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REGION 6
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ADMINISTRATIVE COMPLAINT

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PRELIMINARY STATEMENT

1. This complaint is filed by Keierra Lynn Callaway, through her attorney, pursuant to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"). In October 2025, Baylor Scott & White Medical Center in Round Rock ("Baylor Scott & White") and St. David's Round Rock Medical Center ("St. David's") violated EMTALA when they refused Ms. Callaway medical treatment necessary to stabilize her emergency medical condition. Specifically, Baylor Scott & White and St. David's failed to offer procedural or medical treatment to terminate Ms. Callaway's pregnancy during a dangerous miscarriage.

2. In October 2025, Ms. Callaway, while experiencing a miscarriage, was repeatedly denied care at multiple medical facilities in Texas. It would take seven days, three hospital emergency rooms ("ERs"), and countless calls to her OB/GYN before anyone would agree to give her proper medical care. Ms. Callaway's pain was dismissed, her signs of infection ignored, and she was forced to pass the pregnancy without medical assistance from Texas physicians. Yet at the same time she was denied miscarriage care, she was subjected to unnecessary STD testing.

3. What Ms. Callaway experienced has now become standard in states with abortion bans: When ERs are unable to conclusively identify a continuing intrauterine embryo in the early weeks of pregnancy, they send patients home. This is even when their pregnancies are potentially ectopic, and even when their pain and bleeding continue to worsen. Ms. Callaway was told that despite every indication that she was miscarrying—including precipitously declining hCG—her providers could not intervene when her hCG was "that high." And even though her labs were elevated and abnormal, she was told that she was not entitled to treatment in the ER because her condition was "not necessarily life or limb threatening." As Ms. Callaway explained to her providers: "No one seems to think this is an emergency but me."

4. EMTALA requires hospitals to provide immediate medical attention to prevent "material deterioration" of a patient's condition that can lead to a medical emergency, particularly during pregnancy. *See* 42 U.S.C. § 1395dd(e)(3) (defining "stabilize" to include preventing "material deterioration"). In the context of a miscarriage, the absence of medical treatment for pain, bleeding, and potential infection during early pregnancy loss can "reasonably be expected to result" in (1) placing the health of the pregnant patient "in serious jeopardy," (2) causing "serious impairment to bodily functions," and (3) resulting in "serious dysfunction of any bodily organ or part." *See* 42 U.S.C. § 1395dd(e)(1). By this standard, both Baylor Scott & White and St. David's failed to provide appropriate treatment for Ms. Callaway's miscarriage and instead left her to pass the pregnancy on her own without medical supervision.

5. Ms. Callaway's experience is not isolated. Since *Roe v. Wade* was overturned in 2022, there have been numerous reports of delays and denials of pregnancy-related care in ERs in states with abortion bans, even for care that is legal under state law.[1] This is because of the extreme penalties for physicians who violate state abortion bans. In Texas, a physician who provides a prohibited abortion faces up to life in prison, loss of medical license, and at least $100,000 in fines. *See* Tex. Health & Safety Code §§ 170A.004–170A.007; Tex. Penal Code §§ 12.32–12.33; Tex. Health & Safety Code §§ 171.207–171.211. Thus, some clinicians have been reluctant to provide medical intervention for a suspected or presumed miscarriage. Instead, they have forced patients to wait days or weeks and undergo additional testing to confirm and reconfirm the diagnosis.[2] They are doing so out of concern that, if their diagnosis is incorrect, termination would be a prohibited

[1] Amanda Seitz, *Emergency Rooms Refused to Treat Pregnant Women, Leaving One to Miscarry in a Lobby Restroom*, THE ASSOCIATED PRESS (April 19, 2024), https://apnews.com/article/pregnancy-emergency-care-abortion-supreme-court-roe-9ce6c87c8fc653c840654de1ae5f7a1c.

[2] *See* Daniel Grossman et al., *Preliminary Findings: Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing New Standards in Reproductive Health at 8 (May 2023) ("Care Post-*Roe* Report"), https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf.

abortion that could result in criminal and civil penalties. The results for patients are often disastrous.[3]

6. While many Texas lawmakers claim to have fixed these problems, Ms. Callaway's experience is proof that they have not. And the Texas Attorney General's actions have been counterproductive, as his litigation regarding former EMTALA guidance has led the federal government—and CMS specifically—to pause all enforcement of EMTALA against hospitals denying pregnancy care in Texas, pending an interminable, year-long legal "review."

7. All the while, however, EMTALA has remained unchanged. Hospitals cannot justify refusing to treat miscarriages under EMTALA by pointing to state abortion bans or litigation related to those bans. Regardless of concerns about state law, EMTALA forbids hospitals like Baylor Scott & White and St. David's from refusing stabilizing treatment to patients experiencing emergency symptoms related to miscarriage, like Ms. Callaway, because such patients' health is in serious jeopardy without immediate treatment. And no federal court has said otherwise. Moreover, although Texas law bans nearly all abortions, Texas law explicitly *allows* termination of pregnancy in cases of miscarriage.

8. Ms. Callaway respectfully requests that the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS") and Region 6 Office investigate Baylor Scott & White and St. David's refusal to provide her with emergency medical treatment in October 2025 and issue a finding that Baylor Scott & White and St. David's violated EMTALA by failing to provide her with stabilizing care. This investigation and finding are necessary to safeguard access to emergency medical treatment for all pregnant Texans who remain at risk that

[3] *See* Charlotte Huff, *In Texas, Abortion Laws Inhibit Care for Miscarriages*, NPR (May 10, 2022), https://www.npr.org/sections/health-shots/2022/05/10/1097734167/in-texas-abortion-laws-inhibit-care-for-miscarriages.

hospitals will deny them care if they experience an emergency medical condition during a miscarriage. Especially in states like Texas that severely criminalize certain pregnancy-related care, enforcing EMTALA's mandates is critical to protect the lives, health, and fertility of pregnant patients.

