

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

**DEFENDANTS' OPPOSITION TO PLAINTIFF'S
EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER**

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INTRODUCTION

This Court should deny Plaintiff's request for extraordinary injunctive relief.

The world is facing a historic, unprecedented outbreak of the Coronavirus Disease 2019 (COVID-19). The virus that causes COVID-19, known as SARS-CoV-2, spreads easily and quickly across national borders. At this time, COVID-19 has no widely available therapeutics or vaccine, and it can have a high mortality rate for some of the most vulnerable members of society. The World Health Organization has classified the outbreak as a pandemic. Across the world, countries are implementing emergency measures to help curb the spread of this highly contagious disease. Nations have closed their borders and imposed severe travel restrictions. In the United States, the President has declared a National Emergency, and the Secretary of Health and Human Services similarly declared a public health emergency. The Department of State has issued a global Level 4 "do not travel" advisory—the highest level it can issue. And the United States and its two neighboring countries, Mexico and Canada, have closed their shared borders to nonessential travel.

To help avert the serious danger of COVID-19 further spreading into the United States, the Director of the U.S. Centers for Disease Control ("CDC") invoked, for the first time in the Nation's history, his authority under section 362 of the Public Health Service Act, 42 U.S.C. § 265 ("Section 265"), to temporarily suspend the movement of certain aliens who are without valid travel documents into the United States from Canada and Mexico. In an order issued in March 2020, the Director found that that suspension is necessary because aliens covered by the Order potentially are vectors of COVID-19, and they are typically held in congregate settings for immigration processing at ports of entry and Border Patrol stations. Those facilities are not equipped to quarantine, isolate, or enable social distancing for large populations, and the use of their congregate holding areas for quarantine or isolation would present a significant risk of transmitting COVID-19. Nor are they designed to provide the level of medical care that vulnerable populations with COVID-19 may require. Therefore, allowing the introduction of aliens subject to the Order into the United States, the Director found, would put the American public, U.S. Customs and Border

Protection (“CBP”) personnel, and other travelers at risk and potentially strain the American healthcare system. Given such public health risks, the Director determined that it is imperative to return covered aliens to the country from which they entered the United States or to their home country as quickly as possible. The Director requested the assistance of the Department of Homeland Security (“DHS”) with implementing his Order pursuant to section 365(b) of the Public Health Service Act, 42 U.S.C. § 268(b), which provides that it shall be the duty of customs officers to aid in the enforcement of such orders.

Plaintiff is a 16-year-old Honduran citizen who was apprehended approximately one mile from the U.S.-Mexico border after illegally entering the United States near El Paso, Texas. He was determined to be subject to the CDC Order and was scheduled to be returned to his home country pursuant to the Order. He seeks to enjoin his return, contending that (1) Section 265 does not authorize the return of individuals to their home countries after they have already crossed the U.S. border; (2) his return would violate the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”) and the procedures afforded under certain immigrations laws; and (3) the CDC Order is arbitrary and capricious.

Plaintiff is unlikely to succeed on these arguments. *First*, Section 265 plainly authorizes his return. In adopting Section 265, Congress gave the Executive Branch the power to prohibit the introduction of persons into the United States during an outbreak of a communicable disease. By granting that broad power, Congress necessarily gave the Executive Branch the authority to take actions needed to exercise that power. That includes, in the circumstances here, the prompt return of covered aliens who have crossed the U.S. border and would otherwise be introduced into congregate settings. *Second*, the Government has complied with its obligations under the CAT. It has conducted a screening interview to assess whether he meets the threshold screening standard required to place Plaintiff in removal proceedings in order to seek protection under the CAT, and has determined that he does not. In any event, this Court does not have jurisdiction to review that determination. Moreover, the statute’s text and structure evince Congress’s intent that the emergency public health provisions would take precedence over the procedures afforded under the

immigration laws in times of a public health crisis, such as the current global pandemic. Were it otherwise, the public health provisions—intended to curb the potentially irreversible and devastating spread of a communicable disease from the mass migration at the Nation’s borders during an outbreak—would be rendered a nullity. Even if Congress’s intent were not clear, the agency’s interpretation of Sections 265 and 268(b) as operating without regard to the immigration laws is reasonable and entitled to deference. *Third*, the CDC fully explained the necessity of the Order, and its action is not arbitrary or capricious.

The equities also weigh decidedly against granting the requested emergency relief here. As Chief Justice Roberts recently observed, “[o]ur Constitution principally entrusts ‘[t]he safety and the health of the people’ to the politically accountable officials of the [government] ‘to guard and protect,’” and “[w]hen those officials ‘undertake[] to act in areas fraught with medical and scientific uncertainties,’ their latitude ‘must be especially broad.’” *S. Bay United Pentecostal Church v. Newsom*, No. 19A1044, 2020 WL 2813056, at *1–2 (S. Ct. May 29, 2020) (Roberts, C.J., concurring in denial of application for injunctive relief) (first quoting *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905), and then quoting *Marshall v. United States*, 414 U.S. 417, 427 (1974)). “Where those broad limits are not exceeded, they should not be subject to second-guessing by an ‘unelected federal judiciary,’ which lacks the background, competence, and expertise to assess public health and is not accountable to the people.” *Id.* at *1 (quoting *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 545 (1985)). “That is especially true where, as here, a party seeks emergency relief in an interlocutory posture, while [government] officials are actively shaping their response to changing facts on the ground.” *Id.* at *2. The Court thus should deny Plaintiff’s motion.

BACKGROUND

I. FACTUAL BACKGROUND

A. The COVID-19 Pandemic

COVID-19 is a communicable disease that primarily transfers from person to person through respiratory droplets from an infected person. Notice of Order Under Sections 362 & 365

of the Public Health Service Act Suspending Introduction of Persons From Countries Where Communicable Diseases Exist, 85 Fed. Reg. 17060-02 (Mar. 26, 2020) [“Order”] at 3 (attached hereto as Exhibit B). The disease can also be transmitted through asymptomatic persons, and it spreads easily and rapidly. *Id.* Today, there are more than 7.6 million confirmed cases and 426,000 deaths globally.¹

To curb the spread of COVID-19, countries have imposed sweeping travel restrictions. *Id.* at 5; *see also* Interim Final Rule, Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons Into The United States From Designated Foreign Countries of Places for Public Health Purposes, 85 Fed. Reg. 16559-01 (Mar. 24, 2020) [“IFR”] at 10-11 (attached hereto as Exhibit A). The United States, Mexico, and Canada have closed their shared borders to non-essential travel.² Beginning in March, the President also suspended the entry of most aliens who were present in countries with substantial outbreaks within 14 days of the aliens’ entry or attempted entry into the United States, including the People’s Republic of China, the Islamic Republic of Iran, the Schengen Area of Europe, the United Kingdom, and the Republic of Ireland. *Id.* at 10. On May 24, 2020, the President further suspended the entry of most aliens from Brazil.³ The CDC has issued various guidelines to help slow the spread of the disease, while states and localities have shut down businesses or otherwise issued shelter-in-place orders. Order at 6.

As of May 9, 2020, the United States reported 1,274,036 confirmed cases of COVID-19 and 77,034 deaths. *See* Amendment and Extension of Order Suspending Introduction of Certain

¹ *See* World Health Organization, Coronavirus 2019, Situation Report 148, at 1, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200616-covid-19-sitrep-148-draft.pdf?sfvrsn=9b2015e9_2.

² Fact Sheet: DHS Measures on the Border to Limit the Further Spread of Coronavirus, https://www.dhs.gov/sites/default/files/publications/20_0519_as1_frn_us-canada-border.pdf.

³ Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting Novel Coronavirus, <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-novel-coronavirus/>.

Persons from Countries Where a Communicable Disease Exists, 85 Fed. Reg. 31503-02 (May 21, 2020) [“May Order”] at 6 (attached hereto as Exhibit D). By June 16, 2020, there were more than 2.1 million confirmed cases and the death toll reached 116,000.⁴ Although certain early hotspots have shown signs of improvement, and certain areas of the country are beginning a phased reopening of their communities, many cities and states, including several located at or near U.S. borders, continue to experience widespread, sustained community transmission. *Id.* at 3, 6.

B. COVID-19 in Canada and Mexico

The pandemic has severely impacted Canada and Mexico. By May 9, 2020, Canada reported 66,780 confirmed cases of COVID-19 and a total of 4,628 deaths. May Order at 4. Canada’s public health agency expects that the number of confirmed COVID-19 cases will continue to increase. *Id.* Canadian modeling indicates that Canada could see 940,000 people with infections, 73,000 hospitalizations, and 23,000 people requiring intensive care over the course of the pandemic. *Id.*

Mexico declared a state of health emergency on March 30, 2020, and temporarily suspended all non-essential activities. See Extension of Order Suspending Introduction of Certain Persons From Countries Where A Communicable Disease Exists, 85 Fed. Reg. 22424 (Apr. 20, 2020) [“April Order”] at 4 (attached hereto as Exhibit C). On April 20, 2020, the country announced its highest level of public health emergency, and, as of May 9, 2020, Mexico had reported 29,616 confirmed cases of COVID-19 and 2,961 deaths. May Order at 5. The Mexican Health Ministry believes that there are approximately eight additional cases for each confirmed case, and the Mexican government’s modeling indicates that 250,656 people could be infected during the acceleration phase of the pandemic, with 70 percent of them expected to seek medical care. *Id.* Non-governmental models and estimates indicate that there may be between 620,000 and 730,000 symptomatic cases. *Id.* Medical experts also believe that the virus will inevitably

⁴ See CDC, Corona Virus Disease 2019 (COVID-19), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

spread at migrant camps and shelters along the U.S. border. Order at 9. Indeed, the disease has spiked in Mexico. The World Health Organization reported that as of June 16, 2020, Mexico has 146,837 confirmed cases and 17,141 deaths.⁵

C. CBP's Operations at or Near the U.S.-Canada and U.S.-Mexico Borders

The U.S.-Canada border spans nearly 4,000 miles, and the U.S.-Mexico border runs approximately 2,000 miles. *Id.* at 7, 10. There are 328 land ports of entry along the borders, where CBP processes aliens to determine their admissibility. CBP also operates 136 Border Patrol stations to apprehend, process, and temporarily hold aliens who seek to unlawfully enter the country between ports of entry. *Id.* at 12.

Through February of Fiscal Year (“FY”) 2020, CBP processed more than 20,000 inadmissible aliens at ports of entry along the U.S.-Canada border and apprehended an additional 1,200 inadmissible aliens. *Id.* at 7. These aliens included nationals of countries with significant COVID-19 outbreaks. *Id.* The number of inadmissible aliens CBP processed along the U.S.-Mexico border is much higher; as of March, CBP processed more than 34,000 inadmissible aliens at ports of entry and apprehended an additional 117,000 inadmissible aliens in FY 2020. *Id.* at 10. Over 15,000 of the apprehended individuals were nationals of countries other than Mexico that have been experiencing sustained human-to-human COVID-19 transmission. *Id.*

Aliens who lack proper travel documents would typically be deemed inadmissible and take much longer to screen than U.S. citizens and those with valid travel documents. *Id.* at 11. During the extended processing time for those aliens—which may run from several hours to several days—they typically remain in close proximity to CBP personnel and other travelers. *Id.* As for aliens apprehended between ports of entry and taken to a Border Patrol station, they too are held in close proximity to others in the ordinary course of the administration of U.S. immigration laws. Although Border Patrol stations vary significantly in size and layout, they generally have

⁵ See WHO Coronavirus 2019, Situation Report 138, at 8, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200616-covid-19-sitrep-148-draft.pdf?sfvrsn=9b2015e9_2.

congregate holding areas that can temporarily hold only 150 to 300 people standing shoulder-to-shoulder. *Id.* at 12. A typical station also has only two to five separate holding areas. *Id.* If not released by CBP, an alien subject to the Order would spend an average of roughly 78 hours in a Border Patrol station before being transferred to U.S. Immigration and Customs Enforcement (“ICE”). *Id.* Only 46 of CBP’s 136 Border Patrol stations offer any medical services at all, and those services are limited to basic emergency care, as well as testing for glucose, pregnancy, and influenza. *Id.*

II. STATUTORY AND REGULATORY BACKGROUND

A. The Public Health Service Act

As previously noted, the CDC Order was issued under the authority found in 42 U.S.C. § 265, which provides:

Whenever [the Secretary] determines that by reason of the existence of any communicable disease in a foreign country there is serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health, the [Secretary], in accordance with regulations approved by the President, shall have the power to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate in order to avert such danger, and for such period of time as he may deem necessary for such purpose.

The provision is substantively identical to its predecessor statute, the Act of February 15, 1893, ch. 114, § 7, 27 Stat. 449, 452, which initially vested the authority in the President. That authority was later vested in the Surgeon General by the Public Health Service Act of 1944, Pub. L. No. 78-410, 58 Stat. 682, and then in the Secretary of Health and Human Services in 1966.⁶

⁶ Reorganization Plan No. 3 of 1966 abolished the Office of the Surgeon General and transferred the Surgeon General’s statutory powers and functions to the Secretary of Health, Education and Welfare, now the Secretary of Health and Human Services, 31 Fed. Reg. 8855, 80 Stat. 1610 (June 25, 1966); *see also* Pub. L. No. 96-88, § 509(b), 93 Stat. 668, 695 (1979) (codified at 20 U.S.C. § 3508(b)). Although the Office of the Surgeon General was re-established in 1987, the Secretary of Health and Human Services has retained the authorities previously held by the Surgeon General.

A separate provision of the Public Health Service Act, section 365(b), authorizes “customs officers” to assist in the implementation of any Section 265 order. *See* 42 U.S.C. § 268(b) (“It shall be the duty of the customs officers . . . to aid in the enforcement of quarantine rules and regulations . . .”). Pursuant to 19 U.S.C. § 1401(i), U.S. Border Patrol agents have been designated as “customs officers.” *See* Declaration of Robert Danley, ¶ 2, dated June 17, 2020. Similarly, officers in Enforcement and Removal Operations at the U.S. Immigration and Customs Enforcement (“ICE”) have been delegated the authority of “customs officers” identified in the CDC Order. *See* Declaration of Danielle Hernandez, ¶ 3, dated June 17, 2020.

B. The Interim Final Rule

The COVID-19 pandemic highlighted the need for an efficient regulatory mechanism to suspend the introduction of persons who would otherwise increase the serious danger of introducing a communicable disease into the United States. *See* IFR at 11. As the CDC found, “[i]nternational travel and migration play a significant role in the global transmission of infectious biological agents or their toxic products,” as travelers can serve as unwitting vectors of disease—*i.e.* carriers of a pathogenic agent and potential sources of infection for others—and thus increase the risk of introducing the disease into the United States. *Id.* at 5. That risk increases when travelers are in “congregate settings,” such as ships or planes, as well as terminals with shared sitting, sleeping, eating, or recreational areas. *Id.* at 6.

