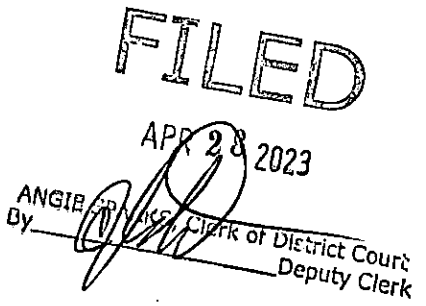
Raphael Graybill*
Graybill Law Firm, PC
300 4th Street North
PO Box 3586
Great Falls, MT 59403
(406) 452-8566
rgraybill@silverstatelaw.net

Tanis M. Holm
Edmiston & Colton Law Firm
310 Grand Ave.
Billings, Montana 59101
(406) 259-9986
tholm@yellowstonelaw.com



Peter Im**
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., N.W., Suite 300
Washington, D.C. 20005
(202) 803-4096
peter.im@ppfa.org

Dylan Cowit**
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038
(212) 541-7800
dylan.cowit@ppfa.org

Attorneys for Plaintiffs Planned Parenthood of Montana and Samuel Dickman, M.D.
**Additional Counsel Listed on Next Page*

MONTANA FIRST JUDICIAL DISTRICT COURT,
COUNTY OF LEWIS AND CLARK

PLANNED PARENTHOOD OF MONTANA; ALL FAMILIES HEALTHCARE; BLUE MOUNTAIN CLINIC; SAMUEL DICKMAN, M.D.; and HELEN WEEMS, APRN-FNP, on behalf of themselves and their patients Plaintiffs, vs. STATE OF MONTANA; MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; and CHARLIE BRERETON, in his official capacity as Director of the Department of Public Health and Human Services Defendants.	Cause No.: CDV-23-299 Judge: Seeley **BRIEF IN SUPPORT OF APPLICATION FOR TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, AND WRIT OF PROHIBITION**

Erin M. Erickson
Bohyer, Erickson, Beaudette,
and Tranel P.C.
283 West Front St., Suite 201
Missoula, MT 59802
(406) 532-7800
erickson@bebtlaw.com

Akilah Deernose
Alex Rate
ACLU of Montana
PO Box 1986
Missoula, MT 59806
(406) 203-3375
deernosea@aclumontana.org
ratea@aclumontana.org

Hillary Schneller**
Jen Samantha D. Rasay**
Adria Bonillas**
Center for Reproductive Rights
199 Water Street, 22nd Floor
New York, NY 10038
(917) 637-3777
hschneller@reprorights.org
jrasay@reprorights.org
abonillas@reprorights.org

Attorneys for Plaintiffs All Families Healthcare, Blue Mountain Clinic, and Helen Weems

**Applications for admission pro hac vice forthcoming

TABLE OF CONTENTS

INTRODUCTION

Plaintiffs Planned Parenthood of Montana ("PPMT"); All Families Healthcare ("All Families"); Blue Mountain Clinic ("Blue Mountain"); Samuel Dickman, M.D.; and Helen Weems, APRN-FNP (collectively, "Plaintiffs"), on behalf of themselves and their patients, seek a temporary restraining order, preliminary injunction, and a writ of prohibition to prevent enforcement during the pendency of this litigation of an unconstitutional rule restricting abortion access in Montana.

The rule adopted by the Department of Public Health and Human Services ("DPHHS") ("the Rule") amends Mont. Admin. R. 37.82.102 and 37.86.104. It was proposed at MAR Notice 37-1024 and adopted as proposed in the April 28, 2023, edition of the MAR. **The Rule *directly* contravenes controlling, on-point decisions by this Court and the Montana Supreme Court.** Absent injunctive relief, it will take effect on May 1, 2023, and immediately end access to abortion for most Montanans on Medicaid[1] at a time when abortion access in Montana—and indeed, throughout the nation—is under threat. In an effort to avoid these emergency proceedings, undersigned counsel twice requested that the agency consider delaying the effective date of the rule or stipulating to a stay of enforcement pending a ruling on the instant request for relief. DPHHS refused.

This case is squarely controlled by binding precedent. Twenty-eight years ago, this Court held that the Medicaid program in Montana may not deny patients access to medically necessary abortions, yet this is exactly what the Rule will do. Order — Mots. Sum. J., *Jeannette R. v. Ellery*, No. BDV-94-811, 1995 WL 17959705 (1st Jud. Dist., May 22, 1995) ("*Jeannette R.*"). Four years later, the Montana Supreme Court confirmed that the Montana Constitution's right to privacy guarantees Montanans the right to access abortion from their chosen provider and held unconstitutional a statute that restricted provision of abortion to physicians only. *Armstrong v. State*, 1999 MT 261, ¶ 48, 296 Mont. 361, 989 P.2d 364. More recently, this Court and the Montana Supreme Court reaffirmed Montanans' right to access abortion care from a chosen provider when that provider is an advanced practice clinician ("APC"). *Weems v. State* ("*Weems I*"), 2019 MT 98, 395 Mont. 350, 440 P.3d 4 (affirming preliminary injunction against statute that restricted

[1] References to "Medicaid patients" or "Montanans on Medicaid" herein are intended to include all Montanans eligible for Medicaid, including not only Montanans currently enrolled in Medicaid but all low-income people who are eligible to enroll.

provision of abortion to physicians and physician assistants only); *Weems v. State* ("*Weems II*"), No. ADV-2018-73 (1st Jud. Dist., Feb. 25, 2022) ("*Weems II* Order") (granting summary judgment and entering permanent injunction), *appeal pending* No. DA 22-0207. And this Court and the Montana Supreme Court have enjoined the State from imposing needless waiting period requirements and banning telehealth. *Planned Parenthood of Mont. v. State by & through Knudsen*, No. DV-21-0999, 2021 WL 9038524 (13th Jud. Dist., Oct. 7, 2021) (granting preliminary injunction against such restrictions), *affirmed by Planned Parenthood of Mont. v. State by & through Knudsen* ("*PPMT v. State*"), 2022 MT 157, 409 Mont. 378, 515 P.3d 301.

