS OFFICIALS AS *AMICI CURIAE* SUPPORTING RESPONDENT

NICOLE SAHARSKY
Counsel of Record
MINH NGUYEN-DANG
CHARLEY B. LANTER
GABRIELA DUEÑAS
Mayer Brown LLP
1999 K Street, NW
Washington, DC 20006
(202) 263-3000
nsaharsky@mayerbrown.com

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes

TABLE OF AUTHORITIES (continued)

TABLE OF AUTHORITIES
(continued)

Other Authorities **Page(s)**

TABLE OF AUTHORITIES (continued)

Other Authorities (continued) **Page(s)**

INTEREST OF THE *AMICI CURIAE*

Amici are a former Secretary of Health and Human Services (HHS), former Administrators of the Centers for Medicare and Medicaid Services (CMS) or its predecessor the Health Care Financing Administration, and other former senior federal health officials who served during the administrations of President George H.W. Bush, President Bill Clinton, President George W. Bush, and President Barack Obama.[1] They are:

Donald M. Berwick, Administrator, Centers for Medicare and Medicaid Services, 2010-2011.

Marilyn Dahl, Director, Division of Acute Care Services, Survey and Certification Group, Center for Clinical Standards & Quality, Centers for Medicare and Medicaid Services, 2006-2015.

Robin Schneider, Senior Counsel, Office of Inspector General, Department of Health and Human Services, 1986-2013.

Donna Shalala, Secretary of Health and Human Services, 1993-2001.

Andrew M. Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services, 2015-2017.

Bruce C. Vladeck, Administrator, Health Care Financing Administration, 1993-1997.

---

[1] Pursuant to Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to its preparation or submission. *Amici* submit this brief in their individual capacities and not on behalf of their organizations or institutions.

Timothy Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, 1999-2001.

This case involves the application of the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, which is administered and enforced by CMS, a component of HHS. EMTALA requires hospitals that participate in Medicare to stabilize patients presenting with emergency medical conditions or to safely transfer the patients to facilities that can provide the appropriate care, regardless of the patients' ability to pay. 42 U.S.C. 1395dd(b).

The question presented is whether EMTALA preempts Idaho's near-complete ban on abortion to the extent that the ban prohibits a physician from providing an abortion that is required to stabilize a patient under EMTALA. In *amici*'s view, the answer is yes.

Amici have significant expertise regarding EMTALA as a result of their experience leading HHS and CMS (totaling more than 40 years of government service). They have particular knowledge of EMTALA's requirements from their roles administering and enforcing EMTALA. They file this brief to explain that EMTALA always has been understood to require a covered hospital to provide an abortion if that procedure is necessary to stabilize the patient.

INTRODUCTION AND SUMMARY OF ARGUMENT

EMTALA is a vital component of our Nation's healthcare system. It ensures that those who urgently need care can obtain it. HHS, which administers EMTALA, has long understood that in appropriate circumstances, that care can include abortion.

EMTALA requires all hospitals that participate in Medicare and that have an emergency department – which is virtually all major and many smaller hospitals in the United States – to provide care to patients with emergency medical conditions, regardless of their ability to pay. In particular, EMTALA specifies that when a patient arrives at a covered hospital needing emergency care, the hospital either must provide the care needed to stabilize the patient before it can discharge the patient, or must safely transfer the patient to a hospital that is capable and willing to provide that care. The stabilizing-care requirement sets a national minimum standard for stabilizing emergency medical conditions that preempts state laws allowing a hospital to provide a lesser level of care.

For some emergency medical conditions, the necessary stabilizing care can include an abortion. Those conditions include internal bleeding due to an ectopic pregnancy, emergent high blood pressure due to preeclampsia, and acute blood clots due to thromboembolism. Each of those emergency conditions could seriously impair a patient's bodily functions or organs or even threaten the patient's life, and in many cases an abortion is the only appropriate treatment to stabilize the condition. Thus, although EMTALA does not directly address abortion, a hospital may be required to provide an abortion in certain circumstances to fulfill its duty to stabilize the patient.