Accordingly, on March 20, 2020, HHS issued an interim final rule to allow the CDC Director to invoke the authority in Section 265. The IFR took effect immediately due to the national emergency, *see* 5 U.S.C. § 553(b)(3)(B) and (d), and defines “introduction into the United States of persons from a foreign country” or place to mean “the movement of a person from a foreign country” or place into the United States (1) “so as to bring the person into contact with persons” in the United States or (2) to cause the contamination of property in the United States “in a manner that the Director determines to present a risk of transmission of a communicable disease to persons or property, even if the communicable disease has already been introduced, transmitted, or is spreading within the United States.” IFR at 27. Further, it defines “[s]erious danger of the

introduction of such communicable disease into the United States” to mean “the potential for introduction of vectors of the communicable disease into the United States, even if persons or property in the United States are already infected or contaminated with the communicable disease.” *Id.* at 28. Finally, the IFR excludes U.S. citizens and lawful permanent residents, among others, from the scope of any Section 265 order. *Id.* at 18-19.

The comment period for the IFR has since closed. The CDC is currently considering the public comments it received and expects to issue a final rule in due course. *Id.* at 13.

C. The CDC’s Section 265 Order

The same day the Interim Final Rule took effect the CDC Director issued an order temporarily suspending the introduction of certain aliens from Canada and Mexico into the United States. The Director found a serious danger that COVID-19 will be introduced into ports of entry and Border Patrol stations, as well as the interior of the country, because the disease exists in Canada, Mexico, and the countries or places of origins of the aliens who travel to the United States by crossing our northern and southern borders. Order at 15–16.

Based on information provided by DHS and a U.S. Public Health Service Scientist Officer’s visit to the El Paso del Norte Port of Entry, Paso del Norte Border Crossing, *id.* at 13; Ex. 1 to Order, the CDC Director determined that ports of entry and Border Patrol stations at or near the northern and southern borders are not structured or equipped to effectively mitigate the risks presented by COVID-19—*i.e.*, to implement quarantine, isolation, or social distancing protocols—even for small numbers of aliens. Order at 14. Rather, these facilities were designed for short-term holding in a congregate setting. *Id.* And many aliens (typically those who lack valid travel documents and would therefore be found inadmissible during immigration processing) are held in the common areas of these facilities, in close proximity to one another, for hours or days, as they undergo immigration processing. *Id.* at 1; *see also id.* at 12 (noting that, on average, an alien subject to the Order apprehended between ports of entry would otherwise spend approximately 78 hours in a Border Patrol station before being transferred to ICE).

The CDC Director also found CBP's then-existing screening protocol for COVID-19 unworkable for large numbers of individuals. An influx of infected, asymptomatic aliens would present significant infection control challenges for CBP because the screening of such aliens may not trigger testing (to the extent that testing resources are available). *Id.* at 12. The aliens would remain in congregate areas while CBP finishes the screening and processing. *Id.* During that time, the alien could infect CBP personnel or other aliens with COVID-19. *Id.* If CBP determined that an alien may be exposed to or infected with COVID-19, it would notify the local health department and the CDC personnel, if available, to determine whether the individual should be tested for COVID-19 and where that testing should occur. *Id.* If testing was to occur, CBP followed guidance from CDC and local health officials regarding transport to the testing site, including disinfecting the vehicles used for such transport. *Id.*

As of March 20, 2020, testing required analyzing collected specimens in a laboratory setting with results available only after three to four days.⁷ *Id.* at 4. And for those aliens who test positive for COVID-19 as a result of following the above protocol, the ports of entry and Border Patrol stations lack the capacity to provide the necessary medical care. *Id.* at 15. Only a handful of facilities offer medical services directly, and those services are relatively limited. *Id.* Thus, DHS must rely on local and regional hospitals (which sometimes can be far away) and emergency medical resources. *Id.* But states along the southern border have some of the lowest numbers of hospital beds per 1,000 inhabitants in the United States. *Id.* Moreover, Arizona, California, and Texas also have some of the largest numbers of residents living in primary care shortage areas. *Id.* Shifting resources to large numbers of infected aliens, the CDC Director found, would divert the

⁷ Although rapid testing for COVID-19 has since been developed, such testing is not yet widely available. April Order at 5–6. The CDC Director also determined that rapid testing should be prioritized at places such as hospitals so as to increase the availability of care providers by eliminating the need for such individuals to self-isolate while awaiting results. *Id.*

limited resources away from the domestic population, while increasing the risk of exposure to the virus for healthcare workers.⁸ *Id.*

To mitigate the risks presented by COVID-19, the CDC Order requires returning all “covered aliens” as rapidly as possible and with as little time spent in congregate setting as is feasible, to the country from which they entered the United States, their country of origin, or to another location as practicable and appropriate. *Id.* at 16. “Covered aliens” are those persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land port of entry or Border Patrol station at or near the U.S. borders with Canada and Mexico.⁹ *Id.* at 2. Excluded from the scope of the Order are, among others, U.S. citizens and aliens who arrive at a point of entry with valid travel documents or are in the visa waiver program and are not otherwise subject to travel restrictions.¹⁰ *Id.* The Director explained that the sooner a covered alien is returned, the lower the risk that alien spreads COVID-19 into ports of entry, Border Patrol stations, and the interior of the country. *Id.*

The Director also found that conditional release is not a viable option because there is significant uncertainty that covered aliens would be able to effectively self-quarantine, self-isolate, or otherwise comply with existing social distancing guidelines, not to mention that the CDC lacks the resources and personnel necessary to effectively monitor a large number of people so released. *Id.* at 15; May Order at 11. Finally, the Order requested DHS’s assistance in its implementation because the CDC lacks the capability and resources to do so. *Id.* at 16. Such assistance is expected

⁸ The CDC Director later also determined that, while it is theoretically possible—although not immediately feasible—to structurally expand and retrofit ports of entry and Border Patrol stations, and to equip and train DHS personnel, in order to contain COVID-19, such an endeavor would be ill-advised because it would consume a significant amount of scarce medical resources that could otherwise be used to meet the needs of domestic population. May Order at 7.

⁹ The Director has expanded the scope of the Order to apply it to *coastal* points of entries and Border Patrol stations at or near the U.S.-Canada and U.S.-Mexico borders. May Order at 6.

¹⁰ In addition, customs officers may, with supervisor approval, except otherwise covered aliens from the Order based on the totality of the circumstances, including considerations of significant law enforcement, officer and public safety, humanitarian, and public health interests. Order at 2.

within the Title 42 scheme, which imposes a duty on customs officers to help implement any section 265 orders. 42 U.S.C. § 268(b).

The Order was initially effective for 30 days, but the CDC Director has extended it twice. The Order will now remain in effect—subject to periodic review every 30 days—until the CDC Director determines that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and continuation of the Order is no longer necessary to protect the public health. May Order at 1. In extending the Order, the Director found that the public health risks sought to be mitigated by the Order remain and are unlikely to abate in the near term. *See id.* at 10; April Order at 2. In the Director’s view, limiting the spread of COVID-19 to unaffected or less-affected areas of the United States and slowing the spread of COVID-19 in highly impacted areas are critical as individual states begin to ease public health restrictions on businesses and public activities (in an effort to mitigate the economic and other costs of the COVID-19 pandemic). May Order at 6. This requires limiting the number of infected individuals who may enter these areas. *Id.*; April Order at 5. And it would be counterproductive to relax restrictions on the introduction of covered aliens who risk transmitting COVID-19 within DHS facilities and the country’s interior and crippling DHS’s workforce and local and regional healthcare systems. May Order at 4; April Order at 2. This is particularly the case given the lack of vaccines or approved and widely available therapeutics for COVID-19. May Order at 10.

Indeed, the Government has a particularly significant interest in ensuring the protection of DHS personnel, who in addition to performing various immigration functions, also perform important law enforcement functions and work to ensure the smooth flow of goods and essential personnel across the U.S. borders with Canada and Mexico. Significant outbreaks of COVID-19 among DHS personnel could, for example, have significant adverse impacts on the country’s food and manufacturing supply chains. Finally, in extending the Order in May 2020, the Director also found that the Order has significantly mitigated the specific public health risk identified in the initial issuance of the Order by significantly reducing—by 88 percent—the population of covered

aliens held in congregate settings in ports of entry and Border Patrol stations, thereby reducing the risk of COVID-19 infection among DHS personnel and others within these facilities. *Id.* at 3.

D. The Immigration Processing of Aliens at the Border

1. Asylum, Withholding of Removal, and the CAT

DHS's infection control challenges must be assessed against the backdrop of immigration processes occurring at ports of entry and Border Patrol stations that otherwise allow aliens to apply for protection from removal from this country. One such process is an application for asylum, which is a form of discretionary relief. *See* 8 U.S.C. § 1158(a)(1). An alien may be eligible for asylum if he demonstrates, *inter alia*, that he is "unable or unwilling to return to" his home country "because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." *Id.* § 1101(a)(42)(A); *see id.* § 1158(a)(1) and (b)(1)(B)(i). In addition, an alien may be entitled to withholding of removal if he establishes the likelihood that his life or freedom would be threatened in the country of removal on account of race, religion, nationality, membership in a particular social group, or political opinion. *Id.* § 1231(b)(3). And an alien may be entitled to protection under Article 3 of the CAT, if he demonstrates that there are "substantial grounds for believing that he would be in danger of being subjected to torture." Dec. 10, 1984, S. Treaty Doc. No. 20, 100th Cong., 2d Sess. 19 (1988), 1465 U.N.T.S. 85, 114; *see also* 8 C.F.R. § 1208.16(c)(2)(providing for statutory protection of withholding under CAT if it is "more likely than not that he or she would be tortured if removed to the proposed country of removal.").

The Immigration and Nationality Act ("INA") establishes general procedures for DHS to process aliens who are "applicant[s] for admission" to the United States, whether they arrive at a port of entry or cross the border unlawfully. 8 U.S.C. § 1225(a)(1), (3). Under the INA, all such aliens must be inspected by immigration officers concerning their right to enter the United States. *Id.* § 1225(b)(1), (b)(2)(A). A full removal proceeding is authorized for any "applicant for admission" whom an immigration officer determines is "not clearly and beyond a doubt entitled to be admitted." *Id.* § 1225(b)(2)(A); *see also id.* § 1229; § 1229a; 8 C.F.R. § 1003.1. An

immigration officer, however, may elect to place certain aliens in an expedited removal proceeding described in 8 U.S.C. § 1225(b)(1), in which the alien will be “removed from the United States without further hearing or review,” unless he claims a fear of persecution or torture, or expresses an intent to apply for asylum. *Id.* § 1225(b)(1)(A)(i). An alien is detained during inspection or an asylum interview, *id.* § 1225(b)(1)(B)(ii), (iii)(IV), (iv), and may request to be paroled into the United States under § 1182(d)(5), or, in certain cases, under § 1226, pending resolution of his or her immigration proceedings.

The credible fear interview by an asylum officer assesses whether there is a significant possibility that the alien could establish eligibility for asylum, withholding of removal or protection under the CAT. *See id.* §§ 1225(b)(1)(B)(v), 1158, 1231(b)(3); 8 C.F.R. §§ 208.16-.18, 1208.16-.18, 208.30(e). If the officer finds that the individual does not have a credible fear, that finding shall not become final until reviewed by a supervisory asylum officer. 8 C.F.R. § 208.30(e)(8). If the supervisory asylum officer agrees that there is no credible fear, the asylum officer shall provide the alien with a written notice of that decision. *Id.* § 208.30(g). The alien may request review of a negative credible fear determination by an immigration judge. *Id.* § 1225(b)(1)(B)(iii)(III); *see also* 8 C.F.R. § 235.3(b)(4)(i)(C). If the asylum officer or immigration judge determines that the alien has established a credible fear of persecution or torture, the alien is referred for removal proceedings under 8 U.S.C. § 1229a to challenge his or her removability. 8 C.F.R. §§ 1225(b)(1)(B)(ii), 208.30, 1208.30.

All of these procedures affect an alien’s length of stay at a port of entry or Border Patrol station and in the United States, and potentially present the public health concerns of further spread of COVID-19 into the United States. Even expedited removal proceedings require examination by immigration officials that could put both aliens held together in congregate setting and DHS personnel at risk of contracting COVID-19.

2. The Processing of Unaccompanied Alien Children

Section 235 of the William Wilberforce Trafficking Victims Protection and Reauthorization Act of 2008 (“TVPRA”), Pub. L. No. 110-457 (codified in principal part at 8

U.S.C. § 1232), provides certain additional protections to unaccompanied alien minors subject to the removal scheme under the immigration provisions of Title 8 of the U.S. Code, as defined in 6 U.S.C. § 279(g)(2). For example, an unaccompanied minor from a non-contiguous country sought to be removed generally must be placed in full removal proceedings under 8 U.S.C. § 1229a, in lieu of expedited removal proceedings. *See* 8 U.S.C. § 1232(a)(5)(D)(i). And unaccompanied minors who remain in the country, subject to Title 8 immigration provisions, must be placed in the custody of the Office of Refugee Resettlement (“ORR”) of the Department of Health and Human Services (“HHS”), which must place the child with a care provider in the “least restrictive setting that is in the best interest of the child,” subject to considerations of danger to self, danger to others, and risk of flight. *See id.* § 1232(c)(2)(A). ORR also conducts ongoing assessments as to whether a proposed custodian is capable of providing for the child’s physical and mental well-being. *See id.* § 1232(c)(3)(A).

In addition, in the ordinary course, any federal department or agency that has custody of an unaccompanied minor must transfer custody of the minor to ORR within 72 hours of determining that the child is unaccompanied, as defined by 6 U.S.C. § 279(g)(2). *See id.* § 1232(b)(3). This requirement does not apply “in the case of exceptional circumstances.” *Id.*

III. Plaintiff and His Request for Emergency Relief

Plaintiff is a 16-year-old from Honduras. Compl. ¶ 3, ECF No. 1. On June 4, 2020, he was apprehended approximately one mile from the border after illegally entering the United States near El Paso, Texas. *Id.* ¶¶ 17, 80; Danley Decl., ¶ 3. He asserts that he was afraid for his life in Honduras and journeyed to the United States to join his father, who lives in Texas and is awaiting his own immigration proceedings. Pl.’s TRO Motion & Br. in Supp. [“Mot.”] at 3, 4, ECF No. 2-1; Compl., ¶ 3. On or about June 4, U.S. Border Patrol determined that he is a “covered alien” under the CDC Order. Danley Decl., ¶ 4. Accordingly, he was scheduled to be returned to Honduras and was moved to a hotel to await the next available flight to Honduras, which was scheduled for June 10, 2020. Hernandez Decl., ¶¶ 4, 5. In moving him to a hotel, DHS ensured that Plaintiff is provided basic necessities, including daily medical visits, room cleaning, and

telephone (or video) calls with family. *Id.* ¶ 7. On June 10, 2020, the U.S. Citizenship and Immigration Services (“USCIS”) provided a screening interview. *Id.* ¶ 6. Based on that interview, USCIS issued a decision finding that Plaintiff did not meet his burden of establishing that it is more likely than not that he would be subjected to torture if returned to Honduras. *Id.* In other words, USCIS determined that Plaintiff does not meet the threshold screening required to place Plaintiff in removal proceedings in order to seek protection under the CAT.