Despite this controlling law, the Rule unlawfully eliminates or restricts access to abortion for Medicaid patients in Montana in at least three overlapping ways:

- First, the Rule imposes on Medicaid-eligible Montanans a de facto ban on abortions by APCs, such as nurse practitioners and physician assistants, by barring DPHHS from covering abortions provided by APCs, who provide a majority of abortions in the state. As recognized in *Armstrong*, *Weems I*, and *Weems II*, this is patently unconstitutional, and there is currently a permanent injunction in place against such a ban.
- Second, the Rule requires pregnant Medicaid patients to obtain prior authorization for abortions and imposes a medically unnecessary in-person examination requirement. The Rule thus bans Medicaid patients' access to direct-to-patient telehealth for medication abortion, which many of Plaintiffs' patients rely on to access care. As the Montana Supreme Court recognized when it affirmed the preliminary injunction in *PPMT v. State*, laws that require patients to make an unnecessary in-person visit to receive a physical exam violate the Montana Constitution because they impose a ban on telehealth for abortion and a de facto waiting period. For patients seeking procedural abortion, the Rule will effectively require that patients visit a health center *twice* to obtain an abortion, and for all patients, the Rule only serves to delay the patients' access to care.
- Finally, the Rule narrows the generally applicable definition of "medically necessary service" in Mont. Admin. R. 37.82.102(18)(a) for abortions but for no other health services. Accordingly, even those patients who manage to get an appointment with a physician, visit a health center, and obtain the required prior

authorization may have their medically necessary claims denied because they do not fit into the Rule's new definition, which *only* applies to abortions, and which carves out for coverage only a subset of the medically necessary abortions DPHHS is required to cover under *Jeannette R.*

The Rule violates the Montana Constitution's guarantee of privacy because it infringes on Medicaid patients' right to abortion and to access abortion from their chosen provider without any medical purpose. And it violates equal protection because it discriminates against pregnant Medicaid patients seeking abortions as compared to pregnant Medicaid patients seeking other medical care, including those who decide to continue their pregnancies and give birth. Separately, the physician-only requirement violates equal protection because it discriminates against Medicaid patients seeking an abortion from an APC, as compared to those seeking care from a physician. The invasion of these constitutional rights constitutes irreparable harm.

The Rule was adopted on April 28, 2023, and will take effect on May 1. To preserve the status quo, this Court should enter a temporary restraining order, set a hearing on Plaintiffs' motion for a preliminary injunction, and grant Plaintiffs' request for a preliminary injunction.

FACTUAL BACKGROUND

Access to safe, legal, and timely abortion is an important component of public health. Abortion is very common, extremely safe, and much safer than carrying a pregnancy to term; the risk of death associated with childbirth is approximately 13 times higher than that associated with abortion. Dickman Aff. ¶ 15.

Plaintiffs PPMT, All Families, and Blue Mountain operate the only clinics that provide abortion in Montana. In 2022, Medicaid patients made up 45% of PPMT's abortion patients, over 50% of All Families' abortion patients, and 40% of Blue Mountain's abortion patients. *See* Fuller Aff. ¶ 14; Weems Aff. ¶ 12; Smith Aff. ¶ 45. Plaintiffs provide medication abortion up to 11 weeks as measured from the first day of the patient's last menstrual period ("LMP"). Fuller Aff. ¶ 11; Weems Aff. ¶ 12; Smith Aff. ¶ 14. All of them provide medication abortion in person and via telehealth. Fuller Aff. ¶ 8; Weems Aff. ¶¶ 13-14; Smith Aff. ¶ 12. Medication abortion is typically provided via a two-drug regimen, which consists of one dose of mifepristone followed up to 72 hours later by one dose of misoprostol; it can also be provided via misoprostol alone. Dickman Aff. ¶ 13.

Each clinic also provides procedural abortion. All Families provides procedural abortion up to 12 weeks and 6 days ("12.6 weeks") LMP; PPMT and Blue Mountain provide procedural abortion up to 21.6 weeks LMP. *Id.*; Weems Aff. ¶ 12; Smith Aff. ¶ 14. Aspiration abortion, which takes less than ten minutes to complete, is the most common technique for early procedural abortions and involves removing the contents of the uterus using suction aspiration. Dickman Aff. ¶ 13. Beginning at approximately 15 weeks LMP, clinicians often perform a dilation and evacuation procedure, which involves dilation of the cervix, followed by removal of the pregnancy using a combination of aspiration and instruments, and typically takes less than 30 minutes. *Id.*

Evidence and experience, including in Montana, demonstrate that APCs provide medication and aspiration abortions with the same safety and efficacy as their physician counterparts. *Id.* at ¶ 20; Weems Aff. ¶ 17. APCs also provide miscarriage care, which is identical to abortion care. Dickman Aff. ¶ 19; Weems Aff. ¶ 18. Accordingly, an overwhelming consensus in the medical community supports APCs as abortion providers. Dickman Aff. ¶ 21; Weems Aff. ¶ 17. Ms. Weems, a nurse practitioner, is the sole clinician at All Families, and the sole abortion provider in the Flathead Valley, Weems Aff. ¶ 20, and PPMT and Blue Mountain rely heavily on APCs to provide abortions, Fuller Aff. ¶¶ 13–14 (in 2022, APCs provided 86% of abortions at PPMT); Smith Aff. ¶ 21 (APCs provide about 24% of abortions and 42% of medication abortions for Medicaid patients). All told, APCs currently provide a majority of abortions in Montana. Their role is particularly crucial given that in the entire state, there are only two physicians employed full-time by abortion clinics, in addition to two contract physicians who provide part-time, and these physicians provide abortions only in Helena and Missoula. Fuller Aff. ¶ 19 (PPMT employs one full-time and one contract physician, who provide in Helena and Missoula); Smith Aff. ¶ 2, 16 (Blue Mountain employs one full-time and one contract physician in Missoula).