9. Ms. Callaway further requests that, for reasons discussed herein, CMS initiate an independent investigation into this Complaint without referral to the Texas Department of State Health Services, or, at a minimum, conduct an independent assessment of the facts discussed in this Complaint before reaching its final compliance determination.

JURISDICTION

10. CMS is responsible for ensuring compliance with EMTALA. The CMS Region 6 Office, based in Dallas, Texas, serves the region that includes Texas, where the Recipients Baylor Scott & White and St. David's are located.[4]

11. CMS Regional Offices evaluate EMTALA complaints and, for those requiring further investigation, generally refer the case to state survey agencies to investigate on CMS's behalf.[5] However, even when a state agency conducts the investigation, CMS Regional Offices "retain delegated enforcement authority and final enforcement decisions are made there."[6] Moreover, administrative decisionmaker CMS Regional Offices are not bound by a state agency's

[4] Ctrs. for Medicare & Medicaid Servs., *CMS Regional Offices*, https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices (last visited June 16, 2026).

[5] Ctrs. for Medicare & Medicaid Servs., State Operations Manual, Chapter 5 – Complaint Procedures § 5430.1 (Feb. 10, 2023), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c05pdf.pdf (hereinafter "SOM Ch. 5").

[6] SOM Ch. 5, Appendix V; *see also id.* (noting that "it is the responsibility of the [Regional Office]" to determine if an EMTALA violation has occurred).

factual findings and may consider additional information to determine whether a facility is in compliance with EMTALA.[7]

12. In certain instances, CMS does not refer alleged EMTALA violations to state survey agencies. For example, "CMS refers appropriate cases to the OIG [Office of Inspector General] for investigation."[8] "Appropriate cases" for OIG investigation may include those where a physician failed to treat or stabilize a patient with a condition that required immediate medical care.[9]

13. Here, CMS should not rely solely on a state agency's assessment of the facts in reaching its determination because of Texas state officials' hostility toward interpreting EMTALA as requiring hospitals to provide pregnancy termination to pregnant patients experiencing emergency medical conditions. Texas submitted an amicus brief to the U.S. Supreme Court arguing that EMTALA does not require hospitals to provide abortions that are necessary to stabilize a pregnant person's emergency medical condition because such abortions "place the health of an unborn child in serious jeopardy—indeed, it results in the child's destruction."[10] And after a federal district court in Texas issued an order in *Texas v. Becerra* preliminarily enjoining part of CMS's post-*Dobbs* EMTALA guidance, Texas Attorney General Ken Paxton issued a press release lauding the decision: "We're not going to allow left-wing bureaucrats in Washington to transform our hospitals and emergency rooms into walk-in abortion clinics," and "I will fight back

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[7] *See* SOM Ch. 5 § 5460 *et seq.*; *see also* SOM Ch. 5 Appendix V (advising state survey agencies that staff should not tell hospitals whether investigation shows an EMTALA violation occurred "since it is the responsibility of the [CMS regional office] to make that determination").

[8] SOM Ch. 5 § 5480.2.

[9] *Id.*

[10] *Idaho v. United States*, No. 23A470, 2024 WL 1421914, Br. of Indiana, et al., as Amici Curiae in Supp. of Idaho's Emergency Appeal for Stay Pending Appeal at 6, (Nov. 27, 2023) (internal citations and quotations omitted), https://www.supremecourt.gov/DocketPDF/23/23727/290617/20231127144632815_23A470%20tsac%20Indiana%20et%20al%20ISO%20Emergency%20Application%20for%20Stay.pdf.

to defend our pro-life laws and Texas mothers and children."[11] That decision was affirmed on appeal.

14. Outside the EMTALA context, Texas officials have fought efforts to allow pregnancy termination necessary to protect patient health. In *Cox v. Texas*, a Texas physician went to state trial court and obtained a court order allowing her to provide abortion care to Kate Cox for a non-viable pregnancy that posed a risk to her future fertility, but before even requesting appellate relief, the Attorney General threatened the hospitals where the physician practices with enforcement of Texas's abortion bans for civil or criminal liability if the hospitals allowed the court-authorized abortion.[12] And in *Zurawski v. Texas*, twenty Texas patients who were denied or delayed abortion care for serious obstetrical complications and two Texas OB/GYNs sought clarity regarding the medical exception to Texas's abortion bans, but the Attorney General and Texas Medical Board fought against any clarity in the trial court and in the Texas Supreme Court.[13] The state's medical expert in both *Cox* and *Zurawski* works for an anti-abortion advocacy organization and was appointed to Texas's Maternal Mortality and Morbidity Review Committee.[14] And despite the Texas Supreme Court's urging, the Texas Medical Board issued regulations failing to meaningfully clarify when physicians can provide abortion care under the exceptions to Texas's abortion bans.[15]

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[11] Ken Paxton, Tex. Att'y Gen., *Paxton Secures Victory Against Biden Administration, Blocks HHS from Forcing Healthcare Providers to Perform Abortions in Texas* (Aug. 24, 2022), https://www.texasattorneygeneral.gov/news/releases/paxton-secures-victory-against-biden-administration-blocks-hhs-forcing-healthcare-providersperform.