STANDARD OF REVIEW

“The standard for obtaining injunctive relief through either a temporary restraining order or a preliminary injunction is well established.” *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 6, 7–8 (D.D.C. 2010). The movant must satisfy a four-prong test, establishing “that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). A TRO or a preliminary injunction “is an extraordinary and drastic remedy.” *Munaf v. Geren*, 553 U.S. 674, 689 (2008) (citation omitted). It is “never awarded as of right,” *id.* at 690, and “should not be granted unless the movant, by a clear showing, carries the burden of persuasion.” *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). Here, Plaintiff fails to meet his burden.

ARGUMENT

I. PLAINTIFF IS UNLIKELY TO SUCCEED ON THE MERITS

In challenging the Government’s plan to return him to his home country, Plaintiff argues that the CDC Order is contrary to law and is otherwise arbitrary and capricious. He is not likely to succeed on either of those theories.

A. Plaintiff Is Unlikely to Succeed in Showing that the CDC Order Is Unauthorized by Section 265

Plaintiff argues that Title 42 does not allow the Government to return aliens like him—who have physically crossed the border into the United States but are apprehended at or near the border—to their home countries. *See* Mot. at 8. But Section 265 gives the CDC Director the

“power to prohibit . . . the introduction of persons” from a foreign country to prevent a communicable disease from spreading to the United States. 42 U.S.C. § 265. To effectuate Section 265’s purpose of preventing the transmission of a communicable disease, the power to “prohibit” a person’s “introduction” necessarily includes the power to physically remove the person even after he has unlawfully crossed the border into the United States and is apprehended near the border. Indeed, it has long been recognized that “where a general power is conferred or duty enjoined, every particular power necessary for the exercise of the one, or the performance of the other, is also conferred.” *Luis v. United States*, 136 S. Ct. 1083, 1097 (2016) (Thomas, J., concurring) (quoting Thomas Cooley, *Constitutional Limitations* 63 (1868)); see also 1 J. Kent, *Commentaries on American Law* 464 (13th ed. 1884) (“whenever a power is given by a statute, everything necessary to the making of it effectual or requisite to attain the end is implied”). Congress’s use of the term “introduction”¹¹ also signals that the Executive’s authority under Section 265 is not limited to the Nation’s borders.¹² As the current pandemic illustrates, the insidious nature of communicable diseases does not lend itself to limitation by geographic boundaries. Congress clearly intended public health experts to be able to flexibly respond to the exigency posed by the spread a contagious disease, including by suspending the introduction of vectors from abroad.

¹¹ See *Universal English Dictionary* 1067 (John Craig ed. 1861) (defining “introduction” to include, inter alia, “the act of bringing into a country” as well as “the ushering of a person into presence”); 1 *American Dictionary of the English Language* 113 (Noah Webster ed., 1st ed. 1828) (similar definitions).

¹² Moreover, even those aliens who are “apprehended within hours of surreptitiously entering the United States” are still treated as “‘alien[s] seeking initial admission to the United States.’” *Castro v. U.S. Dep’t of Homeland Sec.*, 835 F.3d 422, 445 (3d Cir. 2016) (quoting *Landon v. Plasencia*, 459 U.S. 21, 32, (1982)); see also *Cruz v. Dep’t of Homeland Sec.*, No. 19-CV-2727, 2019 WL 8139805, at *5 (D.D.C. Nov. 21, 2019) (fact that plaintiff was apprehended within the territorial bounds of the United States after crossing the U.S.-Mexico border does not overcome the fact that he has not “effected entry into this country”); cf. *Leng May Ma v. Barber*, 357 U.S. 185, 188–190 (1958) (alien “paroled” into the United States pending admissibility determination had not effected an “entry”).

To the extent the statute leaves any ambiguity, the agency has reasonably interpreted “the introduction of persons” to “encompass those who have physically crossed a border of the United States and are in the process of moving into the interior in a manner the Director determines to present a risk of transmission of a communicable disease.” IFR at 16. That interpretation is reasonable and entitled to *Chevron* deference because, again, the public health concerns that Section 265 is designed to address do not evaporate the minute an alien crosses the border into the United States, nor do they depend on how quickly Border Patrol agents are able to apprehend the alien near the border. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984).

As the CDC Director found, the risk of transmission of COVID-19 into the United States by aliens who have illegally crossed the border is no less than that posed by aliens seeking to enter the United States through a port of entry. *See Order* at 11–13. In both situations, the aliens would be processed or otherwise held in congregate settings if found inadmissible during immigration processing. *Id.* Indeed, “covered aliens” are not likely to present themselves at ports of entry or Border Patrol stations. CBP can apprehend them only after they have crossed into the United States. The border itself is an invisible line defined in cartographic terms, and given these practicalities, Congress surely would not have intended to exempt aliens once they cross into the United States, since that is the only place CBP can apprehend them.

It would be incongruous to say that section 265 orders could be legally applied to aliens seeking to lawfully enter the country at a port of entry but not to aliens who sought to circumvent the law by surreptitiously crossing the border between points of entry. The legality of the Section 265 authority cannot turn on whether an alien happened to be caught before successfully slipping across the border. Otherwise the proper applicability, and lawfulness, of Section 265 would perversely turn on whether an alien had attempted to evade the law. Likewise, it makes no difference whether the alien is captured one foot or, here, approximately one mile from the border. Congress enacted a statute that aims to mitigate the introduction of such aliens altogether; Congress did not limit that aim to the border line alone. For this reason, “covered aliens” under

the CDC Order include aliens who unlawfully enter the United States between ports of entry and are apprehended at or near the U.S.-Canada or U.S.-Mexico borders.

Plaintiff makes several arguments, none of which has merit.

First, he argues that Title 42 of the U.S. Code, which governs public health, authorizes only “testing, and in extreme cases, detention and quarantine,” not “the removal of people from the United States.” Mot. at 1–2, 9. This is clearly belied by the relevant statutory text. Section 264 of Title 42 does authorize those public health measures. *See* 42 U.S.C. § 264(b), (d)(1). But as discussed above, Section 265 separately authorizes the Secretary to prohibit the introduction of persons from a designated country or place. The power to return individuals such as Plaintiff to their home countries is necessary for the Secretary to stop the introduction of those persons into the United States.

Second, Plaintiff contends that returning him to his home country would be an unauthorized penalty under 42 U.S.C. § 271(a). Mot. at 8. That provision prescribes “[p]enalties for violation of quarantine laws,” and as Plaintiff says, it does not mention “removal” from the United States, *id.* at 8. But halting the introduction of the person by returning him to his home country is not a criminal punishment like that specified in section 271(a). It is a measure designed to protect the public health and mitigate the spread of a communicable disease into the interior of the United States. Moreover, section 271(a) has no bearing on the scope of Section 265. By its plain terms, section 271 imposes fines and imprisonment for violations of *regulations* promulgated under Section 265 and other Public Health Service Act provisions related to quarantine. *See* 42 U.S.C. § 271(a). Plaintiff’s return, in contrast, occurs under Section 265 itself pursuant to the Interim Final Rule and the CDC Order.

Third, Plaintiff argues that Congress could not possibly have intended to authorize “expulsion” because Section 265 applies to citizens and non-citizens alike. Mot. at 9. “It is inconceivable,” Plaintiff asserts, “that Congress would seek to give the executive branch that (plainly unconstitutional) power.” *Id.* at 10. Plaintiff is wrong. As an initial matter, the Interim Final Rule explicitly excludes U.S. citizens from the scope of any section 265 order. *See* IFR at

18-19. It is an academic question whether Section 265 could constitutionally be applied to U.S. citizens to temporarily delay their entry into the United States; Plaintiff is not a U.S. citizen and again, the IFR excludes U.S. citizens from any section 265 order. As relevant here, however, U.S. citizens entering the United States are not similarly situated to persons within the scope of the Order because they would not typically be held in congregate settings at ports of entry or Border Patrol stations.

In any event, Plaintiff's interpretation finds no support in the statute's text or legislative history, which evince Congress's intent to grant the Executive Branch very broad powers to prevent the spread of communicable diseases into the United States. Section 265 has its origin in the Act of February 15, 1893, ch. 114, § 7, 27 Stat. 449, 452. As initially proposed, the 1893 Act would have given the President the power to suspend "immigration" from such foreign countries or places that he shall designate. *See* H.R. 9757, 52nd Cong., 2d Sess., Report No. 2210 (Jan. 9, 1893); *see also* 24 Cong. Record 470 (Jan. 10, 1893) (Senator George Gray explaining that the exigency posed by "invasion of contagious disease[] is sufficient . . . to justify this extraordinary power of the entire suspension of immigration"). But ultimately, the specific reference to immigration was removed, not to circumscribe the Executive's authority but rather, to give the President even broader authority. As enacted, the Executive had the power to "prohibit, in whole or in part, the introduction of" all "*persons.*" *Id.* 471; *see id.* (Senator William Chandler: "A discretion to do an act of this kind in a great emergency certainly ought to have the authority coupled with it to act either in whole or in part according to the exigency."). That is, the inclusion of U.S. citizens within the scope of Section 265 in no way indicates the limitation Plaintiff proposes. *Id.*

Finally, contrary to Plaintiff's argument, his planned return is not a "deportation," "expulsion," or "removal" within the meaning of the INA. *See* Mot. at 7. Rather, his planned return is for the express purpose of halting his "introduction" into the United States and thereby protecting the public health, as Section 265 permits. Indeed, CBP's apprehension of Plaintiff was pursuant to the Public Health Service Act, which provides that "it shall be the duty of customs

officers . . . to aid in the enforcement” of the CDC Order, *see* 42 U.S.C. § 268(b), not as part of CBP’s statutory authorities under the immigration laws. And as the CDC Director found, “[i]t is necessary for the public health to immediately suspend the introduction of covered aliens,” and such suspension “requires the movement of all such aliens to the country from which they entered the United States, [] their country of origin, or another location as practicable, as rapidly as possible, with as little time spent in congregate settings as practicable under the circumstances.” Order at 16.

In sum, Section 265 authorizes the Government to return Plaintiff to his home country and Plaintiff’s contrary arguments are unlikely to succeed.

B. Plaintiff Is Unlikely to Succeed in Showing that the CDC Order Violates the CAT, the TVPRA, and the Asylum and Withholding of Removal Statutes

Plaintiff contends that whatever Title 42 authorizes, “it cannot override the provisions of the immigration laws providing protection to unaccompanied alien children and those seeking protection.” Mot. at 11. This is so, according to Plaintiff, because such immigration laws—*i.e.*, the CAT, the TVPRA, and the asylum and withholding of removal statutes—are more specific than Section 265 and were enacted later in time. Plaintiff is unlikely to succeed on this argument.

1. The Government’s plan to return Plaintiff to Honduras does not violate its obligations under the CAT.

As an initial matter, the Government has complied with its obligations under the CAT in this case. The United States’ obligations under Article 3 of the CAT were implemented through the Foreign Affairs Reform and Restructuring Act of 1998 (“FARRA”), Pub. L. No. 105-207, Div. G, Title XXI, 112 Stat. 2681 (codified at 8 U.S.C. § 1231 note). FARRA provides that “[i]t shall be the policy of the United States not to expel, extradite, or otherwise effect the involuntary return of any person to a country in which there are substantial grounds for believing the person would be in danger of being subjected to torture, regardless of whether the person is physically present in the United States.” FARRA § 2242(a). FARRA further specifies that except as provided by regulation, no court shall have jurisdiction to review any claim or determination raised under the

CAT “except as part of the review of a final order of removal pursuant to section 242 of the [INA].” *Id.* § 2242(d); *see also Omar v. McHugh*, 646 F.3d 13, 18 (D.C. Cir. 2011) (Kavanaugh, J.) (“It is true that § 2242(a) of the FARR Act states a broad ‘policy’ that the Executive Branch presumably has a responsibility to follow with respect to all transfers, at least absent any claim of unconstitutionality under Article II of the Constitution. The Act also plainly says, however, that only immigration transferees may obtain judicial review of conditions in the receiving country before they are transferred.”). DHS and DOJ regulations promulgated under FARRA prohibit the “removal” of an alien if it is more likely than not that the alien would be tortured in the country of removal either by or with the acquiescence of a public official. 8 C.F.R. §§ 208.16(c)(2), 1208.16(c)(2); *see also id.* §§ 208.16(c)-.18, 1208.16(c)-.18; FARRA § 2242(b).

Here, Plaintiff’s planned return is not pursuant to “a final order of removal” under the INA. Moreover, as Plaintiff concedes, even when implementing the CDC Order, DHS will refer an alien for a CAT interview if the alien claims a fear. *See Mot.* at 14 n.4; *see also Hernandez Decl.*, ¶ 6. The screening interview is conducted by an USCIS asylum officer who assesses whether it is more likely than not that the alien would be tortured, as that term is defined by the CAT, in the country to which he or she would be sent. *Hernandez Decl.*, ¶ 6. Here, Plaintiff was given a screening interview on June 10, 2020. *Id.* ¶ 6. Based on that interview, USCIS determined that he does not meet the threshold screening standard required to place Plaintiff in removal proceedings in order to seek protection under the CAT. *Id.* And in any event, the FARRA is clear that this Court has no jurisdiction to review that determination. FARRA § 2242(d); *cf. Trinidad y Garcia v. Thomas*, 683 F.3d 952, 957 (9th Cir. 2012) (en banc) (if process to determine whether alien will not be subject to torture under FARRA has been applied, “the court’s inquiry shall have reached its end”). Plaintiff, therefore, is unlikely to be able to show that his planned return to his home country violates the United States’ obligations under Article 3 of the CAT.

As discussed below, Plaintiff also is not likely to succeed in showing a violation of the other immigration laws he identified.

2. Congress intended the Public Health Service Act provisions to temporarily take precedence over the procedures afforded under the immigration laws.

Using traditional tools of statutory construction, it is evident that Congress did not intend Section 265 to operate alongside the procedures afforded under the immigration laws in times of a public health crisis governed by Section 265—namely when there is a serious danger of a communicable disease spreading into the United States through the introduction of persons.¹³ This Court should give effect to the intent embodied in the Public Health Service Act provisions, Sections 265 and 268(b). *See Chevron*, 467 U.S. at 843 n.9 (“If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.”); *see, e.g., Nat’l Ass’n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 666 (2007) (analyzing two statutory provisions to see if they could coexist); *Career Coll. Ass’n v. Riley*, 74 F.3d 1265, 1272 (D.C. Cir. 1996) (analyzing statute to see if Congress resolved a situation where “two statutory provisions are . . . in considerable tension”).

At least three canons of statutory construction supports the reading that the immigration laws must temporarily give way.