Montana Medicaid, which provides medical assistance to low-income residents, covers medically necessary abortions using state funds pursuant to a 1995 holding by this Court that failure to do so violates Montanans' privacy and equal protection rights. *Jeannette R.* Currently, DPHHS regulations define a "medically necessary service" as

> a service or item reimbursable under the Montana Medicaid program, as provided in these rules . . . [w]hich is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:
> (i) endanger life;
> (ii) cause suffering or pain;

(iii) result in illness or infirmity;
(iv) threaten to cause or aggravate a handicap; or
(v) cause physical deformity or malfunction.

Mont. Admin. R. 37.82.102(18)(a). This definition applies generally to all medical care.

DPHHS certified a proposed version of the Rule to the Secretary of State on December 13, 2022—the proposed version was published at MAR Notice No. 37-1024 on December 23. On April 18, 2023, it certified a notice of adoption stating that the Rule would be adopted as proposed. The Rule was adopted in the April 28, 2023, edition of the MAR. *See* Compl. Ex. B. The Rule's effect will be to reduce the number of abortions covered by Medicaid by limiting the number of providers, erecting medically unnecessary barriers for Montanans seeking abortions, and allowing DPHHS to second guess providers' medical judgment.

The Rule denies abortion access to most Montanans on Medicaid. First, it categorically bars Medicaid coverage for abortions by APCs, including physician assistants, nurse practitioners, and nurse midwives, thereby eliminating access to most of the abortion providers available to Medicaid-eligible Montanans. Second, it mandates an additional in person visit to a health center, thereby eliminating the option for providing medication abortion through direct-to-patient telehealth. This is because, as part of an arbitrary, onerous, and invasive prior authorization process, a provider must submit the results of an in-person physical exam, which for most patients will be medically unnecessary. Dickman Aff. ¶ 41. The prior authorization requirement also builds in delay for a time-sensitive service by further requiring extensive supplemental documentation, including, inter alia, an extensive medical history, ultrasound images (if available), and "documentation that the diagnosis of the physical or psychological condition leading to the medical necessity determination has been made by a medical professional qualified by education, training, and/or experience to make such diagnosis and that the woman is receiving care for such condition." Compl. Ex. A at 2355. The regulation does not prescribe a period of time during which the agency must decide whether to approve or deny coverage for the abortion and seemingly leaves this decision at the discretion of unknown individuals at DPHHS—which could include officials with no medical training or a contractor DPHHS hires. DPHHS states that its contract with its Medicaid utilization review contractor requires completion of the prior authorization review "within three working days, considering the submission of timely and accurate documentation," Compl. Ex. B at 417, but the Rule itself contains no such requirement. Medicaid does not currently require prior

authorization or a waiting period for abortion, contraception, ultrasound, or any other gynecological services. Smith Aff. ¶ 35.

Finally, the Rule also narrows the definition of "medically necessary" solely for abortions, allowing coverage only when:

> (a) 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; or
> (b) although it does not place the woman in danger of death unless an abortion is performed, a woman suffers from:
> (i) a physical condition that would, as certified by a physician, be significantly aggravated by the pregnancy; or
> (ii) a psychological condition that would, as certified by a physician, be significantly aggravated by the pregnancy.

Id. at 2354. This impermissibly singles out abortions and will result in patients being denied or having to delay care, even if they are able to jump through the Rule's myriad other hoops. Weems Aff. ¶ 25.

LEGAL STANDARD

Pursuant to recent legislation (2023 Senate Bill 191 or "SB 191"), as of March 2, 2023, "[a] preliminary injunction order or temporary restraining order may be granted when the applicant establishes that: (a) the applicant is likely to succeed on the merits; (b) the applicant is likely to suffer irreparable harm in the absence of preliminary relief; (c) the balance of equities tips in the applicant's favor; and (d) the order is in the public interest." *See* SB 191, 2023 Leg. Reg. Sess. (Mont. 2023) (amending §27-19-201, MCA) ; *see also Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The Montana Legislature intended for this standard to "mirror the federal preliminary injunction standard," and "closely follow United States supreme court case law." SB 191, § 1. The new standard replaces Montana's statutory standards for preliminary injunctions and temporary restraining orders. The standard for issuing either now operates on the same four-part, federal-style test. *See* SB 191, §§ 1, 3.[2]

[2] Although House Bill 695 alters the standard for seeking temporary restraining orders issued without notice, that law does not specify an effective date and as such, will be effective on October 1, 2023. *See* § 1-2-201, MCA. Likewise, changes to certain dates related to temporary

Since January, shortly after the Rule was proposed, Plaintiffs have endeavored to avoid emergency proceedings or the need for a temporary restraining order. On January 23, 2023, undersigned counsel contacted Paula Stannard, Chief Legal Counsel for DPHHS, and asked for either a delay of the effective date of the Rule to 90 days after publication of the adoption notice or a stipulation to a stay of enforcement of the Rule pending a court ruling on Plaintiffs' request for relief, citing the above authorities. *See* Compl. Ex. C. Stannard declined. *See* Compl. Ex. D. On April 19, 2023, after learning that DPHHS had submitted a notice of adoption of the Rule for publication, undersigned counsel requested a copy of the final rule from Stannard. *See* Compl. Ex. G. On April 20, Stannard responded, refusing to provide a copy of the final version of the Rule. *See* Compl. Ex. H. On April 21, undersigned counsel contacted Stannard, explaining that the single business day between publication and the effective date of the Rule does not give sufficient time for Montana abortion providers to undertake the planning necessary to comply with the Rule, in particular any changes to the Rule made since it was proposed, or to avoid emergency litigation. *See* Comp. Ex. E. Counsel renewed the request that DPHHS consider delaying the effective date of the Rule to 90 days after publication of the adoption notice or stipulating to a stay of enforcing the Rule pending a court ruling on Plaintiffs' request for relief. *Id.* On April 26, Stannard refused. *See* Compl. Ex. F. Accordingly, Plaintiffs seek a temporary restraining order until such time as the Court can conduct a hearing and consider the merits of Plaintiffs' application for a preliminary injunction. *See* § 2-4-701, MCA. The motion was filed *ex parte* due to the extenuating circumstances of an unconstitutional regulation going into effect on May 1, 2023.