Idaho suggests that this understanding of EMTALA was newly invented as a response to this Court's decision in *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022). Nothing could be further from the truth.

HHS has consistently interpreted the stabilizing-care requirement in EMTALA to include abortion

when clinically necessary. For example, an HHS rulemaking in 2008 recognized that the necessary care to stabilize a patient under EMTALA can include an abortion, and HHS's subsequent rulemakings reaffirmed that understanding. HHS's pre-*Dobbs* interpretive guidance to hospitals, issued in response to a state abortion restriction, similarly explained that an abortion could be required to stabilize a patient under EMTALA. And in several pre-*Dobbs* enforcement actions, HHS found that hospitals violated EMTALA's stabilizing-care requirement by failing to provide abortions in particular circumstances.

The understanding that EMTALA can require a covered hospital to provide an abortion as stabilizing care thus is neither novel nor unique. It simply follows the plain meaning of the stabilizing-care provision in EMTALA, as HHS always has understood.

ARGUMENT

HHS HAS LONG RECOGNIZED THAT EMTALA CAN REQUIRE A HOSPITAL TO PROVIDE AN ABORTION AS PART OF STABILIZING EMERGENCY CARE

A. EMTALA Requires Covered Hospitals To Provide Stabilizing Care, Which Can Include Abortion

EMTALA establishes a national minimum standard of care that covered hospitals must provide to stabilize patients with emergency medical conditions. In the appropriate circumstances, that stabilizing care can include abortion.

1. Congress enacted EMTALA in 1986 to ensure that every person in the United States who seeks emergency care at a hospital emergency department

receives a minimum level of care. The statute applies to all hospitals that participate in Medicare and that have emergency departments – which, in practice, is virtually every major hospital in the United States, along with many smaller hospitals including all small rural critical access hospitals. 42 U.S.C. 1395dd(a), (e)(2). The statute also applies to hospitals that participate in Medicare and that do not have emergency departments, but that have the capability and capacity to provide care to patients transferred from other hospitals' emergency departments. 42 U.S.C. 1395dd(g). The statute thus effectively sets out a nationwide minimum standard for providing stabilizing care to a patient with an emergency medical condition.

The Secretary of HHS is responsible for administering and enforcing EMTALA. See 42 U.S.C. 1301(a)(6), 1395dd(c)(1)(iii). The Secretary has delegated those responsibilities to CMS (formerly the Health Care Financing Administration), which administers and enforces EMTALA as part of Medicare. See 42 C.F.R. 489.24.

EMTALA imposes two basic obligations on a covered hospital when a patient comes to its emergency department and requests treatment. First, the hospital must determine whether the patient has an "emergency medical condition." 42 U.S.C. 1395dd(a). The statute defines an "emergency medical condition" as a condition that, in the "absence of the immediate medical attention," could "reasonably be expected to result in" the health of the patient (or the patient's unborn child) being placed "in serious jeopardy," "serious impairment" to the patient's "bodily functions," or "serious dysfunction" of the patient's "bodily organ or

part." 42 U.S.C. 1395dd(e)(1)(A)(i)-(iii).[2] Thus, EMTALA's definition of "emergency medical condition" is not limited to life-threatening situations.

Second, if the hospital determines that the patient presents with an emergency medical condition, the hospital must provide the care needed to "stabilize" the patient if it is able to do so, or else safely transfer the patient to a different medical facility that can provide that care. 42 U.S.C. 1395dd(b)(1), (c)(1). That second facility must accept the transfer and provide the necessary stabilizing treatment. 42 U.S.C. 1395dd(g).

The hospital owes these obligations to any patient who requests treatment at the emergency department (or is transferred from another hospital), regardless of the patient's ability to pay. 42 U.S.C. 1395dd(a), (b)(1). Indeed, the hospital may not delay examination or treatment "in order to inquire about the individual's method of payment or insurance status." 42 U.S.C. 1395dd(h); see 42 C.F.R. 489.24(d)(4).