First, the canon of “the specific governs the general” supports the Government’s interpretation. This canon applies to disentangle the interplay between “laws of equivalent dignity,” *Nitro-Lift Techs., LLC v. Howard*, 568 U.S. 17, 21 (2012), and resolves the perceived conflict by “carving out an exception from the more general enactment for the more specific

¹³ Even aside from the congressional intent that immigration laws, including the TVPRA, must give way in times of a public health crisis, the Government did not violate the TVPRA’s provision concerning the transfer of an unaccompanied alien child to HHS custody within 72 hours. *See* Mot. at 11. By its plain terms, the TVPRA does not require such transfer of custody in “exceptional circumstances,” 8 U.S.C. § 1232(b)(3), which plainly are present here, given the current pandemic and the CDC Order requiring the return of covered aliens like Plaintiff as soon as practicable. As noted before, although Plaintiff could not be immediately repatriated to his home country due to the flight schedule, he was moved to a hotel where his basic necessities are being met. *Hernandez Decl.*, ¶¶ 4, 7.

statute.” *Stewart v. Smith*, 673 F.2d 485, 492 (D.C. Cir. 1982) (citing *Fourco Glass Co. v. Transmirra Prods. Corp.*, 353 U.S. 222, 228-29 (1957)); *see also RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). Courts have used this rule of construction to interpret provisions in different titles of the U.S. Code, *see, e.g., Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153 (1976); *Lewinsohn v. United States*, 278 F. 421, 429 (7th Cir. 1921), and clauses in different articles of the Constitution, *see, e.g., Aurelius Inv., LLC v. Puerto Rico*, 915 F.3d 838, 851 (1st Cir.), *rev’d on other grounds sub nom. Fin. Oversight Bd. for P.R. v. Aurelius Inv., LLC*, -- S. Ct. --, 2020 WL 2814298 (S. Ct. June 1, 2019); *Albright v. Oliver*, 510 U.S. 266, 273–74 (1994) (plurality opinion) It does not matter that the specific statute was enacted earlier than the more general statute. *See Radzanower*, 426 U.S. at 153 (“It is a basic principle of statutory construction that a statute dealing with a narrow, precise, and specific subject is not submerged by a later enacted statute covering a more generalized spectrum.”); *Bulova Watch Co. v. United States*, 365 U.S. 753, 758 (1961) (same).

Here, contrary to Plaintiff’s argument, the public health provisions are more specific than the immigration laws, as made clear by the scope of their application. They apply only in a rare and specific circumstance—when the CDC Director determines that there is a serious danger of a communicable disease spreading into the United States from a foreign country and, consequently, a temporary suspension of introduction of persons from that country is necessary for the public health. The immigration laws, by contrast, apply across the board whenever an alien seeks to enter the United States without regard to the existence of a public health emergency.

Beyond the plain language of Section 265, which evinces the narrowness of its scope, the legislative history confirms that Congress intended to confer a specific, targeted power that would supersede the immigration laws for the duration of a public health emergency. As discussed above, the provision’s predecessor is the Act of February 15, 1893, ch. 114, § 7, 27 Stat. 449, 452. As initially proposed, the 1893 Act would have provided the President the “power to suspend immigration” from specified foreign countries or places. *See H.R. 9757*, 52nd Cong., 2d Sess., Report No. 2210 at 3 (Jan. 9, 1893); *see also id.* at 4 (noting that “[t]housands of immigrants may

pass through inspection at a port of entry, and still upon arriving at their destination . . . may disseminate the poison that has been slumbering in their midst and imperil the lives of any community in which they happen to locate”); 24 Cong. Record 470 (Jan. 10, 1893) (statement of Senator George Gray explaining that the exigency posed by “invasion of contagious disease[] is sufficient . . . to justify this extraordinary power of the entire suspension of immigration”). Ultimately, the specific reference to immigration was removed and replaced with the power to prohibit the introduction of all *persons*. Importantly, Congress did so not to circumscribe the President’s authority, but rather to give the President even broader power to respond to a public health crisis. *See* 24 Cong. Record 472. That this is the first time the Government has invoked Section 265 in 127 years—and did so only in the face of the World Health Organization’s declaration of an unprecedented global pandemic—underscores the specific, targeted nature of the provision.¹⁴

Plaintiff and amici argue that Congress has already accounted for public health concerns about communicable diseases in the immigration laws. *See* Mot. at 9 (citing 8 U.S.C. § 1182(a)(1) (“[h]ealth-related grounds” of inadmissibility, including communicable diseases); 8 U.S.C. § 1222 (“[d]etention of aliens for physical and mental examination”)); Br. for Scholars of Refugee & Immigration Law as Amici Curiae at 9, ECF No. 19 (no motion for leave filed). In amici’s view, the purportedly “earlier enacted” Section 265 does not “free the Executive Branch from the restrictions against removal in those later-enacted laws.” *Id.*

But Congress clearly did not intend for the cited immigration law provisions to address the type of national public health emergency the country currently faces. Those provisions are focused on individual aliens’ circumstances, whereas Section 265 is specifically designed to address the public health consequences of allowing persons from other countries to enter the United States

¹⁴ Of course, this is not the only travel-related public health measure that the Government is taking to combat the pandemic. As discussed above, the President has suspended the entry of most aliens from the People’s Republic of China, the Islamic Republic of Iran, the Schengen Area of Europe, the United Kingdom, the Republic of Ireland, and Brazil.

during an outbreak of a communicable disease when doing so would risk spreading the disease into the United States. Moreover, Plaintiff himself concedes that the health-related grounds of inadmissibility have been in existence since “the earliest days of [the Nation’s] immigration regulation—predating the 1893 enactment of the predecessor to § 265.” Mot. at 9 (citing Act of Mar. 3, 1891, ch. 551, 26 Stat. 1085, 1085); *see, e.g., Kaplan v. Tod*, 267 U.S. 228, 229 (1925) (alien minor, who was brought to this country in 1914, was “certified to be feeble minded” and “upon examination” was ordered to be excluded). There is no reasonable basis then to construe those provisions as narrowing Section 265. Not only did Congress see fit to enact the 1893 Act, but it re-codified the Act in the Public Health Service Act of 1944, fully aware of the existence of these health-related immigration law provisions.

Thus, the cited immigration provisions cannot fairly be read to constrain Section 265. *See Radzanower*, 426 U.S. at 153 (explaining that the “reason and philosophy of the [specific-over-general] rule is, that when the mind of the legislator has been turned to the details of a subject, and he has acted upon it, a subsequent statute in general terms, or treating the subject in a general manner, and not expressly contradicting the original act, shall not be considered as intended to affect the more particular or positive previous provisions” (citation omitted)); *cf. Trump v. Hawaii*, 138 S. Ct. 2392 (2018) (refusing to interpret anti-discrimination provision applicable to issuance of immigrant visas to constrain separate provision authorizing the President to suspend entry of classes of aliens because the two provisions “operate in two different spheres”; observing that if the interpretation were correct, the President would not be permitted to suspend entry from particular foreign states in response to an epidemic confined to a single region, among other possible actions, which is an illogical result).

Second, the canon that a court should not interpret a statute in a way that frustrates the purpose evident from its text and structure also supports the Government’s interpretation. Nothing suggests that Congress intended for the public health provisions to be applied in tandem with the immigration laws in a way that would undermine the efficacy of the public health provisions during a global pandemic. *See Keppel v. Tiffin Sav. Bank*, 197 U.S. 356, 361 (1905) (noting the “cardinal

rule” that a statute “should, if possible, be given a meaning in accord with the general purpose which the statute was intended to accomplish”). When the Director invokes Section 265, by definition, he has determined that there is a “serious danger” that a communicable disease in a foreign country would be spread into the United States by persons arriving from that foreign country, and, as such, it is necessary to suspend their introduction to avoid the spread of the disease. *See* 42 U.S.C. § 265. As the preamble to the Interim Final Rule recognizes, the danger of transmitting a communicable disease through international travel can be significant, and the Government must “respond promptly and effectively” to halt the potential transmission. *See* IFR at 4; *see also id.* at 5–6 (“travelers can serve as unwitting vectors of disease, and . . . the risk increases when travelers are in congregate settings”).

To interpret the emergency public health provisions as operating in tandem with the routine procedures afforded under the immigration laws would mean that Congress intended to allow potential vectors of a communicable disease to be introduced into the United States, notwithstanding the dangerous consequences for the public health. Such an interpretation would “‘bring about an end completely at variance with the purpose of [the public health provisions]’ and must be rejected.” *United Steelworkers of Am., AFL-CIO-CLC v. Weber*, 443 U.S. 193, 201–02 (1979) (collecting cases); *see also Trans World Airlines, Inc. v. Thurston*, 469 U.S. 111, 128 (1985) (declining to interpret a statutory provision “in a manner that frustrates [the legislative] intent”); *Freeman v. Quicken Loans, Inc.*, 566 U.S. 624, 632 (2012) (rejecting interpretation that would undermine the purpose of statute). It would also directly contradict the means by which Section 265 is designed to achieve its purpose—*i.e.*, by prohibiting the introduction of persons who would otherwise increase the serious danger of spreading a communicable disease into the United States. *See Dir., Office of Workers’ Comp. Programs, Dep’t of Labor v. Newport News Shipbuilding & Dry Dock Co.*, 514 U.S. 122, 136 (1995) (“Every statute proposes, not only to achieve certain ends, but also to achieve them by particular means.”).

And, it would render Section 265 a nullity. *Randall v. Loftsgaarden*, 478 U.S. 647, 661 (1986) (repeal by implication “is not favored”). If, in suspending the introduction of an alien in

order to avert danger to the public health, the Government must concurrently provide the panoply of procedures to that alien, thereby creating the very public health dangers that the suspension seeks to avoid, then Section 265 would have no effect, defeating the Government’s compelling interest in preventing a public health threat to the life and safety of its citizenry.

Temporarily suspending certain procedures afforded under the immigration laws, on the other hand, would not frustrate those provisions’ general purpose of providing immigration benefits outside the context of a global pandemic (or other threat to public health of comparable magnitude). Such an interpretation would also be consistent with established principles governing the admission and exclusion of aliens: (1) that aliens have no “claim of right” to enter the United States, *United States ex rel. Knauff v. Shaughnessy*, 338 U.S. 537, 542–543 (1950), as “the admission and exclusion of foreign nationals is a ‘fundamental sovereign attribute exercised by the Government’s political departments,’” *Trump*, 138 S. Ct. at 2418 (quoting *Fiallo v. Bell*, 430 U.S. 787, 792 (1977)); and (2) that in reviewing immigration-related decisions, courts must exercise the “greatest caution” to avoid inhibiting the political branches’ “flexibility . . . to respond to changing world conditions,” *Mathews v. Diaz*, 426 U.S. 67, 81 (1976); *cf. Knauff*, 338 U.S. at 543 (“because the power of exclusion of aliens is also inherent in the executive department of the sovereign, Congress may in broad terms authorize the executive to exercise the power . . . for the best interests of the country during a time of national emergency”).

For all these reasons, this Court should reject the interpretation offered by the amici—that “Section 265 is about the prohibition of ‘the introduction of persons and property’ into the United States” and “is not about removal (or expulsion) of persons from the United States.” Br. for Scholars of Refugee & Immigration Law as Amici Curiae at 8. They essentially proffer that Section 265 should be interpreted to authorize only the turning away of covered aliens who present themselves at ports of entry but not the physical removal of aliens who have illegally crossed the border between ports of entry and are apprehended near the border. But as already explained, Congress chose the terms “prohibit” and “introduction” for a reason. And the amici’s interpretation would defeat the purpose of Section 265, as both aliens who present themselves at

ports of entry and aliens who have illegally crossed the border can transmit and spread COVID-19 into the United States. It is telling that the amici do not suggest how the Government might go about offsetting the public health concerns that would flow from their reading, especially considering the fact that few aliens subject to the Order will present themselves at ports of entry (or Border Patrol stations) and, as a practical matter, the amici's interpretation would prevent the CDC from protecting the public health. In fact, the CDC Director has already determined that the Government cannot do so given the current practical constraints related to the physical structure and operation of CBP facilities, the way in which COVID-19 is transmitted, and prioritization of healthcare resources.

Third, the canon “that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme,” *Davis v. Mich. Dep’t of Treasury*, 489 U.S. 803, 809 (1989), similarly supports the interpretation that the public health provisions take precedence. The interpretation is consistent with Congress’s broad grant of powers in the context of the federal quarantine laws, which generally defer to the expertise of the public health officials to determine how best to protect the country from the dangers of a communicable disease.

Several subsections in the adjacent provision, section 264, highlight the Secretary’s broad powers in this area. The first is section 264(a), which empowers the Secretary to “make and enforce such regulations as *in his judgment are necessary* to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States.” 42 U.S.C. § 264(a) (emphasis added); *compare with id.* § 265 (“[w]henver the [Secretary] determines . . . [he] shall have the power to prohibit, in whole or in part, the introduction of persons . . . from such countries or places as he shall designate . . . and for such period of time as he may deem necessary”). This similarly phrased section is broad, deferring entirely to the Secretary’s “judgment.” In interpreting the provision, at least one court has observed that “Congress has granted broad, flexible powers to federal health authorities who must use their judgment in attempting to protect the public against the spread of communicable disease.” *Louisiana v. Mathews*, 427 F. Supp. 174, 176 (E.D. La. 1977). Because “[a] basic principle of interpretation is that courts ought to interpret similar

language in the same way, unless context indicates that they should do otherwise,” *Shirk v. United States ex rel. Dep’t of the Interior*, 773 F.3d 999, 1004 (9th Cir. 2014) (citing *Powerex Corp. v. Reliant Energy Servs., Inc.*, 551 U.S. 224, 232 (2007)), this Court should interpret the similar language in Section 265 to grant the Secretary broad powers to act in the face of an epidemic.

Next, subsections 264(b) through (d) indicate that the Secretary’s powers in this area are especially broad with respect to foreign travelers. As discussed above, those provisions authorize the Secretary to use various public health measures—apprehension, detention, conditional release, and examination—to prevent the introduction, transmission, or spread of communicable diseases. 42 U.S.C. § 264(b). They treat foreign and domestic travelers differently; with respect to the latter, the Secretary’s authority is limited: he may (1) apprehend them only if they are “reasonably believed to be infected with a communicable disease in a qualifying stage,” and (2) detain them only if they are determined to be infected. *Id.* § 264(d)(1). But even in limiting the Secretary’s apprehension and detention authority for individuals in the United States, the subsection sweeps broadly in that an individual “reasonably believed to be infected” need only be “in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals.” *Id.* § 264(d)(2). And as interpreted by regulation, the “precommunicable stage” begins “upon an individual’s earliest opportunity for exposure to an infectious agent.” 42 C.F.R. § 70.1.

These provisions show that through the federal quarantine laws, Congress gave the Secretary sweeping authority to protect the country from potentially devastating communicable diseases. Interpreting the public health provisions to supersede temporarily the immigration provisions for the duration of an outbreak would give effect to this clear intent.

In sum, traditional canons of statutory construction demonstrate that the public health and immigration provisions can be harmonized by interpreting the immigration provisions to give way temporarily in a public health emergency. This interpretation honors both sets of provisions and gives effect to clearly expressed congressional intent, consistent with the Supreme Court’s admonition that “[w]hen confronted with two Acts of Congress allegedly touching on the same

topic,” the Court “must strive ‘to give effect to both.’” *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018) (quoting *Morton v. Mancari*, 417 U.S. 535, 551 (1974)).