Finally, the Court should issue a writ of prohibition pursuant to § 27-27-101, MCA ("The writ of prohibition is the counterpart of the writ of mandate. It arrests the proceedings of any tribunal, corporation, board, or person exercising judicial functions when such proceedings are without or in excess of the jurisdiction of such tribunal, corporation, board, or person."). "[T]he purpose of a preliminary injunction and a writ of prohibition is to direct a party to refrain from performing certain activities until further order of the court." *Awareness Grp. v. Bd. of Trustees of Sch. Dist. No. 4* (1990), 243 Mont. 469, 475, 795 P.2d 447. "[T]he parties seeking the writ must demonstrate that the acts by public officials are clearly unlawful." *Kimble Properties, Inc. v. State Dep't of State Lands* (1988), 231 Mont. 54, 56, 750 P.2d 1095. Because the Rule is clearly

---

restraining orders in Senate Bill 134 also do not specify an effective date and will thus also be effective on October 1, 2023.

unlawful, Plaintiffs request that the Court issue a writ of prohibition directing Defendants to refrain from enforcing it.

ARGUMENT

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

Under *Jeannette R.*, *Armstrong*, *Weems I*, *Weems II*, and *PPMT v. State*, the Rule violates Plaintiffs' patients' rights to privacy and equal protection under the Montana Constitution. Because it infringes on Medicaid-eligible Montanans' fundamental right to abortion, it is subject to strict scrutiny, which it cannot withstand.

A. The Rule violates Plaintiffs' patients' right to privacy.

Article II, section 10 of the Montana Constitution protects a patient's right to "obtain[] a . . . pre-viability abortion . . . from a health care provider of her choosing." *Armstrong*, ¶ 2. This guarantee is stronger and more expansive than, and independent from, its federal counterpart. *Id.* at ¶ 34 ("Montana adheres to one of the most stringent protections of its citizens' right to privacy in the United States."). It protects "a woman's moral right and moral responsibility to decide, up to the point of fetal viability, what her pregnancy demands of her in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation." *Id.* at ¶ 49. To pass constitutional muster, the state must show "a compelling interest in and obligation to legislate or regulate to preserve the safety, health and welfare of a particular class of patients or the general public from a medically-acknowledged, *bona fide* health risk." *Id.* at ¶ 59. "Subject to this narrow qualification, however, the legislature has neither a legitimate presence nor voice in the patient/health care provider relationship superior to the patient's right of personal autonomy which protects that relationship from infringement by the state." *Id.*

This applies with equal force to infringements on Medicaid patients' right to abortion because "once a state enters the constitutionally protected area of choice, protected in Montana by the right of privacy, the state must do so with genuine indifference or neutrality." *Jeannette R.*, 17. And *Jeannette R.* is consistent with numerous state high court decisions holding restrictions on Medicaid coverage for abortion violate state constitutional guarantees. *See, e.g.*, *State v. Planned Parenthood of the Great Nw.*, 436 P.3d 984 (Alaska 2019) (holding statute and regulation restricting Medicaid abortion coverage discriminated between pregnant women based on their choice whether to continue the pregnancy and violated equal protection); *Women of State of Minn.*

by Doe v. Gomez, 542 N.W.2d 17 (Minn. 1995) (holding statute that permits Medicaid funds for childbirth but not for therapeutic abortions violates fundamental right to privacy); *Comm. To Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981) (holding Medicaid funding restriction an unconstitutional condition on exercise of a fundamental right); *Moe v. Sec'y of State Admin. & Fin.*, 417 N.E. 2d 387 (Mass. 1981) (holding state provisions restricting Medicaid funding for abortions to cases only where a physician certified the abortion was necessary to prevent death violated due process and equal protection by intruding into fundamental right to choose whether to terminate a pregnancy).

The Rule's physician-only requirement, prior authorization requirement, and narrowed definition of medical necessity all, separately and together, violate Medicaid patients' right to privacy. DPHHS offers several rationales in an attempt to justify each aspect of the Rule, but none meets *Armstrong*'s requirement that the state show the Rule protects against a "medically-acknowledged, *bona fide* health risk." *Armstrong*, ¶ 59.[3] The Rule fails strict scrutiny on this basis alone.

1. The Physician-Only Requirement Violates the Right to Privacy

As an initial matter, the Rule's physician-only requirement contravenes precedent. *Armstrong*, *Weems I*, and *Weems II* hold that Montanans' right to privacy includes the right of every individual to obtain an abortion from a chosen health care provider. *See Armstrong*, ¶ 62; *Weems I*, ¶ 1; *Weems II* Order. "Health care provider," as used in each case, means a professional licensed and competent to provide abortions and specifically includes physician assistants, nurse practitioners, and nurse midwives. *Armstrong*, ¶ 2 n.1; *Weems I*, ¶ 1; *Weems II* Order 10–11. Barring Montanans on Medicaid from accessing abortion from an APC circumvents this controlling law: it prevents Medicaid patients from accessing their chosen abortion provider. It is no answer that, where Medicaid may cover abortions, patients may be able to seek an abortion from a physician—just as it was no answer in *Armstrong* that Montanans could access abortions from physicians. *See Armstrong*, ¶ 63. Nor was it an answer in *Weems* that Montanans could access abortions from physicians or physician assistants. *Weems I*, ¶¶ 2–4, 25; *Weems II* Order 12.