2. Idaho asserts (Br. 32) that EMTALA's stabilizing-care requirement does not establish a nationwide standard for stabilizing care, but instead requires only that covered hospitals provide indigent patients with the same level of emergency care that they would provide to paying patients under state law. That is incorrect. HHS always has understood EMTALA's stabilizing-care requirement to set out a national

---

[2] The statute further specifies that a pregnant patient who is having contractions has an "emergency medical condition" if there is not enough time to safely transfer the patient to another hospital before delivery, or if the transfer would pose a threat to the health or safety of the patient or the unborn child. 42 U.S.C. 1395dd(e)(1)(B).

standard that all covered hospitals must meet for all patients regardless of their ability to pay.

First, the statute expressly preempts any state or local law requirement "to the extent that the requirement directly conflicts with" EMTALA's requirements, including its requirement for stabilizing care. 42 U.S.C. 1395dd(f). HHS consistently has interpreted this provision to mean that EMTALA preempts state or local regulation that would permit (or require) hospitals to provide a lower standard of care than the standard required by EMTALA.

For example, some states require particular patient groups (such as indigent patients, psychiatric patients, or pregnant persons) be treated only at specifically designated facilities. CMS, Pub. 100-07, *State Operations Manual, Appendix V – Responsibilities of Medicare Participating Hospitals in Emergency Cases* 40 (2019) (CMS, *2019 SOM*). But since at least 2004, HHS has made clear that EMTALA preempts that requirement with respect to emergency care. In particular, HHS guidance has explained that a covered hospital in one of those states violates EMTALA if it does not screen and, if necessary, stabilize the patient as required by the statute before transferring the patient to the state-designated facility. CMS, Pub. 100-07, *State Operations Manual, Appendix V – Responsibilities of Medicare Participating Hospitals in Emergency Cases* 31 (2004).

Second, EMTALA directs HHS to apply a national standard in assessing whether a hospital has provided stabilizing care. Specifically, the statute instructs HHS to use a "quality improvement organization" to evaluate whether a hospital provided appropriate stabilizing care in a particular case. 42 U.S.C. 1395dd(d)(3); see pp. 16-17, *infra*. A "quality improve-

ment organization" is an organization under contract with HHS that applies "professionally developed norms of care" to review the services provided by Medicare providers. 42 U.S.C. 1320c-3(a)(6)(A). Congress specifically required that a quality improvement organization make its assessment based on "*national* norms." *Ibid.* (emphasis added).

HHS accordingly has recognized that quality improvement organizations apply "national standards that are clearly linked to better patient outcomes." CMS, *QIO Fact Sheet: Overview* (2009), https://perma.cc/7HPK-JWSF. EMTALA's requirement that HHS use quality improvement organizations to enforce EMTALA's stabilizing-care standard thus confirms that the standard is a national one.

EMTALA's legislative history further demonstrates that the statute sets out a national standard for stabilizing care. Congress enacted EMTALA in 1986 in response to a growing concern about the practice of "patient dumping." Under that practice, a hospital, "for purely financial reasons" would "refuse[] to initially treat or stabilize an individual with a true medical emergency" and instead "dump[]" the patient at another hospital, often a public hospital. 131 Cong. Rec. S13,904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole); see H.R. Rep. No. 241, pt. 1, 99th Cong., 1st Sess. 27 (1985). Although 22 states already had taken measures to address patient dumping, and some courts had imposed a common-law duty on doctors and hospitals to provide necessary emergency care, that patchwork approach had proven insufficient. See H.R. Rep. No. 241, pt. 3, 99th Cong., 1st Sess. 4-5 (1985). Congress accordingly enacted EMTALA as a "federal" solution setting a national floor on emergency care. *Ibid.*

3. The stabilizing-care requirement in EMTALA is context-specific. Stabilizing care is the treatment "as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from" the patient's discharge from the hospital or transfer to another facility. 42 U.S.C. 1395dd(e)(3)(A), (e)(4).[3]

For example, if a patient with a history of asthma presents with symptoms of an asthma attack (such as chest tightness, wheezing, and shortness of breath), the hospital must provide treatment to alleviate the acute respiratory symptoms until those symptoms have passed. CMS, *2019 SOM* 50.