3. The CDC’s interpretation of the public health provisions is entitled to deference.

Although this Court need not proceed further on Plaintiff’s statutory challenge, the CDC’s interpretation of the public health provisions as operating without regard to the immigration laws is permissible and entitled to deference under *Chevron*. See *Nat’l Cable & Telecomms. Ass’n v. Brand X Internet Servs.*, 545 U.S. 967, 980 (2005) (“*Chevron* requires a federal court to accept the agency’s [permissible] construction of the statute, even if the agency’s reading differs from what the court believes is the best statutory interpretation.”). At a minimum, it is entitled to deference under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). See *Brown v. United States*, 327 F.3d 1198, 1205 (D.C. Cir. 2003) (“Under *Skidmore*, the court grants an agency’s interpretation only as much deference as its persuasiveness warrants.”), *as amended* (May 6, 2003).

In analogous contexts, courts have upheld agencies’ reasonable interpretations in the face of perceived statutory conflicts. In *National Ass’n of Home Builders v. Defenders of Wildlife*, the Supreme Court examined “the interplay between two federal environmental statutes” that imposed “seemingly categorical—and, at first glance, irreconcilable—legislative commands.” 551 U.S. 644, 649, 661 (2007). After analyzing the provisions using the traditional tools of statutory construction, the Court was “left with a fundamental ambiguity that [wa]s not resolved by the statutory text.” *Id.* at 666. Recognizing that one of the “differing mandates . . . must give way,” the Court looked to the agency’s interpretation to determine which one must give. *Id.* The Court ultimately found the agency’s interpretation “reasonable in light of the statute’s text and the overall statutory scheme.” *Id.*; see also *Scialabba v. Cuellar de Osorio*, 573 U.S. 41, 64 (2014) (plurality) (“When an agency thus resolves statutory tension, ordinary principles of administrative deference require us to defer.”).

The D.C. Circuit similarly has held that where two unambiguous statutes are in apparent conflict and neither indicates how Congress intended to resolve that conflict, the ambiguity created

by such a conflict may be resolved by the agency’s reasonable interpretation. *See W. Coal Traffic League v. Surface Transp. Bd.*, 216 F.3d 1168, 1173 (D.C. Cir. 2000) (“The statute does not address the unanticipated conflict this case presents Because the Congress has not ‘directly spoken to the precise question at issue,’ . . . we review the [agency’s] resolution of that conflict under *Chevron* step two.”); *Career Coll. Ass’n*, 74 F.3d at 1271-72 (noting that “the Secretary has some discretion to resolve the apparent conflict between the two [statutory] provisions because “it appears that the draftsmen did not contemplate this scenario”); *Mylan Labs., Inc. v. Thompson*, 389 F.3d 1272, 1281 (D.C. Cir. 2004) (explaining that “the FDA was called upon to construe the statutes so as to resolve these two conflicts” and concluding that the FDA’s construction satisfied *Chevron*).

Here, the CDC reasonably interpreted Sections 265 and 268 to operate without regard to the immigration laws. The Interim Final Rule reasonably interprets “introduction of persons” from foreign countries to mean movements that bring persons from foreign countries into contact with others in the United States in a manner that the Director determines to present a risk of transmission of the communicable disease to persons in the United States. IFR at 16-17. Specifically, the term “encompass those who have physically crossed a border of the United States and are in the process of moving into the interior.” *Id.* at 16. The CDC Order then directs CBP to move covered aliens out of the country, with as little time spent in congregate settings as possible. In the CDC’s expert judgment, it is imperative “to halt the travel of such persons and rapidly mov[e] them outside the United States” to “prevent[] their ‘introduction’” because they otherwise would be held for extended periods of time in congregate settings during immigration processing, which would be conducive to the transmission of COVID-19. Order at 11; *id.* at 12

As discussed before, the limited size and capacity of the congregate holding areas at ports of entry and Border Patrol stations—and the sheer number of covered aliens seeking to enter the United States—would present a serious public health risk during the COVID-19 outbreak. Moreover, an alien exposed to or infected with COVID-19 would most likely go to healthcare facilities for testing or medical care, increasing the risk of introducing COVID-19 to domestic

healthcare workers as well as burdening the limited domestic healthcare resources. *Id.* at 13. Thus, “the faster a covered alien is returned to the country from which [he] entered the United States, to [his] country of origin, or another location as practicable, the lower the risk the alien poses of introducing, transmitting, or spreading COVID-19 into [ports of entry], Border Patrol stations, other congregate settings, and the interior.” *Id.* at 16.

The CDC did not contemplate that CBP would implement the immigration laws concurrently with the CDC Order. Indeed, such concurrent implementation would defeat the main purpose of the CDC Order by keeping covered aliens in congregate settings for material amounts of time, and then allowing covered aliens to fan out into the interior, where they may act as vectors for spreading COVID-19. The CDC’s interpretation is reasonable because it averts danger to the public health without permanently affecting the application of the immigration laws. *Cf. Util. Air Regulatory Grp. v. EPA*, 573 U.S. 302, 332 (2014) (upholding agency interpretation under *Chevron* step two: “[o]ur narrow holding is that *nothing in the statute categorically prohibits* EPA from interpreting the BACT provision to apply to greenhouse gases emitted by ‘anyway’ sources” (emphasis added)). Accordingly, the agency’s interpretation is entitled *Chevron* to deference, or at a minimum to *Skidmore* deference, and should be upheld.

For all these reasons, the CDC Order is not contrary to law, and Plaintiff is unlikely to succeed in showing otherwise.

C. Plaintiff Is Unlikely to Succeed on His Arbitrary and Capricious Challenge

Finally, Plaintiff also argues that the CDC Order is arbitrary and capricious because the CDC (1) did not adequately explain its actions, (2) did not consider important aspects of the problem, and (3) cannot justify the Order on public health grounds. *See* Mot. at 15–16. These arguments have no merit.

The scope of review under the “arbitrary and capricious” standard is “narrow,” *Motor Vehicle Mfrs. Ass’n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), and “highly deferential,” *Epsilon Elecs., Inc. v. U.S. Dep’t of Treasury*, 857 F.3d 913, 918 (D.C. Cir.

2017). “A court is not to ask whether [an agency’s] decision is the best one possible or even whether it is better than the alternatives.” *FERC v. Elec. Power Supply Ass’n*, 136 S. Ct. 760, 782 (2016). Nor is the court to “substitute its own judgment for that of the agency.” *Mayo v. Reynolds*, 875 F.3d 11, 19–20 (D.C. Cir. 2017) (citation and alteration omitted). Rather, the court’s “only task is to determine whether the [agency] has considered the relevant factors and articulated a rational connection between the facts found and the choice made,” and to ensure that the agency remained “within the bounds of reasoned decisionmaking.” *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council, Inc.*, 462 U.S. 87, 105 (1983). Even if the agency decision is “of less than ideal clarity,” it must be upheld “if the agency’s path may reasonably be discerned.” *State Farm*, 463 U.S. at 43. The court only considers “whether there has been a clear error of judgment.” *Id.* (citation omitted). Here, the agency’s action easily satisfies this highly deferential review.

1. The CDC Order sufficiently explained its necessity.

First, the agency’s path is clear and there is no clear error of judgment, which is all the APA requires. The CDC acted in the midst of a historic pandemic with COVID-19 spreading rapidly. With international travel and migration playing a significant role in spreading the highly contagious disease, IFR 5–6, countries around the globe responded with sweeping travel restrictions, and the United States, Mexico, and Canada closed their shared borders to non-essential travel. Order at 5, 8. As already discussed above, the CDC Director fully explained why he chose to focus on CBP’s operations at or near those borders. There are significant practical and operational constraints on CBP’s ability to implement effective infection control measures in congregate settings at ports of entry and Border Patrol stations at or near the borders. Allowing aliens to spend hours or days in those congregate settings during the COVID-19 pandemic “would be fraught with public health risks for not only the aliens but also the DHS personnel nearby.” Order at 11–14.

Second, Plaintiff is mistaken that the CDC Director should have explained why he did not “exempt unaccompanied children, including unaccompanied children fleeing abuse, persecution, and torture” from the scope of the Order. See Mot. at 15. The APA requires only that an agency

explain its action well enough for a court to discern the path of the agency’s decision-making; it does not require an agency to address every imaginable scenario. *See Balt. Gas & Elec. Co.*, 462 U.S. 87, at 105 (the court’s “only task is to determine whether the [agency] has considered the relevant factors and articulated a rational connection between the facts found and the choice made”). In fact, it is Plaintiff’s burden to show why the absence of an exception for children renders the Order arbitrary despite the public health objective of the Order and the fact that children are not immune from this disease. In any event, the CDC Director explicitly recognized that it may be appropriate to exempt certain otherwise covered aliens from the scope of the Order based on humanitarian grounds, and he specifically granted CBP agents and officers the discretion to do so on a case-by-case basis, based on the alien’s individual circumstances. *See Order* at 2.

Third, contrary to Plaintiff’s argument, Defendants are not required, in this instance, to explain their “decision specifically to apply the Title 42 Process to [Plaintiff].” *Mot.* at 15. Plaintiff clearly is a “covered alien” under the CDC Order. He crossed the border illegally and was taken into custody approximately one mile from the U.S.-Mexico border. *Danley Decl.*, ¶ 3. As an alien who illegally crossed the U.S.-Mexico border between ports of entry who would have otherwise been held in congregate settings in a Border Patrol station to facilitate immigration processing, CBP determined that he is a “covered alien” under the Order. *Id.*, ¶ 4. He was later moved to a hotel to await his flight back to his home country in order to implement the CDC’s directive that any “covered alien” be returned as soon as practicable. *See Hernandez Decl.*, ¶¶ 4, 5; *Order* at 16.

It is immaterial to the analysis that Plaintiff does not exhibit any symptoms of COVID-19, *Compl.* ¶ 86, or, as amici assert, that “children at Plaintiff’s age have a lower ‘attack rate’ of COVID-19.” *See Declaration of Les Roberts, MPH, PHD, and Stephen Patrick Kachur, MD. MPH, in Support of Plaintiff’s Motion for Stay of Removal*, ¶ 13, ECF No. 18-1 (“Public Health Amici’s Declaration”) (no motion for leave filed). Even if one is asymptomatic or a minor, and the risk of COVID-19 transmission might be *lower*, there is still some risk. The purpose of the CDC Order is to avert the danger of spreading COVID-19. The presence of covered aliens in

congregate settings—even covered aliens with “a lower ‘attack rate’ of COVID-19”—would defeat that purpose and undermine the public health. Plaintiff is therefore unlikely to succeed on any as-applied challenge to the CDC Order.

2. The CDC’s well-reasoned Order appropriately considered the problem.

Plaintiff next accuses Defendants of “failing to consider or address how their new process would impact unaccompanied children” or “the need to protect individuals fleeing from persecution.” Mot. at 16. But the CDC properly promulgated the Order under Section 265, and Congress did not limit the Section 265 authority by requiring the agency to consider statutes administered by other agencies that may be impacted by a section 265 order. Indeed, this case bears no resemblance to the cases Plaintiff cites, which involve statutory directives that the agency failed to consider. See Mot. at 15; *Nat’l Lifeline Ass’n v. FCC*, 921 F.3d 1102, 1111 (D.C. Cir. 2019) (agency action was arbitrary and capricious because agency failed to consider changes on affordability and access, even though “availability and affordability” were “long-stated primary tenets for the program,” and the statutory principles underlying the program required making “[q]uality services’ . . . ‘available at just, reasonable, and affordable rates’” (first alteration in original) (citation omitted)); *Am. Wild Horse Preservation Campaign v. Perdue*, 873 F.3d 914, 931 (D.C. Cir. 2017) (statute requires “that an agency’s environmental analysis candidly confront the relevant environmental concerns”).

But even if the Court concludes that the Director had an obligation to consider the Order’s impact on the immigration scheme that the CDC itself is not responsible for administering, the Director satisfied that obligation by consulting with DHS and by relying on that agency’s expertise. See Order at 16; cf. *Cellular Phone Taskforce v. FCC*, 205 F.3d 82, 90 (2d Cir. 2000) (promulgation of standards “not arbitrary and capricious” because “[a]ll of the expert agencies consulted . . . found the FCC’s approach to be satisfactory”). Again, Plaintiff’s argument ignores that the CDC Order allows for case-by-case exceptions based on the totality of the circumstances. The Director’s decision to rely on customs officers to make the totality-of-circumstances

determinations is reasonable because DHS has the most expertise with the array of migration and public safety issues that arise at the borders. Plaintiff has not shown that the CDC failed to consider important aspects of the problem when issuing the Order.

3. Public health concerns justify the CDC Order.

Plaintiff argues that the CDC Order cannot be justified on public health grounds because “the Title 42 process exempts numerous categories of individuals, such as students and commercial truck drivers, who carry at least as great a risk of COVID-19 as asylum seekers [and] unaccompanied minors.” Mot. at 16. But Plaintiff cannot show that the CDC acted arbitrarily and capriciously by not addressing in a single order *all* problems created by travel in a global pandemic. The CDC’s measured approach is grounded in its finding that covered aliens without travel documents—in contrast to students and truck drivers who typically arrive at a border with readily verifiable travel authorization—would be held in congregate settings for materially longer periods than other travelers, thus increasing the public health risks for travelers and DHS personnel alike.

This Court should dismiss out of hand Plaintiff’s blanket assertion that “public health experts” disagree with the public health rationale of the CDC Order. *See id.* As discussed above, in APA review, the Court “is not to substitute its judgment for that of the agency,” *State Farm*, 463 U.S. at 43, 52, nor does the Court ask “whether [an agency’s] decision is the best one possible or even whether it is better than the alternatives,” *Elec. Power Supply Ass’n*, 136 S. Ct. at 782. Deference to the agency is at its height where, as here, the Court is reviewing the CDC’s expert, science-based predictive public health judgment during a global pandemic. *See Jacobson*, 197 U.S. at 30 (explaining that “[i]t is no part of the function of a court or a jury to determine” how best to protect the public from a disease); *S. Bay United Pentecostal Church*, 2020 WL 2813056, at *1 (S. Ct. 2020) (Roberts, C.J., concurring) (explaining that the latitude “to guard and protect” “[t]he safety and the health of the people” “must be especially broad” when acting “in areas fraught with medical and scientific uncertainties”); *Rural Cellular Ass’n v. FCC*, 588 F.3d 1095, 1105 (D.C. Cir. 2009); *Cardinal Health, Inc. v. Holder*, 846 F. Supp. 2d 203, 225 (D.D.C. 2012).