[3] For example, the Rule cites a concern about a hypothetical audit, Compl. Ex. A at 2357–58, which does not address a health risk; such a concern cannot take precedence over Plaintiffs' patients' constitutional rights.

Montanans on Medicaid have a right to their *chosen* provider, and a categorical prohibition directly infringes on that right.

DPHHS cites no medically acknowledged bona fide health risks to justify the physician-only provision. In response to comments, DPHHS claims that the Rule does not bar APCs from providing abortion care. Compl. Ex. B at 423. But barring APCs from seeking reimbursement for services is effectively the same as barring APCs from providing those services to Medicaid-eligible Montanans. The agency also states the physician-only provision is necessary to protect the integrity of the Medicaid program and to comply with federal and state law, but these vague goals are not medically acknowledged bona fide health risks. It claims—with no basis—that the provision is necessary to protect patients' "health and safety." Compl. Ex. A at 2362. But APCs have provided safe and effective abortions, including for Montana Medicaid patients, for years. *Cf. Armstrong*, ¶¶ 63–64 (Montana physician assistants have provided abortions since the 1980s); *Weems I*, ¶¶ 20–23 (citing medical consensus supporting APCs as abortion providers); *Weems II* Order 10–11 (Board of Nursing agrees nurse practitioners and nurse midwives may provide abortions). That APCs may continue, under the Rule, to provide miscarriage care to Montanans with Medicaid coverage further undermines any alleged safety rationale. *See* Compl. Ex. A at 2362. Abortion care and miscarriage care are identical. Weems Aff. ¶ 18. There is simply no reason—health-protective or otherwise—to bar APCs from providing one but not the other. *See Weems II* Order 10–11 (nurse midwives and nurse practitioners provide care comparable to abortion care without issue). Instead, the Rule will only harm patient health by denying or delaying Medicaid patients' access to abortion and compelling them to continue pregnancies and give birth against their will. *See infra* Part II.A.

2. The Prior Authorization Requirement Violates the Right to Privacy

DPHHS also fails to justify the prior authorization requirement, which bans telehealth, requires an additional trip to a health center for an unnecessary in-person physical exam, and imposes a de facto waiting period with no specified time limit. Even waiting periods of 24 hours have been found to violate strict scrutiny, *see, e.g.*, *PPMT v. State*, ¶ 51 (affirming preliminary injunction of 24-hour waiting period law); *Planned Parenthood of Missoula v. State*, No. BDV-95-722 (1st Jud. Dist., Dec. 29, 1999) (declaring unconstitutional 24-hour delay law). The agency cites its intent to avoid covering abortions that are not medically necessary to justify the prior authorization requirement, analogizing to other care for which prior authorization is required.

Compl. Ex. A. at 2359–61. But of course, Medicaid patients' right to abortion—unlike these other types of medical care—is unquestionably constitutionally protected, *see Jeannette R.*, 20. Medicaid does not require prior authorization for any other reproductive or sexual health care service, including contraception, pregnancy tests, miscarriage management, or other gynecological care. And although other care requiring prior authorization is not of the same time-sensitive nature as abortion, the Rule's documentation requirements are more burdensome than those for other medical services.[4] And in any event, DPHHS does not explain how each aspect of the voluminous required documentation and medically unnecessary tests helps support a finding of medical necessity.

The agency also states that the physical examination requirement would "establish that the safety and wellbeing of the female patient has been considered," and states this is especially important for medication abortions. Compl. Ex. A at 2361; *see also* Compl. Ex. B at 426. Medication abortion is safe, Dickman Aff. ¶¶ 14–15, and as this Court has recognized, can be safely provided via telehealth, *PPMT v. State*, ¶ 51. Imposing a physical examination requirement is medically unnecessary and is not narrowly tailored to prevent any health risk posed by medication or procedural abortion. And DPHHS's note that the Rule's documentation requirements are consistent with federal medical records requirements for ambulatory surgical centers, Compl. Ex. A at 2361, is a non sequitur; medication abortions involve only taking pills, procedural abortion is not surgery as that term is commonly understood,[5] and outpatient clinics—not ambulatory surgical centers—provide abortion care in this state.

The Rule provides that "[i]f prior authorization is not obtained, due to an emergency situation or otherwise, a claim for payment for such physician services will undergo post-service, prepayment review." Compl. Ex. A at 2354. DPHHS points to this provision in response to multiple commenters' concern that the Rule will force Medicaid-eligible Montanans to delay their abortions unnecessarily. Compl. Ex. B at 4. But to the extent that this provision permits Plaintiffs to provide abortions before receiving prior authorization, it forces them to choose between (1)

[4] The Rule cites the prior authorization requirements for cosmetic procedures in Mont. Admin. R. 37.86.104(3), *see* Rule at 2360, but for such procedures, there is no requirement for an invasive medical history, imaging, or a physical examination.

[5] Experts agree that abortion can be safely provided in outpatient clinic and clinician office settings. Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 14 (2018), https://nap.nationalacademies.org/read/24950/.

delaying abortions for Medicaid-eligible Montanans to wait for a prior authorization or (2) providing care without knowing whether they will be reimbursed for it. The possibility of seeking post-service, prepayment review does not cure the unconstitutionality of the Rule's "require[ment]," Compl. Ex. A at 2354, that Medicaid patients obtain prior authorization for abortions.