[12] Ken Paxton (@TXAG), Twitter (Dec. 7, 2023, 2:49 PM), https://twitter.com/TXAG/status/1732849903154450622; *In re Texas*, 682 S.W.3d (Tex. 2023) (per curiam).

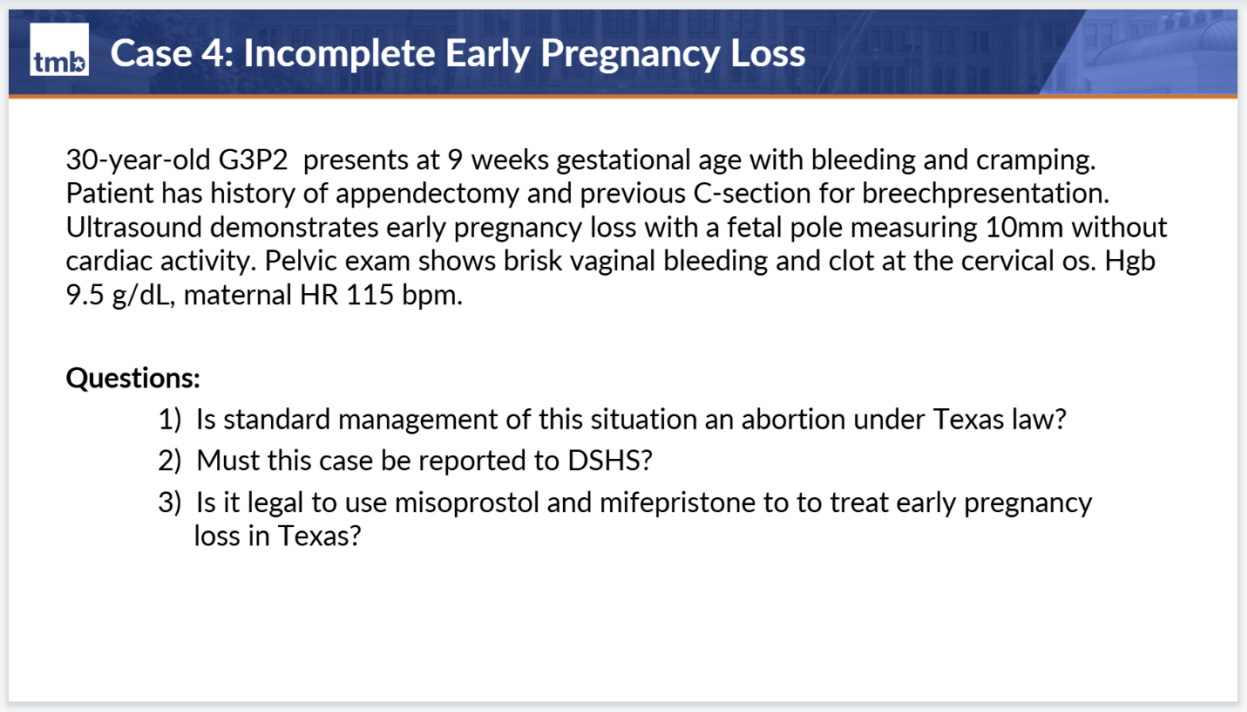
[13] *Texas v. Zurawski*, No. 23-0629, 2024 Tex. LEXIS 401 (Tex. May 31, 2024).

[14] Eleanor Klibanoff, *Anti-Abortion Doctor Appointed to Texas Maternal Death Review Committee*, TEXAS TRIBUNE (May 22, 2024), https://www.texastribune.org/2024/05/22/texas-maternal-mortality-committee-ingrid-skop-abortion-doctor.

[15] *See Zurawski*, No. 23-0629 at n.6 (Busby, J., & Lehrmann, J., concurring) ("But instead of fulfilling its own obligation to speak clearly and specifically, the Board has proposed a regulation that does nothing more than restate the relevant statutes."); Bayliss Wagner, *Texas OB-GYNs Slam Proposed TMB Abortion Rules: 'Dead Mothers do not*