The hospital's obligation to provide stabilizing care ends when the patient has been stabilized and the emergency medical condition has been resolved. The hospital is not required to further treat any underlying disease that caused the emergency condition, or to provide treatment to prevent the emergency condition from recurring. CMS, *2019 SOM* 50-51. So, in the example above, the hospital is required only to treat the patient's asthma attack, but is not required to treat the underlying condition that caused that attack. *Id.* at 50. Instead, hospitals are "expected within reason" to provide the patient with "the necessary information" for obtaining "follow-up care." *Id.* at 50-51.

4. For some emergency medical conditions, the appropriate stabilizing care includes abortion. A patient with an ectopic pregnancy (in which the fertilized egg implants outside of the uterus, typically in

---

[3] For a patient in active labor, the statute specifies that stabilizing the patient means delivering the child. 42 U.S.C. 1395dd(e)(3)(B).

the fallopian tube) can develop severe internal bleeding that can permanently damage the patient's reproductive organs and that can even be life-threatening. Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 193, *Tubal Ectopic Pregnancy* (Mar. 2018). All of the recognized treatments for ectopic pregnancies involve terminating the pregnancy and removing the fetus, either through surgery or medication. See *ibid.* Thus, for a patient whose ectopic pregnancy constitutes an emergency medical condition, stabilizing care will involve an abortion.

Similarly, an abortion can be required to stabilize a patient experiencing an emergent hypertensive disorder (high blood pressure) such as preeclampsia, or an acute thrombotic event (blood clots). Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020); Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 196, *Thromboembolism in Pregnancy* (July 2018). Left untreated, those conditions could severely and permanently impair the patient's cardiovascular system, and in some circumstances could even threaten the patient's life. See *ibid*. An abortion could be appropriate stabilizing treatment for a patient with those emergency medical conditions.

Notably, Congress itself has recognized that stabilizing care under EMTALA can include abortion in certain circumstances. Specifically, in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), Congress enacted special provisions related to abortion. 42 U.S.C. 18023. For example, Congress allowed states to choose to prohibit abortion coverage in health plans offered on a health exchange, 42 U.S.C. 18023(a), and prohibited any

health plan offered on a health exchange from discriminating against a healthcare provider because of its refusal to perform abortions, 42 U.S.C. 18023(d).

But Congress specified that none of those provisions (and indeed nothing in the entire Act) "shall be construed to relieve any health care provider from providing emergency services as required by * * * section 1395dd of this title (popularly known as 'EMTALA')." 42 U.S.C. 18023(d). This provision – and its placement in the section pertaining specifically to abortion – make clear that Congress understood that stabilizing care under EMTALA could include abortion services.

Thus, although EMTALA does not expressly address abortion, because abortion can be necessary to stabilize an emergency medical condition, fulfilling EMTALA's stabilizing-care requirement can include providing that care.

B. HHS Consistently Has Understood That Stabilizing Care Under EMTALA Can Include Abortion

Idaho asserts (Br. 42) that before *Dobbs* v. *Jackson Women's Health Organization*, 597 U.S. 215 (2022), EMTALA's stabilizing-care requirement had not been understood to include abortion. That is mistaken: HHS long has understood that stabilizing care under EMTALA can include an abortion.

*1. Pre-*Dobbs *Rulemaking*

In a pre-*Dobbs* rulemaking, HHS expressly recognized that stabilizing care under EMTALA can include abortion.