3. The Rule's Definition of Medical Necessity Violates the Right to Privacy

Turning to the Rule's narrowing of the definition of medical necessity, the Montana Constitution requires DPHHS to cover all medically necessary abortions for Medicaid patients. *Jeannette R.*, 20. The agency attempts to circumvent this requirement by restricting the definition of medical necessity solely for abortions. To justify this restriction, DPHHS cites a report from a contractor that conducted a review of abortion claims paid by Montana Medicaid. The contractor found 100% compliance with the requirement to certify that abortions covered by Medicaid are medically necessary and did not point to a single claim for an abortion that it did not believe was medically necessary. Nonetheless, DPHHS concluded that the forms certifying medical necessity "lack[ed] sufficient information" because certain medical conditions were "routinely indicated" and some forms included additional, non-required documentation. Compl. Ex. A at 2357. In other words, despite Plaintiffs' perfect compliance with its own requirements, DPHHS used the fact that some forms provided *additional* information as the basis to conclude that more regulatory burdens were necessary.[6] For the nearly thirty years that DPHHS has covered medically necessary abortions, providers have complied with Medicaid's requirements for documenting medical necessity using a state-issued form, which the agency admits did not require "the submission or attachment of additional documents." *Id.* at 2356. The weakness of the agency's explanations reveals its true intent: to deny abortion access to Medicaid-eligible Montanans and to impermissibly impose its "political ideology, personal values and beliefs" on Montanans. *Armstrong*, ¶ 15.

[6] In response to comments, DPHHS states that "the review concluded that when additional documentation was submitted it often lacked sufficient diagnosis or other information to support medical necessity. Instead the claims typically correlated to an assessment of the situation, rather than documentation to support the medical necessity." Compl. Ex. B at 416. DPHHS cites the alleged insufficiency of documents that Plaintiffs volunteered—documents that it neither required nor requested—to justify the Rule. And in any event, the agency does not explain how an assessment of a patient's situation does not constitute documentation supporting medical necessity.

B. The Rule violates Plaintiffs' patients' right to equal protection.

The Rule also violates Montana's Equal Protection guarantee, which provides that "[t]he dignity of the human being is inviolable. No person shall be denied the equal protection of the laws." Montana Const. art. II, § 4. When considering an equal protection challenge, Montana courts first "identify the classes involved and determine whether they are similarly situated." *Henry v. State Comp. Ins. Fund,* 1999 MT 126, ¶ 27, 294 Mont. 449, 982 P.2d 456. "A law or policy that contains an apparently neutral classification may violate equal protection if in reality it constitutes a device designed to impose different burdens on different classes of persons." *Snetsinger v. Montana Univ. Sys.*, 2004 MT 390, ¶ 16, 325 Mont. 148, 104 P.3d 445 (internal quotation marks and alterations omitted). Second, they determine the appropriate level of scrutiny to apply. *Id.* If a suspect class or fundamental right is affected, courts employ strict scrutiny, meaning that "the legislation [at issue] must be justified by a compelling state interest and must be narrowly tailored to effectuate only that compelling interest." *Armstrong,* ¶ 34.

1. The Rule discriminates against pregnant Medicaid patients seeking an abortion from an APC.

The physician-only provision violates equal protection because it creates two similarly situated classes: pregnant Medicaid patients seeking an abortion from a physician and pregnant Medicaid patients seeking an abortion from an APC. The physician-only provision permits the former group—but not the latter—to exercise their fundamental right to abortion. This classification thus affects a fundamental right and triggers strict scrutiny. *Cf. Jeannette R.*, 21. DPHHS cannot meet its heavy burden under strict scrutiny to show that this discrimination is narrowly tailored to serve a compelling interest. For the reasons discussed *supra* Part I.A, there is no health-protective—or any other—rationale for Medicaid to cover abortion (in the limited circumstances allowed under the Rule) when patients seek that care from one class of licensed clinicians but not another. Instead, as also discussed *infra* Part II.A, the Rule will endanger Montanans' health—forcing some to delay abortions and to try to travel to the limited number of physicians (where they ultimately may be denied care because abortion does not fit the Rule's narrow definition of "medically necessary") and compelling those who cannot get to a physician to stay pregnant, give birth, and endure the attendant physical risks and lifelong effects of pregnancy, childbirth, and parenthood. Such differential treatment simply cannot be squared with

the equal protection guarantee. *See Jeannette R.*, 22.[7]

2. The Rule discriminates against pregnant Medicaid patients who decide to terminate their pregnancy.

The Rule also creates a clear delineation between Medicaid patients who decide to terminate their pregnancy and those who decide to carry their pregnancy to term. Only the former group is subject to the Rule's restrictions. In other words, the state has "taken the class of indigent pregnant Medicaid eligible women and divided them. One class, who needs medically necessary treatment (an abortion) are not entitled to help . . . . However, another class (those women for whom child birth is a medically necessary treatment) are entitled to . . . help." *Id.* As in *Jeannette R.*, pregnant Medicaid patients who decide to continue their pregnancies will have that care covered by Medicaid—but those who decide to end their pregnancies will face significant hurdles to obtaining that medically necessary care, if they can access it at all. For many, access to abortion may not merely be limited, but denied altogether—and the Rule will compel them to endure the heightened health risks of continuing their pregnancies and childbirth. This is particularly true given the Rule's new, narrower definition of "medically necessary," which applies only to abortion and which leaves out many medically necessary abortions that *Jeannette R.* requires DPHHS to cover. To take just one example, the redefinition of medical necessity will mean that Medicaid will no longer cover abortions in cases involving lethal fetal conditions or diagnoses. In response to several comments raising this concern, DPHHS confirms that under the Rule, "there is a possibility that . . . Medicaid coverage would not be available" in these cases if the abortion does not meet the narrow new definition of medical necessity. Compl. Ex. B at 429.