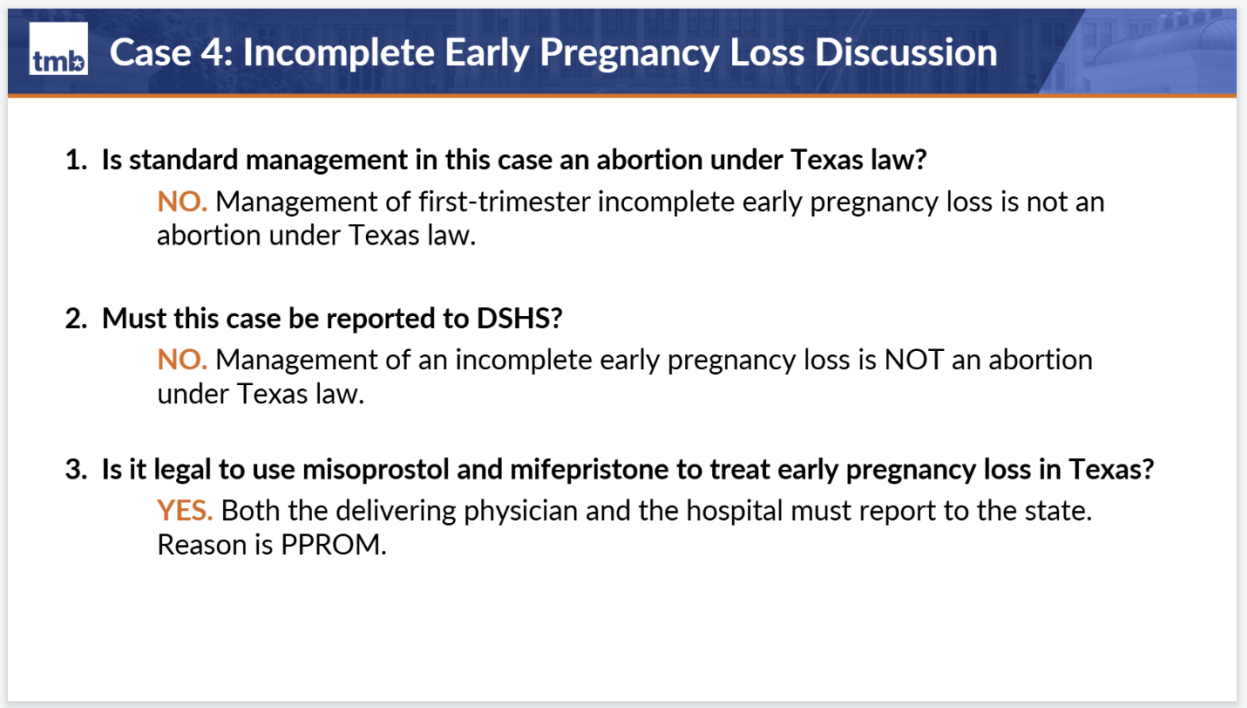
15. During the 2025 legislative session, some Texas legislators expressed concern over the administrative and judicial inaction on these issues and drafted legislation they hoped would clarify at least some of the medical community concerns regarding implementation of the abortion bans. Yet as they so often do, the anti-abortion lobbyists took over the process, and the Texas legislative ultimately passed a bill that did nothing more than statutorily codify the clarifying language the Texas Supreme Court had written in its decisions on *Zurawski* and *Cox* that already have the force of law.

16. In fact, the legislation explicitly purports to clarify "miscarriage care" by including a case example in the training materials the Texas Medical Board released under the new law:[16]



Lead to Live Babies,' AUSTIN AMERICAN-STATESMAN (May 21, 2024), https://www.statesman.com/story/news/politics/state/2024/05/21/texas-medical-board-abortion-guidelines-women-obgyns-hospital-associations-slam-proposed-rules/73767779007.

[16] Texas Medical Board, Texas Abortion Law (February 2, 2026), *available at* https://www.documentcloud.org/documents/26781649-texas-medical-boards-texas-abortion-law-education.



This legislation went into effect in August 2025.[17] Ms. Callaway was denied appropriate miscarriage care in October 2025.

17. In the meantime, most EMTALA investigations in Texas are effectively stalled. Specifically, undersigned counsel has been informed by officials at CMS that even where a CMS investigation finds a Texas hospital violated EMTALA by refusing to provide stabilizing care to a patient when such stabilizing care involves terminating a pregnancy, the DOJ must review all potential violations for compliance with the court orders in Paxton's litigation over EMTALA. This is true even for denials of care related to ectopic pregnancy and miscarriage, notwithstanding the fact that such terminations are *excluded from the definition of abortion under Texas law*. And rather than act on such complaints, the DOJ has been sitting on them—for years.

18. In light of these concerns and events, Ms. Callaway requests that CMS and the Region 6 Office conduct an independent investigation of this Complaint, whether by referring this

[17] S.B. 31, 89(R) Leg. (Tex. 2025).

matter to OIG or otherwise. Alternatively, if CMS refers the matter to the Texas Department of State Health Services for investigation, Ms. Callaway requests that CMS conduct a full, independent investigation and consider the facts contained in this Complaint before concluding its investigation and determining whether Baylor Scott & White and St. David's complied with EMTALA.

19. Ms. Callaway further requests that CMS release the results of their EMTALA investigation pursuant to this complaint to her counsel *before* the results are sent to the DOJ for any alleged "legal review."

FACTUAL ALLEGATIONS

A. A Miscarriage Can Lead to an Emergency Medical Condition that Requires Stabilizing Treatment

20. Pregnancy can lead to any number of emergency medical conditions for which stabilizing care is needed because failure to provide such immediate medical attention "could reasonably be expected to result in" "placing the health" of the pregnant patient "in serious jeopardy," "serious impairment to bodily functions," or "serious dysfunction of a[] bodily organ or part," in violation of EMTALA, 42 U.S.C. § 1395dd(b) and (e)(1)(A). Delaying such care can lead to serious complications, including hemorrhage, loss of reproductive organs, sepsis, or even death of the pregnant patient.

21. While used to identify many different kinds of pregnancy outcomes, a "miscarriage" is understood in common parlance to mean premature termination of a pregnancy when that pregnancy, for whatever reason, would or could not continue to a live birth. Under Texas law, miscarriage management by medical professionals—described as "removing a dead fetus"—is excluded from the abortions that are prohibited under Texas law. *See* Tex. Health & Safety Code §§ 245.002(1); 170A.002; 171.204. This means that aiding in the termination of a pregnancy with

no cardiac activity and no hope of developing such activity, through a procedure or via administering or prescribing medications, is not an abortion and remains legal in Texas. In medical terminology, a miscarriage is often referred to as a "spontaneous abortion," "missed abortion," or "early pregnancy loss," which estimates suggest occurs in 15 to 20% of clinically recognized pregnancies.[18]

22. The treatment options for early pregnancy loss include: expectant management (*i.e.*, wait and see), medical management (with misoprostol or a combination of mifepristone and misoprostol pills), or procedural evacuation (referred to by various terms including "uterine aspiration," "suction aspiration," or "D&C").[19] Medical management is shown to be more effective when provided earlier during a miscarriage.[20] Professional guidelines in obstetric medicine recommend that medical providers use a patient-centered approach that utilizes shared decision-making to diagnose and treat early pregnancy loss—in other words, the patient's tolerance for a wait and see approach, concern for their health and future fertility, and preferences for the management of the pregnancy should be paramount. Some patients prefer to experience their early pregnancy losses "naturally," meaning without medical intervention. But many others do not, particularly because an early pregnancy loss can become dangerous if not deadly.