Plaintiff's mere policy disagreements with the CDC's public health determinations do not render the CDC Order arbitrary and capricious. *See Inv. Co. Inst. v. Commodity Futures Trading Comm'n*, 720 F.3d 370, 380 (D.C. Cir. 2013) ("This argument amounts to nothing more than another policy disagreement with [the agency], so we must reject it."). Nor does the declaration of amici lend any support to Plaintiff's argument. The amici suggest that CBP can greatly reduce the risk of transmission if they process Plaintiff in accordance with the CDC's public health guidance issued for the domestic population, including conducting "appropriate symptoms screening," "appropriate use of masks, hygiene practices, and social distancing." Health Expert Amici's Declaration, ¶ 14. The CDC Director, of course, has stressed the importance of those public health measures. He issued the Order precisely because he concluded that such public health measures are not feasible to implement at ports of entry or in Border Patrol stations. Order at 14 ("Because [ports of entry] and Border Patrol stations are not structured or equipped for quarantine or isolation for COVID-19, DHS's alternative would be to try to conduct some type of social distancing in congregate holding areas. The numbers of aliens and the size and capacity of the congregate holding areas are not at all conducive to effective social distancing . . ."). The amici's suggestion ignores the hard, factual realities of ports of entry and Border Patrol stations and should be rejected out of hand.

In sum, the CDC Order is not arbitrary or capricious. *Nat'l Immigration Project of Nat'l Lawyers Guild v. Exec. Office [for] Immigration Review*, --- F. Supp. 3d ----, No. 1:20-CV-00852 (CJN), 2020 WL 2026971, at *11 (D.D.C. Apr. 28, 2020) ("In the wake of the first pandemic the United States has faced since the early twentieth century and the rapidly changing facts and circumstances relating to it, the Court cannot say that Defendants' policies and practices are arbitrary and capricious or otherwise reviewable.").

II. THE BALANCE OF HARMS WEIGHS AGAINST ENTRY OF A TEMPORARY RESTRAINING ORDER

A. Plaintiff Cannot Show that He Will Suffer Irreparable Harm

Because Plaintiff has failed to establish a likelihood of success on the merits, this Court need not consider the remaining factors for emergency injunctive relief. *See Winter*, 555 U.S. at 20; *Sherley v. Sebelius*, 644 F.3d 388, 393 (D.C. Cir. 2011) (“we read *Winter* at least to suggest if not to hold that a likelihood of success is an independent, free-standing requirement for a preliminary injunction” (internal quotation marks and citation omitted)); *see also Nken v. Holder*, 556 U.S. 418, 438 (2009) (Kennedy, J., concurring) (“When considering success on the merits and irreparable harm, courts cannot dispense with the required showing of one simply because there is a strong likelihood of the other.”); *Guttenberg v. Emery*, 26 F. Supp. 3d 88, 100 n.5 (D.D.C. 2014) (“Even a narrow reading of the Court’s holding in *Winter* supports the view that sliding-scale analysis is obsolete.”). But even if the Court does, the remaining factors support the denial of Plaintiff’s request for emergency relief.

Plaintiff has not shown that “irreparable injury is *likely* in the absence of an injunction.” *Winter*, 555 U.S. at 22. That requirement “erects a very high bar for a movant,” *Coal. for Common Sense in Gov’t Procurement v. United States*, 576 F. Supp. 2d 162, 168 (D.D.C. 2008), and it is a “well known and indisputable principle[]” that an “unsubstantiated and speculative” harm is not an irreparable injury for purposes of injunctive relief, *Wisc. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985) (per curiam). Rather, the harm must be “‘certain and great,’ ‘actual and not theoretical,’ and so ‘[i]mminent that there is a clear and present need for equitable relief to prevent irreparable harm.’” *League of Women Voters of United States v. Newby*, 838 F.3d 1, 7–8 (D.C. Cir. 2016) (alteration in original) (quoting *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006)).

Here, Plaintiff asserts that he will be harmed or even killed by gangs if he is returned to his home country. Mot. at 6. Specifically, he alleges that one of his relatives was beaten in his neighborhood, and that a gang threatened him and told his aunt she must close her store and pay

the gang after he witnessed a gang murder while helping at that store. Corchado Decl. ¶ 6, ECF No. 2-3. These allegations, however, show only that harm is a “possibility,” when he “must, at minimum, ‘demonstrate that irreparable injury is likely,’” *Arriva Med. LLC v. Dep’t of Health & Human Servs.*, 239 F. Supp. 3d 266, 277 (D.D.C. 2017) (quoting *Winter*, 555 U.S. at 21). Moreover, contrary to Plaintiff’s belief, the alleged “depriv[ation] . . . of the statutorily guaranteed opportunity to seek bona fide claims,” such as asylum and withholding, Mot. at 6, is not irreparable. That argument “link[s] [his] claim of irreparable harm to [his] showing of a likelihood of success on the merits,” and thus his “failure to establish the latter is fatal to the former.” *Am. Civil Liberties Union Found. v. Wash. Metro. Area Transit Auth.*, 303 F. Supp. 3d 11, 28 (D.D.C. 2018). Finally, the Supreme Court has said in the immigration context that removal “is not categorically irreparable.” *Nken*, 556 U.S. at 435.

B. The Balance of Harms and the Public Interest Weigh Against an Injunction

As for the remaining factors, the balance of harms and the public interest “merge when the Government is the opposing party.” *Nken*, 556 U.S. at 435. Plaintiff largely justifies his request by assuming that he will succeed on the merits of his claims, *see* Mot. at 16-17, but as explained above, he is unlikely to do so, “meaning that a preliminary injunction would likely have no effect on public officials’ compliance with the law,” *Friends of Animals v. U.S. Bureau of Land Mgmt.*, 232 F. Supp. 3d 53, 68 (D.D.C. 2017). On the other hand, the harm to the Government and the public’s interest strongly weigh against injunctive relief.

“It goes almost without saying, of course, that promoting public health—especially during a pandemic—is in the public interest.” *Nat’l Immigration Project of Nat’l Lawyers Guild*, 2020 WL 2026971, at *12. Here, the Government has taken action that is necessary to protect public health during the worst pandemic since 1918. At least 116,000 people have died of COVID-19 in the United States, and the death toll continues to rise.¹⁵ The public health official charged with

¹⁵ *See* CDC, Corona Virus Disease 2019 (COVID-19), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

implementing the laws that protect the public health concluded that the CDC Order is in the public interest. See Order at 2, 3, 14. Plaintiff’s requested relief, however, would tie the Government’s hands and prevent it from taking action that, in the opinion of the Nation’s designated medical expert, is necessary to protect the country from the further spread of a highly contagious virus. Cf. *Bragdon v. Abbott*, 524 U.S. 624, 650 (1998) (“the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority”); see also *Sch. Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987). “[W]here[, as here,] the Court is . . . certainly not well-positioned to second-guess those health and safety determinations, the public interest does not point in favor of granting injunctive relief.” *Nat’l Immigration Project of Nat’l Lawyers Guild*, 2020 WL 2026971, at *12.

On top of putting the American public, DHS personnel, and other travelers, including even unaccompanied minors, at risk and potentially straining the American healthcare system, an injunction would cause additional harm because “[a]ny time [the government] is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury,” *Maryland v. King*, 133 S. Ct. 1, 3 (2012) (Roberts, C.J., in chambers) (citation omitted); see also *Nat’l Propane Gas Ass’n v. U.S. Dep’t of Homeland Sec.*, 534 F. Supp. 2d 16, 20 (D.D.C. 2008). And, as the Supreme Court has recognized, “[t]here is always a public interest in prompt execution of removal orders.” *Nken*, 556 U.S. at 435.

For all these reasons, the balance of equities tip against granting injunctive relief.

CONCLUSION

For the foregoing reasons, this Court should deny Plaintiff’s motion for a temporary restraining order.

Dated: June 17, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that June 17, 2020, I electronically filed a copy of the foregoing. Notice of this filing will be sent via email to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System.

/s/ Jean Lin

JEAN LIN

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

EXHIBIT A



Billing Code: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 71

[Docket No. CDC-2020-0033]

RIN 0920-AA76

Control of Communicable Diseases; Foreign Quarantine: Suspension of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Interim final rule with request for comments.

SUMMARY: The Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS) issues this interim final rule with request for comments to amend its Foreign Quarantine Regulations. This interim final rule provides a procedure for CDC to suspend the introduction of persons from designated countries or places, if required, in the interest of public health.

DATES: *Effective date:* This interim final rule is effective on 11:59PM EDT on March 20th, 2020.

Comment date: Written comments are invited and must be submitted on or before 30 days from the date of publication of this interim final rule in the **Federal Register**.

Expiration Date: Unless extended after consideration of submitted comments, this interim final rule will cease to be in effect on the earlier of (1) one year from the publication of this interim final rule, or (2) when the HHS Secretary determines there is no longer a need for

this interim final rule. The Secretary will publish a document in the **Federal Register** announcing the expiration date.

ADDRESSES:

You may submit comments, identified by Docket No. CDC-2020-0033, by the following method:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Instructions: All submissions received must include the agency name and docket number or Regulatory Information Number (RIN) for this rulemaking. All comments received will be posted without change to <http://www.regulations.gov>, including any personal information provided. For access to the docket to read background documents or comments received, go to <http://www.regulations.gov>.

Any comment that is submitted will be shared with the Department of Homeland Security and the Department of State, and will also be made available to the public. Comments must be identified by **RIN 0920-AA76**. Because of staff and resource limitations, all comments must be submitted electronically to www.regulations.gov. Follow the “Submit a comment” instructions.

Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to comments received.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including personally identifiable or confidential business information that is included in a comment.

FOR FURTHER INFORMATION CONTACT: Kyle McGowan, Office of the Chief of Staff, Centers for Disease Control and Prevention, 1600 Clifton Road, N.E., MS H21-10, Atlanta, GA 30329. Telephone: 404-498-7000; email: cdcregulations@cdc.gov.

SUPPLEMENTARY INFORMATION:

The IFR is organized as follows:

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- I. Background
- II. Statutory Authority
- III. Provisions of New § 71.40
- IV. Request for Comment
- V. Rationale for Issuance of an Interim Final Rule with Immediate Effectiveness
- VI. Regulatory Impact Analysis

I. Background

The Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), is amending the regulations that implement section 362 of the Public Health Service (PHS) Act, 42 U.S.C. 265, as part of its response to Coronavirus Disease 2019 (COVID-19). Section 362 provides that if the Secretary¹ “determines

¹ The statute assigns this authority to the Surgeon General of the Public Health Service. However, Reorganization Plan No. 3 of 1966 abolished the Office of the Surgeon General and transferred all statutory powers and functions of the Surgeon General and other officers of the Public Health Service and of all agencies of or in the Public Health Service to the Secretary of Health, Education, and Welfare, now the Secretary of Health and Human Services, 31 FR 8855, 80 Stat. 1610 (June 25, 1966), *see also* Pub. L. No. 96-88, 509(b), 93 Stat. 695 (codified at 20 U.S.C.

that by reason of the existence of any communicable disease in a foreign country there is serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health,” he has the authority, in accordance with regulations approved by the President,² “to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate in order to avert such danger, and for such period of time as he may deem necessary for such purpose.” PHS Act 362, 42 U.S.C. 265. Pursuant to a delegation of the Secretary’s authority, the CDC Director has promulgated regulations under section 362 to suspend the introduction of property into the United States. Current regulations, however, only address suspension of the introduction of property into the United States and the procedures to quarantine or isolate persons. That is, current regulations permit CDC to quarantine or isolate persons entering the United States, but they do not address the suspension of the introduction of persons into the United States under section 362.

CDC’s experience with COVID-19 is that, under some circumstances, quarantine or isolation is not a viable solution for protecting the public health from the introduction of a communicable disease from another country. For example, the arrival in U.S. ports of cruise ships with numerous passengers requiring quarantine or isolation has presented complex logistical challenges, consumed disproportionate agency resources, and taken CDC personnel away from other critical parts of the domestic and international response to COVID-19. To continue to respond promptly and effectively to the public health emergency presented by

3508(b)). References in the PHS Act to the Surgeon General are to be read in light of the transfer of statutory functions and re-designation. Although the Office of the Surgeon General was re-established in 1987, the Secretary of HHS has retained the authorities previously held by the Surgeon General.

² Executive Order 13295 assigned the functions of the President under section 362 to the Secretary of HHS.

COVID-19, CDC needs a more efficient regulatory mechanism to exercise its section 362 authority and suspend the introduction of persons who would otherwise pose a serious danger of introduction of COVID-19 into the United States.

Even though COVID-19 is present in certain locations within the United States, the suspension of the introduction of persons into the United States may be required in the interest of public health to avert the danger of further introduction of the disease into the same or other locations in the United States. For example, hypothetically, the introduction of COVID-19 into the United States would occur if two infected persons disembarked in a large metropolitan city in the Midwest from an international flight. Another vector for further introduction of COVID-19 into the United States would be a group of two infected persons who entered that Midwestern state by land after crossing the border from Canada. Suspension of the introduction of those two persons into the United States at the land border would mitigate the serious and increased danger of further introduction of COVID-19 in the United States. The same public health analysis would apply if two infected persons walked across the land border from Canada into a Northeastern State.

Past Experience with Migration and Communicable Disease

International travel and migration play a significant role in the global transmission of infectious biological agents or their toxic products that pose risks for vulnerable populations.³ Travelers can serve as unwitting vectors of disease, and thereby increase the risk of communicable disease transmission and of the introduction of communicable disease into the

³ See, e.g., Institute of Medicine (US) Forum on Microbial Threats, “Infectious Disease Movement in a Borderless World: Workshop Summary,” National Academies Press (US); 2010, *available at* <https://www.ncbi.nlm.nih.gov/books/NBK45728/> (hereinafter “Infectious Disease Movement in a Borderless World”); Wilson, ME. Travel and the Emergence of Infectious Diseases. *Emerging Infectious Diseases*. 1995;1(2):39-46. doi:10.3201/eid0102.950201; Tatem, A. J., Rogers, D. J. & Hay, S. Global Transport Networks and Infectious Disease Spread. *Adv. Parasitology* 62, 293–343 (2006).

United States. The risk increases when travelers are in congregate settings, such as carriers (i.e., ships, aircraft, trains, and road vehicles) or terminals with shared sitting, sleeping, eating, or recreational areas, all of which are conducive to disease transmission.⁴

The speed and far reach of global travel were factors in prior outbreaks that expanded to numerous continents. Examples include: the H1N1 influenza pandemic in 2009; severe acute respiratory syndrome (SARs) coronavirus in 2003; tuberculosis; measles; Middle East Respiratory Syndrome (MERS-CoV) in 2012; and Ebola Virus Disease in 2014 and 2018.⁵ All of these high-consequence diseases posed significant public health risks, especially given the compressed timeframes in which the outbreaks occurred.

For example, the Federal response to the H1N1 influenza pandemic in 2009 would have benefitted from the availability of an efficient mechanism for suspending the introduction of persons into the United States. The initial cases of H1N1 occurred in Mexico, before the first confirmed cases in the United States. Retrospective research findings in Mexico indicated that transmission of the virus in Mexico involved person-to-person spread with multiple generations of transmission.⁶

Like 2009 H1N1, COVID-19 is a pandemic. But the new coronavirus is more infectious than 2009 H1N1.⁷ Indeed, it appears that the virus may at times be transmitted by persons who

⁴ E.g., <https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-by-air-land-sea/cruise-ship-travel> (noting that the “often crowded, semi-enclosed environments onboard ships can facilitate the spread of person-to-person, foodborne, or waterborne diseases”); CDC, “Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases,” Updated March 7, 2020, *available at* <https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html>.