By treating similarly situated individuals differently based on how they choose to exercise their right to reproductive autonomy, the classification affects the fundamental right to privacy and triggers strict scrutiny. *See Planned Parenthood of the Great Nw.*, 436 P.3d at 1003 ("Disparate restrictions on government funding for women based on their choice of either abortion or childbirth deter the exercise of a fundamental right because pregnant women in that position are locked in a binary dilemma: the rejection of one option inevitably entails the embrace of the other."). DPHHS has not even attempted to justify its distinction between Medicaid patients who choose abortion

[7] As described in Plaintiffs' Complaint, the Rule also creates several other impermissible classifications that violate equal protection. *See* Compl. ¶¶ 87–95.

and those who choose to continue their pregnancies on any health grounds. Nor can it do so. For the reasons discussed *supra* Parts I.A–B, the Rule cannot withstand strict scrutiny.

II. THE REMAINING FACTORS WEIGH IN FAVOR OF IMMEDIATE RELIEF.

A. If enforced, the Rule will cause Plaintiffs and their patients irreparable injury.

Absent a temporary restraining order and preliminary injunction blocking the Rule, Plaintiffs and their patients will be irreparably harmed. The Rule infringes on Medicaid patients' right to an abortion under Montana's guarantees of privacy and equal protection. These constitutional violations themselves constitute irreparable harm and justify preliminary relief. *See PPMT v. State*, ¶ 6 ("For the purposes of a preliminary injunction, the loss of a constitutional right constitutes an irreparable injury." (citation omitted)).

Beyond the constitutional harm, the Rule will have devastating consequences for low-income Montanans seeking abortions. The physician-only requirement alone will cause irreparable harm. Few *physicians* provide abortions in the state, at few locations, separated by great distances, so the physician-only requirement will drastically reduce the availability of abortions at all of Montana's abortion providers and end Medicaid patients' access to abortion in vast swaths of the state. *See* Fuller Aff. ¶ 19 (PPMT physicians only provide in Helena and Missoula, not Billings and Great Falls); Weems Aff. ¶ 20 (All Families, which employs no physicians, is the only provider in Northwest Montana). Blue Mountain and PPMT rely heavily on APCs for abortion care, and a significant fraction of their patients are Medicaid patients. Fuller Aff. ¶ 14 (45% of PPMT abortions in 2022 covered by Medicaid); Smith Aff. ¶ 17 (almost 40% of Blue Mountains abortions in 2022 covered by Medicaid). And at All Families, a majority of abortion patients are insured through Medicaid, and Ms. Weems, a nurse practitioner, is the sole clinician. Weems Aff. ¶¶ 12, 20. There is no physician—at the clinic or anywhere else in the Flathead Valley—to whom to "shift" services, as the Rule blithely presumes, *see* Compl. Ex. A at 2362. And because most of the care All Families provides is abortion care, the loss of Medicaid coverage for abortions may force the clinic to close completely, thereby harming its entire patient population. Weems Aff. ¶¶ 9, 27.

The Rule's prior authorization requirement will also cause irreparable harm to Plaintiffs and their patients. Medicaid patients will no longer have access to medication abortion via telehealth, which improves access for rural patients, patients with disabilities, and patients with limited access to transportation. Fuller Aff. ¶¶ 10, 24–25. Dickman Aff. ¶¶ 31, 35. Weems Aff.

¶¶ 29–30. Smith Aff. ¶¶ 28–30. Telehealth accounts for a significant proportion of the medication abortions Plaintiffs provide, Fuller Aff. ¶ 15 (28% of medication abortions for Medicaid patients at PPMT), Weems Aff. ¶ 14 (more than half of medication abortions at All Families), and banning it will be especially burdensome for Medicaid patients given the limited locations where physicians are available.[8]

The prior authorization requirement also forces patients to delay care by effectively imposing a requirement of an additional trip and a waiting period. Waiting periods and additional-trip requirements have been shown to have devastating effects on access to abortion, including preventing some patients from accessing care entirely.[9] This will be especially burdensome for those who have limited access to transportation, inflexible work schedules, other caretaking responsibilities, or are victims of intimate partner violence. Dickman Aff. . ¶ 29; Weems Aff. ¶¶ 24–25; Smith Aff. ¶¶ 29–30, 39–40, 46. Although abortion remains safe throughout pregnancy and is far safer than pregnancy and childbirth, the risks associated with abortion increase incrementally as pregnancy progresses. Dickman Aff. ¶ 16; Weems Aff. ¶ 25. And the longer a patient is forced to wait for care, the longer they must endure the symptoms and risks of pregnancy. Dickman Aff. ¶ 63. They may have been eligible for a medication abortion—which is completed with medication alone and can be done safely at home—but because of the delay, be forced to undergo a procedure at a clinic. *Id.* at ¶ 65. They may be pushed to a point in pregnancy that they require a more costly two-day procedure involving dilation overnight and an additional visit to the clinic. *Id.* Or they may be pushed past the gestational age limit for getting an abortion in Montana, forcing them either to carry their pregnancy to term or to travel to distant providers in other states. *Id.*

DPHHS states that its contract with its Medicaid utilization review contractor requires completion of the prior authorization review "within three working days, considering the submission of timely and accurate documentation," and characterizes this delay as "add[ing] only

---

[8] For example, a Medicaid-eligible resident of Sidney, Montana, will need to drive 508 miles to Helena for care. They will not be able to access medication abortion from home via telehealth, and in fact, on the way to Helena, would drive through Billings, where there are APCs who could provide care absent the Rule.