In 2008, HHS promulgated a right-of-conscience rule. That rule was designed to ensure that federal

agencies, state and local governments, and institutions that received federal funds could not require healthcare providers to perform medical procedures to which the providers have sincere religious or moral objections. See *Ensuring that HHS Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law*, 73 Fed. Reg. 78,072, 78,087-88 (Dec. 19, 2008). The rule was intended to implement certain provisions in the Church Amendments, 42 U.S.C. 300a-7, the Public Health Service Act, 42 U.S.C. 238n, and the Weldon Amendment to the Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508(d), 1212 Stat. 1844 (2007). *Id.* at 78,072-73. As HHS explained, the goal of the rule was to "protect[]health care workers and institutions from being compelled to participate in, or from being discriminated against for refusal to participate in, health services * * * that may violate their consciences." *Id.* at 78,074.

In particular, the rule sought to prevent any recipient of HHS funds from "[s]ubject[ing] any institutional or individual health care entity to discrimination for refusing * * * [t]o perform, refer for, or make other arrangements for, abortions." 73 Fed. Reg. at 78,097. Following the publication of the proposed rule, HHS received comments that expressed concern that the proposed conscience rule would conflict with EMTALA. *Id.* at 78,087-88. Two of HHS's responses to those comments recognized that abortion could be a required part of emergency care under EMTALA.

First, some commentators expressed concern that a patient could need an abortion as stabilizing medical treatment, but a hospital might not have staff available because of conscience-based objections. See 73 Fed. Reg. at 78,087. HHS responded that it was "not

aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its entire staff objected to the service on religious or moral grounds." *Ibid.* Notably, HHS did not respond by saying that the concern was invalid because abortion could not be stabilizing care under EMTALA. Instead, its response assumed that EMTALA *could* require a hospital to provide an abortion to stabilize a patient in certain circumstances.

Second, some commentators expressed concern that the rule would prevent patients from receiving abortions as stabilizing treatment because hospitals themselves – and not just individual staff members – would object to providing that care. 73 Fed. Reg. at 78,087. As with the previous comment, HHS responded that it was "unaware of any hospital that has such a policy." *Ibid.* Significantly, HHS's response framed the concern to be that the rule would prevent patients from receiving "abortions that are necessary to stabilize the [patients], as that term has been interpreted in the context of EMTALA." *Ibid.* So in this response, HHS expressly acknowledged that an abortion could be "necessary to stabilize" a patient under EMTALA. *Ibid.*

In 2011, 2019, and 2024, HHS engaged in further rulemaking about conscience-based objections to certain medical care. In 2011, HHS rescinded the 2008 rule in part. See *Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws*, 76 Fed. Reg. 9968 (Feb. 23, 2011). Then in 2019, HHS promulgated a new rule that substantially expanded providers' ability to deny medical care based on conscience-based objections. See *Protecting Statutory Conscience Rights in Health Care*, 84 Fed. Reg. 23,170 (May 21, 2019). The 2019 rule was

vacated by federal courts before it went into effect, in part because of the significant likelihood that the rule would conflict with EMTALA. *New York* v. *HHS*, 414 F. Supp. 3d 475, 535 (S.D.N.Y. 2019); see *Washington* v. *Azar*, 426 F. Supp. 3d 704, 719 (E.D. Wash. 2019); *City & Cnty. of San Francisco* v. *Azar*, 411 F. Supp. 3d 1001, 1011 (N.D. Cal. 2019). In 2024, HHS partially rescinded the 2019 rule. See *Safeguarding the Rights of Conscience as Protected by Federal Statutes*, 89 Fed. Reg. 2078 (Jan. 11, 2024).

None of these later rulemakings suggested any change to HHS's view that abortion could be necessary stabilizing care in appropriate circumstances. To the contrary, in the 2019 rulemaking HHS reaffirmed its view from the 2008 rulemaking that EMTALA's stabilizing-care requirement could include abortion: HHS "agree[d] with its explanation in the preamble to the 2008 Rule that the requirement under EMTALA that certain hospitals treat and stabilize patients who present in an emergency does not conflict" with its new rule. 84 Fed. Reg. at 23,183. Thus, even as HHS sought to expand conscience objections to providing abortions, HHS confirmed its previous acknowledgment that some abortions could be "necessary to stabilize" patients under EMTALA. 73 Fed. Reg. at 78,087.