23. Various complications can occur with early pregnancy loss, including hemorrhage and infection. Incomplete abortion or retained tissue can lead to infection, and the retained tissue must be removed via procedure or medications. Professional guidelines recommend that patients who present with hemorrhage, hemodynamic instability, or signs of infection "should be treated

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[18] Society for Family Planning, *Medication Management for Early Pregnancy Loss* (Dec. 2024), https://societyfp.org/clinical_guidances/medication-management-for-early-pregnancy-loss.

[19] *See* The American College of Obstetricians and Gynecologists ("ACOG"), *Practice Bulletin 200*: *Early Pregnancy Loss*, 132(5) Obstetrics Gyn. E197 (hereinafter "ACOG Practice Bulletin 200").

[20] *See* Antoine Torre et al., *Immediate Versus Delayed Medical Treatment for First-Trimester Miscarriage: A Randomized Trial*, Am. J. of Obstetrics & Gynecology, 206(3): 215.e1-6 (2012), DOI: 10.1016/j.ajog.2011.12.009.

urgently with surgical uterine evacuation."[21] Procedural or medical management of early pregnancy loss is also indicated for patients with anemia, bleeding disorders, cardiovascular disease, and other co-morbidities. Regardless of comorbidities, many patients "prefer surgical evacuation to expectant or medical management because it provides more immediate completion of the process with less follow up." Critically, because no approach is "clearly superior," professional guidelines dictate "that patient preference should guide choice of intervention."[22] When patient preference does not guide the choice of intervention, patients are more likely to hemorrhage, as has been documented in the states where abortion is now illegal.[23]

24. Texas's Maternal Mortality and Morbidity Review Committee (MMRC) and the Department of State Health Services released a joint report in 2022 finding that the leading cause of pregnancy-related deaths in Texas was obstetric hemorrhage and most pregnancy-related deaths were preventable.[24] Following the overturning of *Roe*, it is unclear if Texas will continue to fund its MMRC, and Texas has stopped sharing data collected by its MMRC with the CDC.[25]

B. Baylor Scott & White Refused to Provide Stabilizing Treatment for Ms. Callaway's Miscarriage[26]

25. Ms. Callaway is 40 years old and lives in Austin, Texas with her husband and 8-year-old son.

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[21] ACOG Practice Bulletin 200.
[22] *Id*.

[23] *See generally* Care Post-*Roe* Report.

[24] Texas Health and Human Servs., *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022* at 8, https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/2022-MMMRC-DSHS-Joint-Biennial-Report.pdf.

[25] *See, e.g.*, Cassandra Jaramillo, *"We Want to Save This Investment": Advocates Race to Secure Maternal Health Funding Before It Runs Out*, ProPublica (Aug. 8, 2025), https://www.propublica.org/article/maternal-mortality-erase-mm-funding-cuts.

[26] The allegations contained herein are to the best of Ms. Callaway's knowledge and recollection.

26. In late September 2025, Ms. Callaway missed her period and took a home pregnancy test. It was positive. Excited, Ms. Callaway scheduled her first prenatal appointment and began the agonizing wait that is early pregnancy. It would be weeks before her OB/GYN would initiate prenatal care, so for now, all she could do was get blood tests to monitor presence of the pregnancy hormones hCG and progesterone, and wait. Ms. Callaway's first hCG reading on September 29 was 447 mIU/mL and her progesterone was 19.2 ng/mL. Two days later, on October 1, her hCH was 688 mIU/mL. Her levels weren't high, but they were within potentially normal range and not yet cause for concern.

27. But on Thursday morning, October 9, when Ms. Callaway was seven weeks[27] pregnant, she began spotting. Concerned, Ms. Callaway immediately reached out to her OB/GYN who advised Ms. Callaway to keep an eye on it and monitor any other symptoms.

28. That evening, the bleeding increased and Ms. Callaway began to experience severe abdominal pain. She reached out to her OB/GYN again, and the on-call nurse told her to come into the office the following day.

29. The next morning, Friday, October 10, Ms. Callaway received an ultrasound exam at her OB/GYN's office, and the nurse practitioner could not locate an intrauterine pregnancy or a gestational sac in any location. Ms. Callaway was told that she might have an ectopic pregnancy or be miscarrying. Her OB/GYN's office documented "threatened abortion" in her chart, ordered more hCG testing, and sent Ms. Callaway home. That afternoon, Ms. Callaway received the results: her hCG was now 130 mIU/mL and her progesterone was 1.21 ng/mL.

[27] Consistent with standard medical practice, gestational ages as used in this complaint are dated from the first day of the patient's last menstrual period ("LMP"), which is typically approximately two weeks before the estimated date of fertilization of a pregnancy.