[9] *See* Caitlin Myers, *Cooling off or Burdened? The Effects of Mandatory Waiting Periods on Abortions and Births*, Institute of Labor Economics (IZA), 14434 IZA Discussion Papers 1 (2021); Jason M. Lindo & Mayra Pineda-Torres, *New Evidence on the Effects of Mandatory Waiting Periods for Abortion*, 80 J. of Health & Econ 1 (2021).

minimal time to the process." Compl. Ex. B at 417. But even if a third-party contract requires the process to be completed in three working days, the Rule itself contains no such requirement. Three working days could stretch to five or more calendar days when there is an intervening weekend or long weekend. Smith Aff. ¶ 39. Because of the time-sensitive nature of abortion, this is a significant delay for a patient waiting for an abortion. Dickman Aff. ¶ 36. And if DPHHS denies a patient's prior authorization request, the appeal process would further exacerbate the delay. In any event, if the entire prior authorization process—including approval or denial—is not completed in one day (or even if it is, but not leaving enough time to provide an abortion that day), the physical examination requirement adds an extra visit for Medicaid patients seeking abortions. *Id.* Medicaid patients who now do not need to make a single in-person visit because they receive medication abortion via telehealth will be forced to make a medically unnecessary in-person visit. *Id.* Similarly, patients who now receive in-clinic abortion care in one visit will be forced to visit the clinic in-person another time beforehand to complete the required physical examination. *Id.* In some cases, patients will be forced to forgo care altogether. Smith Aff. ¶ 38.

Finally, the Rule's restriction of the definition of medical necessity will cause irreparable injury. Low-income pregnant people whose abortions would be covered under the definition of medical necessity applicable to all other medical care will be forced to draw on limited financial resources that they need for food, rent, clothing, and other essentials to pay for an abortion. Dickman Aff. ¶ 59. Many will have to delay the abortion to raise money, needlessly subjecting them to increased medical risk as a result. Because Medicaid patients already face significant economic hardship, many will be unable to take on these additional financial and logistical burdens. Weems Aff. ¶ 24–26. Therefore, the Rule will force some Medicaid patients to carry a pregnancy to term, even though an abortion was medically necessary in the judgment of their health care provider. This outright denial of access to a constitutionally protected right is an archetypal example of irreparable harm, and Plaintiffs are entitled to preliminary relief.

B. The balance of the equities and the public interest weigh in favor of Plaintiffs.

The remaining factors—the balance of the equities and the public interest—"merge into one inquiry when the government opposes a preliminary injunction." *Porretti v. Dzurenda*, 11 F.4th 1037, 1050 (9th Cir. 2021). Plaintiffs and their patients face immediate irreparable harm absent preliminary relief, whereas the State will not be harmed by the issuance of an injunction that preserves the status quo. As an initial matter, Defendants have no legitimate interest in

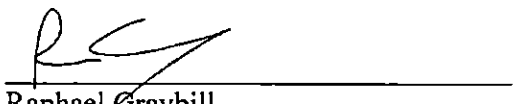
enforcing an unconstitutional law. *See Doe v. Kelly*, 878 F.3d 710, 718 (9th Cir. 2017) ("The government suffers no harm from an injunction that merely ends unconstitutional practices and/or ensures that constitutional standards are implemented." (citation and internal quotation marks omitted)). The status quo protects the ability of Plaintiffs and their Medicaid-eligible patients to make evidence-based medical decisions free from unwarranted government intervention, consistent with the values of privacy, bodily autonomy, and individual dignity secured by the Montana Constitution's Declaration of Fundamental Rights. *Armstrong*, ¶ 56 ("[T]he right to control fundamental medical decisions is an aspect of the right of self-determination and personal autonomy that is 'deeply rooted in this Nation's history and tradition.'") (quoting *Moore v. City of E. Cleveland*, 431 U.S. 494, 503 (1977)). The State, by contrast, loses nothing by way of immediate relief preserving the status quo, given that the Montana Constitution requires it to cover abortions for Medicaid-eligible Montanans.

The public interest in preserving the status quo and in ensuring access to safe, constitutionally protected health care services pending adjudication of a preliminary injunction is strong. "It is always in the public interest to prevent the violation of a party's constitutional rights." *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (internal quotation marks and citation omitted). Here, granting a temporary restraining order followed by a preliminary injunction will serve the public interest by ensuring that Medicaid-eligible Montanans continue to have access to constitutionally protected abortions and safe, effective medical care.

CONCLUSION

For the foregoing reasons, Plaintiffs move for a temporary restraining order until the Court can hold a hearing on Plaintiffs' motion for a preliminary injunction. Plaintiffs further move this Court, upon completion of the hearing and consideration of the merits of the application for a preliminary injunction, to issue preliminary injunctive relief prohibiting Defendants the State of Montana, DPHHS, and Charlie Brereton in his official capacity as Director of DPHHS, and their agents, employees, appointees, and successors from enforcing, threatening to enforce, or otherwise applying the Rule. Plaintiffs also request a writ of prohibition ordering Defendants not to enforce the Rule.

Respectfully submitted this 28th day of April, 2023.



Raphael Graybill
Graybill Law Firm, PC
300 4th Street North
PO Box 3586
Great Falls, MT 59403
(406) 452-8566
rgraybill@silverstatelaw.net

Tanis M. Holm
Edmiston & Colton Law Firm
310 Grand Ave.
Billings, Montana 59101
(406) 259-9986
tholm@yellowstonelaw.com

Peter Im*
Planned Parenthood Federation of America, Inc.
1110 Vermont Ave., N.W., Suite 300
Washington, D.C. 20005
(202) 803-4096
peter.im@ppfa.org

Dylan Cowit*
Planned Parenthood Federation of America, Inc.
123 William St., 9th Floor
New York, NY 10038
(212) 541-7800
dylan.cowit@ppfa.org

Akilah Deernose
Alex Rate
ACLU of Montana
PO Box 1986
Missoula, MT 59806
(406) 203-3375
deernosea@aclumontana.org
ratea@aclumontana.org

Erin M. Erickson
Bohyer, Erickson, Beaudette,
and Tranel P.C.

283 West Front St., Suite 201
Missoula, MT 59802
(406) 532-7800
erickson@bebtlaw.com

Hillary Schneller*
Jen Samantha D. Rasay*
Adria Bonillas*
Center for Reproductive Rights
199 Water Street, 22nd Floor
New York, NY 10038
(917) 637-3777
hschneller@reprorights.org
jrasay@reprorights.org
abonillas@reprorights.org

**Applications for admission* pro hac vice *forthcoming*