⁵ Infectious Disease Movement in a Borderless World (noting that “swine-origin H1N1 has spread globally, its movement hastened by global air travel” and [i]t is easy to see how travelers could play a key role in the global epidemiology of infections that are transmitted from person to person, such as HIV, SARS, tuberculosis, influenza, and measles”) (citing Hufnagel L, Brockmann D, Geisel T. Forecast and Control of Epidemics in a Globalized World. *Proceedings of the National Academy of Sciences*. 2004;101(42):15124–15129).

⁶ <https://www.cdc.gov/h1n1flu/cdcresponse.htm>.

⁷ See generally, CDC, “2009 H1N1 Pandemic Timeline,” *available at* <https://www.cdc.gov/flu/pandemic->

are asymptomatic. As discussed below, COVID-19 is also more likely to cause death in high-risk individuals.

In addition, global travel has increased dramatically since prior infectious disease outbreaks. By 2018, international visitations to the U.S. totaled over 20 million more per year than in 2009, when the 2009 H1N1 pandemic occurred, and 10 million more per year than in 2014, when the Ebola Virus Disease outbreak occurred.⁸ These differences make the availability of an efficient mechanism for exercising the section 362 authority all the more important to the protection of the public health going forward.

The Current Outbreak of COVID-19

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan, Hubei Province, People's Republic of China ("PRC"). The virus is thought to be transmitted primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes. It may also be transmitted through contact with surfaces or objects. While much is still unknown about the transmission of COVID-19, asymptomatic transmission may also occur.

Manifestations of severe disease have included severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the World Health Organization (WHO), as of March 17, 2020, approximately 4.1% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among seniors or those with

resources/2009-pandemic-timeline.html; Van Kerkhove, Maria D et al. Estimating age-specific cumulative incidence for the 2009 influenza pandemic: a meta-analysis of A(H1N1)pdm09 serological studies from 19 countries. *Influenza and Other Respiratory Viruses* vol. 7,5 (2013): 872-86, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5781221/>; CDC, Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

⁸ https://travel.trade.gov/outreachpages/download_data_table/Fast_Facts_2018.pdf

compromised immune systems. Older adults and people who have severe chronic medical conditions like hypertension, heart, lung, or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

As of March 17, 2020, there were over 179,100 cases of COVID-19 globally in over 150 locations (including countries), resulting in over 7,425 deaths; more than 4,225 cases have been identified in the United States, with new cases being reported daily and with at least 75 deaths due to the disease. Continued introduction into the United States of persons from foreign countries where COVID-19 exists presents a danger of disease transmission in congregate settings such as carriers or terminals, which may, in turn, result in a danger of disease transmission in contiguous areas.⁹

Unfortunately, at this time, there is no vaccine that can prevent infection with COVID-19, nor are there therapeutics for those who become infected. Treatment is currently limited to supportive (or palliative) care to manage symptoms while the body fights off the disease. Hospitalization may be required in severe cases and mechanical respiratory support may be needed in the most severe cases. The ease of COVID-19 transmission presents a risk of a surge in hospitalizations for COVID-19, which would limit hospital capacity available to treat other serious conditions.

Testing is available to confirm suspected cases of COVID-19 infection. Testing generally requires specimens collected from the nose, throat, or lungs; such specimens can only be analyzed in a laboratory setting. However, commercial test results are typically available

⁹ See *supra* n.4; see also CDC, Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States, available at <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>.

within three to four days. Currently, the time required to obtain test results—coupled with the incubation period of the disease—makes it impracticable to confirm whether each person moving into the United States is infected with COVID-19 at the time of the movement. Widespread, compulsory Federal quarantines or isolations of such persons pending test results are impracticable due to the numbers of persons involved, logistical challenges, and CDC resource and personnel constraints.

On January 30, 2020, the Director General of WHO declared that the outbreak of COVID-19 is a Public Health Emergency of International Concern under the International Health Regulations.¹⁰ The following day, the Secretary of HHS declared COVID-19 a public health emergency under the PHS Act.¹¹ On March 11, 2020, the WHO declared COVID-19 a pandemic. On March 13, 2020, the President issued a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak.¹² As of March 16, 2020, all 50 states and several local and territorial jurisdictions declared states of emergency.

Global efforts to slow disease transmission have included sweeping measures to limit travel and exposure to COVID-19. A number of countries, such as Russia, Australia, the Philippines, Japan, and Israel, have imposed stringent restrictions on travelers who have recently been to the PRC. On March 17, 2020, the European Union approved a plan to ban all nonessential travel into its bloc for a minimum of 30 days. Many countries are asking persons to

¹⁰ Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (January 30, 2020), *available at* [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

¹¹ HHS, “Determination that a Public Health Emergency Exists,” *available at* <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

¹² “Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak,” March 13, 2020, *available at* <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

self-quarantine for 14 days (a period estimated to encompass the incubation period for the disease) following return from foreign countries or places with sustained community transmission.

The President has exercised his authority in section 212(f) of the Immigration and Nationality Act (“INA”), 8 U.S.C. 1182(f), to suspend entry into the United States of certain foreign nationals who have recently visited PRC (excluding the Special Administrative Regions of Hong Kong and Macau), the Islamic Republic of Iran, the Schengen Area (comprised of 26 countries in Europe), the United Kingdom (excluding overseas territories outside of Europe), and the Republic of Ireland, within 14 days preceding their entry or attempted entry into the United States due to concerns of person-to-person transmission of COVID-19. CDC has issued Level 3 Travel Health Notices recommending that travelers avoid all nonessential travel to PRC (excluding the Special Administrative Regions of Hong Kong and Macau), the Islamic Republic of Iran, the Republic of Korea, and the Schengen Area. The U.S. Department of State has issued a Global Level 3 Health Advisory directing U.S. citizens to reconsider all travel abroad due to the global impact of COVID-19 and Level 4 Travel Advisories (Do Not Travel) for PRC (excluding the Special Administrative Regions of Hong Kong and Macau), Iran, and certain regions of Italy. In addition, CDC has recommended that travelers, particularly those with underlying health conditions, avoid all cruise ship travel worldwide. The U.S. Department of State has similarly issued guidance that U.S. citizens should not travel by cruise ship at this time. On March 16, 2020, the Federal government announced guidelines recommending that the public should avoid discretionary travel; discretionary shopping trips; social visits; gatherings in groups of more than 10 people; and eating or drinking at bars, restaurants, and food courts. Numerous States and cities have gone further and shut down restaurants, bars, nightclubs, and theaters. On

March 18, 2020, the United States and Canada announced plans to, by mutual consent, close the U.S.-Canadian border to nonessential travel.

The COVID-19 pandemic highlights why CDC needs an efficient regulatory mechanism to suspend the introduction of persons who would otherwise increase the serious danger of the introduction of a communicable disease into the United States. Section 212(f) of the Immigration and Nationality Act (“INA”) applies to the “entry” of aliens, but section 362 instead provides the authority to prohibit the “introduction” of persons into the United States. Despite the unprecedented global efforts at mitigating or slowing the transmission of COVID-19, cases of COVID-19 have rapidly propagated and multiplied, crossing international borders with ease. As of March 17, 2020, CDC reported that 229 of the confirmed cases of COVID-19 in the United States with an established source of exposure were travel-related as opposed to community transmission, accounting for almost half of the 474 cases with an established source of exposure; another 3,752 cases remain under investigation. As of March 14, 2020, travelers from Japan have exported at least 20 COVID-19 cases to eight countries. As of March 14, 2020, travelers from the Islamic Republic of Iran have exported at least 145 COVID-19 cases to 17 other countries, as reported by the WHO, and travelers from the Schengen Area have exported 624 COVID-19 cases to 70 countries, including to the United States. In the near future, persons traveling from other foreign countries and jurisdictions may compound the serious danger of further introduction of COVID-19 into the United States.

To summarize, CDC knows that COVID-19 infection transmits easily, spreads quickly through global travel, and can have a high mortality rate for some of the most vulnerable members of society. At this time, there is no vaccine, therapeutic, or rapid testing for the disease. CDC needs a robust, efficient mechanism for exercising its authority under section 362

and other applicable authorities to suspend the introduction of persons into the United States, should the public health require it. In issuing orders pursuant to this interim final rule, CDC would coordinate with the Secretary of State in order to ensure compliance with the international legal obligations of the United States and to take due account of U.S. national and security interests.

Other Public Health Risks

Beyond the current COVID-19 pandemic, the suspension authority is also critical to CDC because there is always a risk of another emerging, or re-emerging, communicable disease that may harm the American public. One such risk is pandemic influenza (as opposed to seasonal influenza), which occurs when a novel, or new, influenza virus strain spreads over a wide geographic area and affects an exceptionally high proportion of the population. In such circumstances, the strain of virus is new, there is usually no available vaccine, and humans do not typically have immunity to the virus, often resulting in a more severe illness. The severity and unpredictable nature of an influenza pandemic requires public health systems to prepare constantly for the next occurrence. Whenever a new strain of influenza virus appears, or a major change to a preexisting virus occurs, individuals may have little or no immunity, which can lead to a pandemic when the virus passes easily from human to human and causes serious illness or death. The most recent influenza pandemics include H1N1 in 2009-2010, the 1968-1969 Hong Kong Flu, the 1957-1958 Asian Flu, and the 1918-1919 Spanish Flu.

It is difficult to predict the impact that another emerging, or re-emerging, communicable disease would have on the U.S. public health system. The 2009 H1N1 pandemic caused between 100,000 and 600,000 deaths worldwide,¹³ while the 1918-1919 Spanish Flu was estimated to

¹³ <https://www.cdc.gov/flu/pandemic-resources/2009-h1n1-pandemic.html>.

have caused over 50 million deaths worldwide.¹⁴ Although advances in health care quality have greatly improved since 1918, the dramatic increases in global mobility in the 21st century have increased the rate at which a communicable disease can spread. Modern pandemics, spread through international travel, can engulf the world in three months or less. Moreover, pandemics can last from 12 to 18 months and are not considered one-time events.

The introduction of another emerging, or re-emerging, communicable disease into the United States is always a risk. The PHS Act section 362 suspension authority would be critical to any effort by CDC and its Federal, State, and local partners to contain or mitigate the risk. CDC expects to mitigate the risk in the future by issuing a Final Rule, after considering comments, to implement a permanent regulatory structure regarding the potential suspension of introduction of persons into the United States in the event a serious danger of the introduction of communicable disease arises in the future.

II. Statutory Authority

The primary legal authority supporting this rulemaking is section 362 of the PHS Act, which is codified at 42 U.S.C. 265. Under section 362, the Secretary¹⁵ has the authority—if he were to determine that the existence of a communicable disease in a foreign country creates a serious danger of the introduction of such disease into the United States, and that this danger is increased by the introduction of persons or property from such country such that suspension of introduction is necessary to protect the public health—to suspend, in accordance with regulations approved by the President,¹⁶ such introduction for determined periods of time.

¹⁴ <https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html>.

¹⁵ See *supra* at n.1.

¹⁶ See *supra* at n.2.

In addition to section 362, other sections of the PHS Act are relevant to this rulemaking, including section 311, 42 U.S.C. 243; section 361, 42 U.S.C. 264; section 365, 42 U.S.C. 268; and section 367, 42 U.S.C. 270. Section 311 authorizes the Secretary to accept State and local assistance in the enforcement of quarantine rules and regulations and to assist States and their political subdivisions in the control of communicable diseases. Section 361 authorizes the Secretary to make and enforce such regulations that in the Secretary's judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States. It also permits the "apprehension, detention, or conditional release of individuals" in order to prevent the "introduction, transmission, or spread" of such communicable diseases as may be specified from time to time in Executive Orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General. Section 365 provides that it shall be the duty of designated customs officers and of Coast Guard officers to aid in the enforcement of quarantine rules and regulations.¹⁷ Section 367 authorizes the application of certain sections of the PHS Act and promulgated regulations (including penalties and forfeitures for violations of such sections and regulations) to air navigation and aircraft to such extent and upon such conditions as deemed necessary for safeguarding public health.¹⁸

¹⁷ The terms "officer of the customs" and "customs officer" are defined by statute to mean, "any officer of the United States Customs Service of the Treasury Department (also hereinafter referred to as the "Customs Service") or any commissioned, warrant, or petty officer of the Coast Guard, or any agent or other person, including foreign law enforcement officers, authorized by law or designated by the Secretary of the Treasury to perform any duties of an officer of the Customs Service." 19 U.S.C. 1401(i). Although this provision refers to the Secretary of the Treasury, the Homeland Security Act transferred to the Secretary of Homeland Security all "the functions, personnel, assets, and liabilities of . . . the United States Customs Service of the Department of the Treasury, including the functions of the Secretary of the Treasury relating thereto . . . [,]" 6 U.S.C. 203(1), such that reference to the Secretary of the Treasury should be read to reference the Secretary of Homeland Security.

¹⁸ HHS quarantine authorities also apply to vessels. *See, e.g.*, PHS Act 364 (providing for quarantine stations at anchorages and vessel quarantine inspections), 366 (providing for bills of health for vessels, authorizing issuance of regulations applicable to vessels, and certificate of a quarantine officer before a vessel can enter any U.S. port to discharge cargo or land passengers).

III. Provisions of New § 71.40

This interim final rule will implement section 362 and other applicable provisions of the PHS Act to enable the CDC Director to suspend the introduction of persons into the United States consistent with the statute and applicable law.

Section 71.40(a) sets forth the statutory requirements for the CDC Director to suspend the introduction of persons into the United States. The provision establishes that the CDC Director may prohibit the introduction into the United States of persons from designated foreign countries (or one or more political subdivisions and regions thereof) or places, only for such period of time that the Director deems necessary for the public health, by issuing an order in which the Director determines that:

(1) By reason of the existence of any communicable disease in a foreign country (or one or more political subdivisions or regions thereof) or place, there is serious danger of the introduction of such communicable disease into the United States, and

(2) This danger is so increased by the introduction of persons from such country (or one or more political subdivisions or regions thereof) or place that a suspension of the introduction of such persons into the United States is required in the interest of the public health.

Section 71.40(b) sets forth definitions of several terms used in § 71.40. CDC defines the “introduction into the United States of persons” from a foreign country (or one or more political subdivisions or regions thereof) or place” as the movement of a person from a foreign country (or one or more political subdivisions or regions thereof) or a place, or series of foreign countries or places, into the United States so as to bring the person into contact with others in the United States, or so as to cause the contamination of property in the United States, in a manner that the Director determines to present a risk of transmission of the communicable disease to persons or

property, even if the communicable disease has already been introduced, transmitted, or is spreading within the United States.

Section 362 refers to the “introduction of persons” from foreign countries. CDC defines “introduction into the United States of persons” from a foreign country (including one or more political subdivisions or regions thereof) or place to clarify that “introduction” can encompass those who have physically crossed a border of the United States and are in the process of moving into the interior in a manner the Director determines to present a risk of transmission of a communicable disease. This additional mechanism to halt the travel of such persons and rapidly moving them outside the United States constitutes preventing their “introduction” into the United States for purposes of § 71.40.