30. By the evening of October 10, Ms. Callaway's condition had worsened: the bleeding was increasing, as was her abdominal pain, and she was lethargic. She called her OB/GYN's office again. The on-call nurse told her that with an hCG "that high," their office "*could not*" offer a D&C or medication like misoprostol to help terminate the pregnancy. Instead, the nurse advised Ms. Callaway to visit the ER *if* her symptoms progressed.

31. This all-too-common response for issues in early pregnancy—go to the ER—is not unique to Texas or other states with abortion bans. OB/GYNs around the country generally do not allow patients in their offices before 8-10 weeks, when they expect to visualize an intrauterine pregnancy on ultrasound. So, in the early weeks of pregnancy, ERs are the only option remaining to manage most pregnancy complications. Yet when abortion bans, so punitive to doctors, are layered atop this broken system, both outpatient OB/GYN offices and hospital ERs are left to guess whether offering the appropriate intervention is even legal. And so, they do nothing, leaving patients with *nowhere* to obtain emergency medical services for the bleeding, pain, and infections that develop during inevitable early pregnancy loss.

32. For Ms. Callaway, this is exactly what happened.

33. After being turned away by her OB/GYN, Ms. Callaway went to the ER at St. David's North Austin Medical Center. It was a Friday evening, and the ER was packed. Ms. Callaway saw another patient waiting to be seen—a pregnant woman in active labor—and she realized she was unlikely to receive speedy care. So she left St. David's and drove instead to the ER at Baylor Scott & White in Round Rock.

34. Ms. Callaway arrived at a relatively empty waiting room in Baylor Scott & White's ER and was taken to triage, where they took her vital signs. Ms. Callaway explained that she was experiencing severe pain and bleeding, and that based on her hCG and progesterone results, she

was having either a miscarriage or an ectopic pregnancy. The ER staff ordered an ultrasound and blood testing.

35. The technician told Ms. Callaway she saw an intrauterine sac on the ultrasound. According to Ms. Callaway's medical records, there was "no fetal pole or yoke sac," the embryo was measuring around 5 weeks, and there was no cardiac activity. Yet by LMP, Ms. Callaway was 7 weeks. These ultrasound results were yet more evidence that the pregnancy had stopped growing and she was miscarrying. Ms. Callaway then waited for the doctor to arrive and explain her options.

36. When the emergency medicine physician arrived at Ms. Callaway's room, however, it was to perform STD testing. Ms. Callaway was confused and explained that she is married and an STD was unlikely if not impossible. Yet Ms. Callaway felt pressured to consent so she ultimately agreed to proceed with the testing. The doctor performed a pelvic exam, which was extremely painful, and left.

37. The emergency medicine physician returned later to inform Ms. Callaway that her hCG was now 105 mIU/mL and the rest of her blood test results "looked good." The doctor explained that from what she could tell, Ms. Callaway was having a miscarriage, but that she only had one option: Ms. Callaway would need to go home where she would experience clotting and pass the pregnancy on her own, and she should follow up with her OB/GYN in around a week. This is also reflected in Ms. Callaway's medical records: "Probable intrauterine pregnancy of uncertain viability. In a hemodynamically stable patient, recommend follow-up with pelvic ultrasound in 7-10 days." When Ms. Callaway expressed concern that she would bleed out if she miscarried at home, the doctor was dismissive, chuckling as she told Ms. Callaway to just expect some cramping.

38. Ms. Callaway was confused. She was already in significant pain and concerned that passing the pregnancy on her own would be like going into labor. The doctor assured her it would be "fine" and that she could take over-the-counter Tylenol if she wanted. Ms. Callaway was then discharged.

39. That evening, Ms. Callaway was unable to sleep. She had chills, was bleeding continuously and cramping, and Tylenol did nothing to ease her significant cramps and pain.

40. In the morning the following day, Saturday October 11, Ms. Callaway began to receive emails from Baylor Scott & White with the results of her lab tests from the day before. She noticed that several of her lab results were elevated or abnormal. For example, her hemoglobin was 11.5 g/dL, below the normal range of 12-16 g/dL. Yet she had been told in the ER that her labs were "fine."

41. Ms. Callaway called Baylor Scott & White and spoke with a nurse who told her that "even though [your labs] are abnormal they are not necessarily life or limb threatening to where we have to get you evaluated or have to do immediate treatment." The nurse asked, Ms. Callaway "does that make sense?" to which she responded "No," and the nurse replied, "I was about to say, I am sure it doesn't." Ms. Callaway asked again why she was not offered some medical intervention to help end her pregnancy, but the nurse continued to insist that doing nothing was "standard," and again, Ms. Callaway should follow up with her OB/GYN. It was Saturday—her OB/GYN's office was closed.

42. As Ms. Callaway reflected at the time: "No one seems to think this is an emergency but me." Ms. Callaway felt she had no choice but to continue trying to manage on her own.

43. On Sunday, October 12, Ms. Callaway's pain was continuing to increase and she had chills, so she decided to try a different ER: St. David's Round Rock Medical Center. Ms.

Callaway explained her symptoms in triage and was taken for testing and an ultrasound. Her hCG was now 50 mIU/mL and she was given morphine and IV fluids for the pain while she waited to see the ER provider.

44. A physician assistant arrived and told Ms. Callaway she was suffering from a miscarriage and had developed an infection, so they would be discharging her with pain medication and antibiotics to take home. Ms. Callaway asked why they were not offering her a procedure or medication to terminate the pregnancy, and the physician said this was not something the ER provided and Ms. Callaway would need to follow up with her OB/GYN.