HHS's rulemakings accordingly make clear that it consistently has understood that EMTALA's stabilizing-care requirement could require a hospital to provide a patient with an abortion.

*2. Pre-*Dobbs *Interpretive Guidance*

In pre-*Dobbs* interpretive guidance to hospitals, HHS expressly recognized that stabilizing care under

EMTALA can require abortion in certain circumstances.

Consistent with EMTALA's context-specific standard for stabilizing care, CMS has only occasionally issued guidance that prospectively describes the care to be provided in particular cases. Instead, CMS has issued interpretive guidance that more generally explains the standard for stabilizing care, see, *e.g.*, CMS, *2019 SOM* 48-52, and CMS then determines EMTALA compliance retrospectively, on a case-by-case basis, *id.* at 6; see pp. 16-17, *infra*.

That said, CMS has provided prospective guidance on a few occasions, typically when a significant public-health event occurs that affects many hospitals. For example, in November 2014, CMS issued guidance about treatment of Ebola in light of "increasing public concerns" due to an outbreak of that highly contagious and often deadly disease in West Africa. Ctr. for Clinical Stds. & Quality, CMS, *EMTALA Requirements and Implications Related to Ebola Virus Disease* 1 (Nov. 21, 2014). Similarly, in March 2020, CMS issued guidance about how hospitals could screen patients in light of the emergence of the Covid-19 pandemic. Ctr. for Clinical Stds. & Quality, CMS, *EMTALA Requirements and Implications Related to Coronavirus Disease 2019* (Mar. 9, 2020).

As relevant here, in September 2021, CMS issued guidance related to abortion. That guidance was prompted by Texas's Senate Bill 8, which prohibited abortions after approximately six weeks. See Ctr. for Clinical Stds. & Quality, CMS, *Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss* (Sept. 17, 2021). CMS's guidance reiterated HHS's view that "[s]tabilizing treatment" under EMTALA could

include abortion. *Id.* at 4. The guidance specifically listed "dilation and curettage," a common abortion procedure, as an example of stabilizing treatment that could be "necessary to stabilize [an] emergency medical condition[]." *Ibid.* The guidance explained that its guidance that stabilizing care potentially can include abortion was not a "new policy," but merely a "remind[er]" to hospitals "of their existing obligation" under EMTALA in light of the entry into effect of the Texas law. *Id.* at 1.

*3. Pre-*Dobbs *Enforcement Actions*

Finally, HHS recognized that EMTALA can require abortion in its pre-*Dobbs* enforcement actions.

EMTALA's enforcement process is complaint-driven. CMS, *2019 SOM* 2. CMS receives complaints from a variety of sources, including from patients who allege that they did not receive the required care and from hospitals that suspect that they received patients who had not been adequately stabilized or transferred by other hospitals. *Id.* at 5. If CMS determines that a complaint warrants an investigation, it sends surveyors to the hospital at issue to investigate the complaint. *Ibid.* That investigation can include collecting relevant medical records, reviewing the hospital's policies and procedures, and interviewing the patient and hospital staff. *Id.* at 6.

If a complaint alleges that the hospital did not provide adequate stabilizing care, CMS forwards the medical evidence it has collected to a quality improvement organization for a professional medical review to determine whether the hospital provided the required treatment. CMS, *2019 SOM* 14-15; see pp. 7-8, *supra*. After that review, CMS determines whether the

hospital violated EMTALA and, if so, the appropriate sanction. CMS, *2019 SOM* 16-17.

CMS publishes its determinations that hospitals have violated EMTALA, known as "statements of deficiencies," on its website. CMS, *Quality, Safety & Oversight – Guidance for Laws & Regulations: Hospitals* (Feb. 13, 2024), https://perma.cc/FCY7-MM6Y (link for "Hospital Surveys with 2567 Statement of Deficiencies") (CMS, *Statements of Deficiencies*). CMS's website includes statements of deficiencies back to October 2010. See *ibid*.