45. Throughout the weekend and into Monday morning, Ms. Callaway was in persistent agony. Her husband monitored her vitals and tried to help her manage the pain with the medications she had received at St. David's. The couple considered traveling out-of-state for care, but Ms. Callaway was still bleeding so much that they feared travel was dangerous. On Monday morning, October 13, Ms. Callaway finally got in touch with her OB/GYN, who scheduled her to come in for an appointment the following day.

46. On Tuesday, October 14, Ms. Callaway saw her OB/GYN in her outpatient office. Her OB did a pelvic exam and ultrasound and confirmed that Ms. Callaway was miscarrying and had developed an infection. Her OB/GYN detected retained tissue and commented that she "did not like" how Ms. Callaway looked. She prescribed stronger antibiotics and finally, for the first time in six days, Ms. Callaway was offered a procedure or medication to terminate the pregnancy. Ms. Callaway opted for medication and began taking the pills that afternoon. When Ms. Callaway asked her physician why she had not been offered the pills in the ER, her OB/GYN was not surprised, saying the ER would "have to be damned sure that it's an actual miscarriage to be offering the pill."

47. For the next four days, Ms. Callaway continued to expel pregnancy tissue at home. She spent her 40th birthday curled on the floor of her bathroom, afraid for her life. On October 16 and October 23, Ms. Callaway had follow-up appointments with her OB/GYN for ultrasounds and to confirm her hCG was continuing to decrease.

48. On Monday, October 20, Ms. Callaway returned to work while she was still healing because she had run out of paid sick days.

49. Months later, at the beginning of January 2026, Ms. Callaway and her husband were on their way to Portugal for a vacation. Ms. Callaway had not had a period since October, but on the plane ride across the Atlantic, she started bleeding. The blood was dark red and something did not seem right, but Ms. Callaway thought it was just a period.

50. Days later, Ms. Callaway was getting into her rental car in Portugal when she felt a gush of blood and excruciating pain. She went to a public toilet in a nearby grocery store and pulled down her tights. There was blood everywhere: soaking her tights, on the toilet, and on the floor of the bathroom. Panicked, Ms. Callaway's husband quickly drove to an ER and through the language barrier, the couple attempted to explain that she had had a miscarriage months ago that she thought was over but something was still wrong with her.

51. Sure enough, the pathology report from the hospital in Portugal revealed that Ms. Callaway had retained tissue from her miscarriage that her OB/GYN and the hospitals in Texas had missed.

52. For Ms. Callaway, it felt like going through the miscarriage all over again. Yet for the first time since the ordeal began, she felt safe with a physician. Even though they did not speak the same language, Ms. Callaway trusted this physician more than any of the providers who had cared for her in Texas.

53. However, Ms. Callaway had no choice but to eventually return to Texas: To her job, her family, and her life.

54. Since her miscarriage, Ms. Callaway has been diagnosed with PTSD and resigned from her job. She could no longer face her work responsibilities, which involved working in partnership with the ER staff at Baylor Scott and White. She feels vulnerable and fearful in a way she never has before. She does not want to be defined by this experience. But she also wants to make sure that others are not made to suffer the same way she has.

LEGAL ALLEGATIONS

55. Congress enacted EMTALA in 1986 to "provide an 'adequate first response to a medical crisis' for all patients." *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)). Any hospital that has an emergency department and receives Medicare funds is subject to EMTALA's requirements. 42 U.S.C. § 1395cc(a)(1). Because Baylor Scott & White and St. David's operate emergency departments and participate in Medicare, they are subject to EMTALA.[28]

56. Under EMTALA, when an individual "comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide "such treatment as may be required to stabilize the medical condition" or transfer the individual to another medical facility. 42 U.S.C. § 1395dd(b)(1). EMTALA defines "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity

[28] The Baylor Scott & White and St. David's locations in Round Rock operate emergency departments. *See* Baylor Scott & White, *Emergency Care*, https://www.bswhealth.com/locations/hospital/round-rock (last visited March 5, 2026); St. David's Round Rock Medical Center, https://www.stdavids.com/locations/st-davids-round-rock-medical-center (last visited March 5, 2026). Both hospitals also participate in Medicare. *See* Baylor Scott & White, *Insurance Plans Accepted* https://www.bswhealth.com/patient-tools/registration-and-billing/insurance-plans-accepted (last visited March 5, 2026); St. David's Round Rock Medical Center, *Insurance Information*, https://www.stdavids.com/locations/st-davids-round-rock-medical-center/for-patients/insurance-information (last visited March 5, 2026).

(including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1).

57. Patients who are determined to have an "emergency medical condition" must receive stabilizing care within the hospital's capabilities. "'[T]o stabilize'" is defined as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during" the patient's discharge or transfer. 42 U.S.C. § 1395dd(e)(3)(A). Although hospitals may admit a patient "as an inpatient in good faith in order to stabilize the emergency medical condition," 42 C.F.R. § 489.24(d)(2)(i), EMTALA "requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well," *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 561 F.3d 573, 582 (6th Cir. 2009).

58. Excessive bleeding and/or signs of infection during an early pregnancy loss both constitute "material deterioration" that can lead to emergency medical conditions if not treated promptly. As explained above, the absence of medical treatment for pain, bleeding, and potential infection during early pregnancy loss can "reasonably be expected to result" in (1) placing the health of the pregnant patient "in serious jeopardy," (2) causing "serious impairment to bodily functions," and (3) resulting in "serious dysfunction of any bodily organ or part." *See* 42 U.S.C. § 1395dd(e)(1).