Before 2022, CMS issued multiple statements of deficiencies for hospitals that failed to provide stabilizing care that included abortion. For example, in 2012, CMS issued a statement of deficiency against Ascension St. John Hospital in Detroit, Michigan, for failing to provide an abortion. CMS, *Statements of Deficiencies* (Event ID V2DH11). The statement explains that the patient arrived at the hospital 17 to 23 weeks pregnant with heavy vaginal bleeding. *Ibid.* The hospital diagnosed the patient with an "inevitable abortion" (a type of miscarriage where the cervix has dilated and the loss of the pregnancy cannot be stopped). *Ibid.* But the hospital did not perform an abortion because its staff could detect fetal "heart tones," and the hospital's policy prevented its staff from performing abortions if fetal heart tones are present. *Ibid*. The patient stayed at the hospital, bleeding and with an unstable heart rate, for six hours before leaving in a "private vehicle" to go to a second hospital for an abortion. *Ibid*. CMS determined that the hospital violated EMTALA by failing to provide the required stabilizing treatment (*i.e.*, an abortion). *Ibid*.

Also in 2012, CMS issued a statement of deficiency to SSM Health St. Anthony Hospital in

Shawnee, Oklahoma, for failing to stabilize a patient with a possible ectopic pregnancy. CMS, *Statements of Deficiencies* (Event ID 6K4911). The statement explains that the patient presented with "lower abdominal pain and symptoms consistent with ectopic pregnancy." *Ibid.* The ER physician ordered an ultrasound and consulted with an on-call obstetrician, but the obstetrician did not examine the patient personally. *Ibid.* The ultrasound revealed a mass and free fluid that were consistent with an ectopic pregnancy. *Ibid.* The statement explains that in the event of an ectopic pregnancy, "[t]he developing cells must be removed to save the mother's life." *Ibid.*; see Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 193, *Tubal Ectopic Pregnancy*. The hospital did not perform any additional examination to confirm that the patient had an ectopic pregnancy and discharged the patient without providing further stabilizing care. CMS, *Statements of Deficiencies* (Event ID 6K4911).

Eight hours later, the patient went to a second hospital, which confirmed that the patient had an ectopic pregnancy and terminated the pregnancy. CMS, *Statements of Deficiencies* (Event ID 6K4911). CMS concluded that the first hospital "failed to provide stabilizing treatment" required under EMTALA by failure to resolve the probable ectopic pregnancy. *Ibid.*

Similarly, in 2018, CMS issued a statement of deficiency to Saint Francis Hospital in Tulsa, Oklahoma, for failing to terminate a patient's ectopic pregnancy. CMS, *Statements of Deficiencies* (Event ID L67011). The statement explains that the patient, who was six weeks pregnant, arrived at the hospital complaining of cramping and vomiting. *Ibid.* The hospital determined that the pregnancy was ectopic, but told the

patient that under its policies, it could not terminate the pregnancy because of the presence of a "fetal heartbeat." *Ibid.* That was inaccurate: Under the hospital's policies, the hospital could perform a surgical abortion but could not provide a medication abortion. *Ibid.* The hospital transferred the patient to a second hospital for treatment. *Ibid.* CMS concluded that the first hospital's failures to provide the "required medical treatment [or] surgical intervention" instead of transferring the patient violated EMTALA's stabilizing-care requirement. *Ibid.*

These examples all confirm that HHS consistently has understood that, in certain circumstances, abortion can be necessary stabilizing care under EMTALA. This was a longstanding view that pre-dated this Court's decision in *Dobbs*. In this litigation, the government simply is defending the policy choice that Congress made when it enacted EMTALA.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

NICOLE SAHARSKY
Counsel of Record
MINH NGUYEN-DANG
CHARLEY B. LANTER
GABRIELA DUEÑAS
Mayer Brown LLP
1999 K Street, NW
Washington, DC 20006
(202) 263-3000
nsaharsky@mayerbrown.com

MARCH 2024