59. Both Baylor Scott & White and St. David's downplayed the severity of Ms. Callaway's symptoms, allowed her condition to further deteriorate untreated, and repeatedly attempted to pass the buck by discharging her without providing the stabilizing care or transfer for

care that she needed—termination of pregnancy. There were repeated signs that expectant management was not the proper treatment for Ms. Callaway, all of which the hospitals ignored. First, the hospitals explicitly disregarded Ms. Callaway's stated preference. As discussed above, the standard of care for early pregnancy loss is to engage in shared decision-making with the patient, yet Ms. Callaway's pleas for procedural or medical assistance to complete her miscarriage were ignored. Second, Ms. Callaway was experiencing significant and persistent bleeding and pain—putting her at risk of hemorrhage—yet neither hospital took those complaints seriously. Baylor Scott & White wouldn't even give Ms. Callaway an IV, pain medication, or antibiotics. Third, Ms. Callaway was showing signs of infection and anemia, as evidenced by her low hemoglobin and persistent chills. St. David's acknowledged the potential for infection as they prescribed Ms. Callaway antibiotics but offered nothing more. Meanwhile, all Baylor Scott & White provided was unnecessary STD testing. Finally, the fact that Ms. Callaway spent days going back and forth between three different hospitals while bleeding, with chills, and in significant pain, should be evidence enough that "managing" her miscarriage at home was inappropriate in her case.

60. Although not required to support a determination that Baylor Scott & White and/or St. David's violated EMTALA based on the above facts, terminating Ms. Callaway's pregnancy earlier in the progression of her condition would have been legal under Texas law. Under Texas's abortion ban, an act "done with the intent to[] . . . remove a dead fetus" "is not an abortion" within the meaning of that state law, and is therefore not prohibited. Tex. Health & Safety Code § 245.002(1)(C); *see also id.* §§ 170A.001(1), 170A.002 (prohibiting "abortion" as defined in Tex. Health & Safety Code § 245.002). For the same reasons, the injunction in *Texas v. Becerra* did not justify discharging Ms. Callaway without offering termination. *Texas v. Becerra*, 89 F.4th 529, 535-36 (5th Cir. 2024). CMS's enjoined guidance does not come into play in Ms. Callaway's

situation because, as the Fifth Circuit explained, Texas physicians can "comply with both EMTALA and state law by offering stabilizing treatment in accordance with state law." *Id.* at 542.

61. It was clear at every ultrasound that Ms. Callaway's pregnancy had no cardiac activity, her hCG levels were extremely low and continuing to drop, and her symptoms were all consistent with early pregnancy loss. There is no medical or legal justification for a physician to claim there is any hCG level "too high" to offer miscarriage management, let alone readings below 200 mIU/mL.

62. To prevent further danger to pregnant patients' health, lives, bodily functions and organs, it is critical that EMTALA be enforced against hospitals like Baylor Scott & White and St. David's that refuse to provide stabilizing treatment for the emergency medical conditions that arise during early pregnancy loss. That is true even if state law were to indicate that such treatment was unlawful, but that issue need not be decided here because the treatment Ms. Callaway sought was *lawful* under Texas law. Enforcing EMTALA in these circumstances would dispel any physician concerns and ensure that hospitals in Texas are appropriately concerned that *refusing* stabilizing treatment for patients with early pregnancy loss would risk investigations, penalties, and liability. Such a determination could provide the clarity Texas physicians still badly need and which neither the courts, nor the medical board, nor the legislature has provided in the over four years since Texas's abortion bans went into effect.

63. The need for enforcement is urgent because Ms. Callaway's mistreatment is not an isolated incident. Studies that include Texas providers show that physicians are undertaking additional documentation and consultations with other physicians before providing care for early pregnancy loss.[29] These additional steps have resulted in delays and refusals in care. Similarly, a

[29] Care Post-*Roe* Report at 10.

study of the impact of Louisiana's abortion ban on maternal health care found that medical treatment of early pregnancy loss pregnancies has been delayed even though the law does not criminalize care in those circumstances.[30] Physicians there are also undertaking burdensome, additional, and unnecessary documentation procedures before providing care to patients with early pregnancy loss to ensure their medical judgment will not be second-guessed by state officials.[31] Patients presenting to hospitals with early pregnancy loss were often required to delay treatment for a day, then return the next day because, as a doctor opined, they "need to prove beyond a very reasonable doubt that the bad thing is happening."[32]

64. This situation is untenable and warrants swift investigation and a determination that Baylor Scott & White and St. David's failure to provide emergency treatment for Ms. Callaway's miscarriage violated EMTALA.

RELIEF REQUESTED

65. Ms. Callaway respectfully requests that CMS and/or HHS OIG:

a. Conduct an independent investigation of Baylor Scott & White and St. David's for EMTALA violations arising from their refusal to provide her with necessary stabilizing treatment to preserve her life, health, bodily functions, and bodily organs;

b. Take all necessary steps to remedy all unlawful conduct identified in its investigation, including by imposing all appropriate penalties;

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[30] *Id.*

[31] *Id.*

[32] Physicians for Human Rights, et al., *Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians* at 28 (Mar. 2024), https://phr.org/wp-content/uploads/2024/03/PHR-Report-Criminalized-Care-March-2024.pdf.

c. Monitor any resulting agreements between CMS and Baylor Scott & White and St. David's to ensure compliance with EMTALA; and

d. Provide other appropriate equitable relief.

Respectfully submitted,

/s/Molly Duane

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