Similarly, Section 362 refers to the “introduction of [a communicable disease] into the United States.” CDC defines “serious danger of the introduction of such communicable disease into the United States” to mean the potential for introduction of vectors of the communicable disease into the United States, even if persons or property in the United States are already infected or contaminated with the communicable disease. CDC establishes this definition to clarify that, even if persons or property (*e.g.* animals) in the United States are already infected or contaminated with a communicable disease in some localities, the potential for introduction of additional vectors that would introduce, transmit, or spread the disease in the same or different localities can present a serious danger of the introduction of the disease into the United States. Suspension of the introduction of persons into the United States may be required, in the interest of public health, to avert the increased danger that results from further introduction, transmission, or spread of the disease within the United States.

Finally, for purposes of this section, CDC defines the term “place” to include any location specified by the Director, including any carrier, whatever the carrier’s nationality. CDC does this in order to remove all doubt that when this interim final rule refers to “place,” it refers not just to territory within or outside of a country, but also to carriers, as that term is defined in 42 C.F.R. 71.1, whatever the carrier’s nationality.

CDC will establish the requirement to suspend the introduction of persons into the United States from certain designated places for certain periods of time by means of an order executed by the CDC Director. In § 71.40(c), CDC describes the required contents of such order. In any § 71.40 order, the CDC Director must designate:

- The foreign countries (or one or more designated political subdivisions or regions thereof) or places from which the introduction of persons is being suspended.
- The period of time or circumstances under which the introduction of any persons or class of persons into the United States is being suspended.
- The conditions under which that prohibition on introduction should be effective in whole or in part, including any relevant exceptions that the CDC Director determines are appropriate.

CDC might at times rely on (1) State and local authorities who agree to help implement orders issued pursuant to § 71.40, or (2) other Federal agencies to implement and execute the orders issued under this section. Accordingly, in § 71.40(d), CDC establishes that, before issuing any § 71.40 order, CDC may coordinate with the appropriate State and local authorities or other Federal agency (or agencies). If the order will be implemented in whole or in part by State and local authorities under 42 U.S.C. 243(a), the Director’s order may explain the procedures and standards by which those State or local authorities are expected to aid in the

order's enforcement. Similarly, if the order will be implemented in whole or in part by designated customs officers (including officers of the Department of Homeland Security with U.S. Customs and Border Protection who exercise the authorities of customs officers) or the United States Coast Guard under 42 U.S.C. 268(b), or another Federal department or agency, the CDC Director, in coordination with the Secretary of Homeland Security or the head of the other applicable department or agency, shall explain in the order the procedures and standards by which any authorities or officers or agents are expected to aid in the enforcement of the order, to the extent that they are permitted to do so under their existing legal authorities.

Section 71.40(e) provides that this section does not apply to members of the armed forces of the United States and associated personnel for whom the Secretary of Defense provides assurance to the Director that the Secretary of Defense, through measures such as quarantine, isolation, or other measures maintaining control over such individuals, is preventing the risk of transmission of a communicable disease to persons or property in the United States. CDC includes this exception because the Secretary of Defense has authority and means to prevent the introduction of a communicable disease into the United States from his personnel returning from foreign countries. Therefore, this interim final rule need not apply to Department of Defense personnel.

Although section 362 applies to "persons," this interim final rule will not apply to U.S. citizens or lawful permanent residents. Congress provided CDC with the authority to prohibit the introduction of persons who would increase a serious danger of introducing into the United States a communicable disease, when required in the interest of the public health. CDC believes that, at present, quarantine, isolation, and conditional release, in combination with other authorities, while not perfect solutions, can mitigate any transmission or spread of COVID-19

caused by the introduction of U.S. citizens or lawful permanent residents into the United States. Section 71.40(f) therefore explains that this interim final rule shall not apply to U.S. citizens and lawful permanent residents. Determining the appropriate protections for U.S. citizens and lawful permanent aliens requires a complex balancing of numerous interests and would benefit from additional consideration and public comment. HHS does not want such concerns to delay the issuance of this interim final rule, which would enable the CDC Director to issue orders that would have the effect of slowing the introduction, transmission, and spread of COVID-19 in the United States.

V. Rationale for Issuance of an Interim Final Rule with Immediate Effectiveness

Agency rulemaking is governed by section 553 of the Administrative Procedure Act (APA) (5 U.S.C. 553). Section 553(b) requires that, unless the rule falls within one of the enumerated exemptions, HHS must publish a notice of proposed rulemaking in the Federal Register that provides interested persons an opportunity to submit written data, views, or arguments, prior to finalization of regulatory requirements. Section 553(b)(3)(B) of the APA authorizes a department or agency to dispense with the prior notice and opportunity for public comment requirement when the agency, for “good cause,” finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. In addition, because this interim final rule represents a critical part of the dialogue between the United States and the Governments of Mexico and Canada in preventing the spread of COVID-19 along our shared borders, it involves a “foreign affairs function of the United States.” 5 U.S.C. 553(a)(1).

As noted above, the United States and numerous other countries have taken unprecedented measures to try to contain or slow the transmission or spread of COVID-19. Such public health actions, especially the actions by the President and the Secretary, have slowed the

introduction and transmission of the disease into the United States, which has benefitted the public health, preserved limited public and private resources, and given the U.S. public health system additional time to implement further measures to protect and support the public.

Nevertheless, these measures have not completely stopped global travelers, and other persons crossing from one country into another country, from spreading COVID-19 across national boundaries and around the globe. The introduction of persons from foreign countries with COVID-19 outbreaks is continuing to cause the introduction of COVID-19 into disparate locations within the United States. The suspension authority is therefore critical to slowing the introduction of COVID-19 into such disparate locations within the United States. The United States is in a phase where suspending the introduction of persons from certain countries or places may be required in the interest of the public health, because it could still materially reduce the transmission and spread of COVID-19 in the United States. Because persons can have COVID-19 and be asymptomatic at the time of introduction into the United States, and because the completion of testing for COVID-19 may take three to four days, it is impracticable to confirm who is infected with COVID-19 and who is not infected with COVID-19 as persons move into the United States. Similarly, Federal quarantines or isolations of all such persons pending test results would be impracticable due to the numbers of persons involved, logistical challenges, and CDC resource and personnel constraints.

In addition, whereas section 212(f) of the INA applies to the “entry” of aliens, section 362 applies to the “introduction” of persons into the United States. Therefore, although 212(f) has been effective in slowing the transmission or spread of COVID-19 in the United States, section 362 provides CDC with a mechanism tied specifically to persons who increase the danger of introducing COVID-19 into the United States.

Given the national emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay these implementing regulations until a full public notice-and-comment process is completed.

Pursuant to 5 U.S.C. 553(b)(3)(B), and for the reasons stated above, HHS therefore concludes that there is good cause to dispense with prior public notice and the opportunity to comment on this rule before finalizing this rule. For the same reasons, HHS has determined, consistent with section 553(d) of the APA, that there is good cause to make this interim final rule effective immediately upon filing at the Office of the Federal Register.

IV. Request for Comment

HHS requests comment on all aspects of this interim final rule, including its likely costs and benefits and the impacts that it is likely to have on the public health, as compared to the current requirements under 42 CFR Part 71.

VI. Regulatory Impact Analysis

Executive Orders 12866 and 13563 and Regulatory Flexibility Act

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, and public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a regulation (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as “economically

significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. This interim final rule is economically significant for the purposes of Executive Orders 12866 and 13563. CDC, however, is proceeding under the emergency provision at Executive Order 12866 Section 6(a)(3)(D) based on the need to move expeditiously during the current public health emergency to limit the number of new cases of COVID-19.

The Regulatory Flexibility Act (RFA) generally requires that when an agency issues a proposed rule, or a final rule pursuant to section 553(b) of the APA or another law, the agency must prepare a regulatory flexibility analysis that meets the requirements of the RFA and publish such analysis in the Federal Register. 5 U.S.C. 603, 604. Specifically, the RFA normally requires agencies to describe the impact of a rulemaking on small entities by providing a regulatory impact analysis. Such analysis must address the consideration of regulatory options that would lessen the economic effect of the rule on small entities. The RFA defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a nonprofit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. 5 U.S.C. 601(3)–(6). Except for such small government jurisdictions, neither State nor local governments are “small entities.” Similarly, for purposes of the RFA, individual persons are not small entities. The requirement to conduct a regulatory impact analysis does not apply if the head of the agency “certifies that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.” 5 U.S.C. 605(b). The agency must, however, publish the certification in the Federal

Register at the time of publication of the rule, “along with a statement providing the factual basis for such certification.” *Id.* If the agency head has not waived the requirements for a regulatory flexibility analysis in accordance with the RFA’s waiver provision, and no other RFA exception applies, the agency must prepare the regulatory flexibility analysis and publish it in the Federal Register at the time of promulgation or, if the rule is promulgated in response to an emergency that makes timely compliance impracticable, within 180 days of publication of the final rule. 5 U.S.C. 604(a), 608(b).¹⁹

This interim final rule establishes a regulatory mechanism for the exercise of the PHS Act section 362 suspension authority, which directly applies against persons and not State, local, or tribal governments, or the private sector. Accordingly, HHS and CDC believe that this interim final rule would likely impact only persons, and that it would, therefore, not have a significant economic impact on a substantial number of small entities. In addition, for the reasons set forth in this document pertaining to the COVID-19 outbreak, the Secretary finds that this interim final rule is being promulgated in response to an emergency that makes timely compliance with the provisions of section 604 impracticable. CDC will assess the potential impacts—including economic effects—of this action on all small entities. Based on that assessment, the Secretary will either certify that the rule will not have a significant economic impact on a substantial number of small entities or publish a final regulatory flexibility analysis.

Unfunded Mandates Reform Act

¹⁹ An agency head may delay the completion of the regulatory impact analysis requirements for a period of not more than 180 days after the date of publication in the Federal Register of a final rule by publishing in the Federal Register, not later than such date of publication, a written finding, with reasons therefor, that the final rule is being promulgated in response to an emergency that makes timely compliance with such requirements impracticable. If the agency has not prepared a final regulatory analysis within 180 days from the date of publication of the final rule, the RFA provides that the rule shall lapse and have no effect and shall not be re-promulgated until a final regulatory flexibility analysis has been completed by the agency. 5 U.S.C. 608(b).

Section 202 of the Unfunded Mandates Reform Act of 1995 (Unfunded Mandates Act) (2 U.S.C. 1532) requires that covered agencies prepare a budgetary impact statement before promulgating a rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. Currently, that threshold is approximately \$154 million. If a budgetary impact statement is required, section 205 of the Unfunded Mandates Act also requires covered agencies to identify and consider a reasonable number of regulatory alternatives before promulgating a rule. HHS has determined that this interim final rule is not expected to result in expenditures by State, local, and tribal governments, or by the private sector, of \$154 million or more in any one year because it only establishes a regulatory mechanism for the exercise of the PHS Act section 362 suspension authority, which applies against persons and not State, local, or tribal governments, or the private sector. Accordingly, HHS has not prepared a budgetary impact statement or specifically addressed the regulatory alternatives considered.

National Environmental Policy Act (NEPA)

HHS has determined that the amendments to 42 CFR Part 71 will not have a significant impact on the human environment.

Executive Order 12988: Civil Justice Reform

HHS has reviewed this rule under Executive Order 12988 on Civil Justice Reform and has determined that this interim final rule meets the standard in the Executive Order.

Executive Order 13132: Federalism

This interim final rule has been reviewed under Executive Order 13132, Federalism. Under 42 U.S.C. 264(e), Federal public health regulations do not preempt State or local public

health regulations, except in the event of a conflict with the exercise of Federal authority. Other than to restate this statutory provision, this rulemaking does not alter the relationship between the Federal government and State/local governments as set forth in 42 U.S.C. 264. The longstanding provision on preemption in the event of a conflict with Federal authority (42 CFR 70.2) is left unchanged by this rulemaking. Furthermore, there are no provisions in this regulation that impose direct compliance costs on State and local governments. Therefore, HHS believes that the interim final rule does not warrant additional analysis under Executive Order 13132.

Plain Language Act of 2010

Under the Plain Language Act of 2010 (Pub. L. 111-274, October 13, 2010), executive Departments and Agencies are required to use plain language in documents that explain to the public how to comply with a requirement the Federal Government administers or enforces. HHS/CDC has attempted to use plain language in promulgating this interim final rule, consistent with the Federal Plain Writing Act guidelines.

Congressional Review Act

The Congressional Review Act defines a “major rule” as “any rule that the Administrator of the Office of Information and Regulatory Affairs (OIRA) of the Office of Management and Budget finds has resulted in or is likely to result in—(A) an annual effect on the economy of \$100,000,000 or more; (B) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or (C) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.” 5 U.S.C. 804(2). This Office of Information and Regulatory Affairs has determined that this interim final rule is a major rule for purposes of the Congressional Review

Act. As this rule is promulgated under the “good cause” exemption of the Administrative Procedure Act, there is not a delay in its effective date under the Congressional Review Act.

Assessment of Federal Regulation and Policies on Families

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires Federal departments and agencies to determine whether a proposed policy or regulation could affect family well-being. If the determination is affirmative, then the Department or agency must prepare an impact assessment to address criteria specified in the law. HHS has determined that this interim final rule will not have an impact on family well-being, as defined in the Act.

Paperwork Reduction Act of 1995

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Ch. 3506; 5 CFR 1320 Appendix A.1), HHS has reviewed this interim final rule and has determined that there are no new collections of information contained therein.

List of Subjects in 42 CFR Part 71

Apprehension, Communicable diseases, Conditional release, CDC, Ill person, Isolation, Non-invasive, Public health emergency, Public health prevention measures, Qualifying stage, Quarantine, Quarantinable communicable disease.

For the reasons set forth in the preamble, the Department of Health and Human Services, on behalf of the Centers for Disease Control and Prevention, amends 42 CFR part 71 as follows:

PART 71 — FOREIGN QUARANTINE

1. The authority citation for part 71 continues to read as follows:

Authority: Secs. 215 and 311 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 216, 243); secs. 361-369, PHS Act, as amended (42 U.S.C. 264-272).

2. Add § 71.40 to Subpart D of part 71 to read as follows:

§ 71.40 Prohibiting the introduction of persons from designated foreign countries and places into the United States.

(a) The Director may prohibit the introduction into the United States of persons from designated foreign countries (or one or more political subdivisions and regions thereof) or places, only for such period of time that the Director deems necessary for the public health, by issuing an order in which the Director determines that:

(1) By reason of the existence of any communicable disease in a foreign country (or one or more political subdivisions or regions thereof) or place there is serious danger of the introduction of such communicable disease into the United States; and

(2) This danger is so increased by the introduction of persons from such country (or one or more political subdivisions or regions thereof) or place that a suspension of the introduction of such persons into the United States is required in the interest of the public health.

(b) For purposes of this section:

(1) *Introduction into the United States* of persons from a foreign country (or one or more political subdivisions or regions thereof) or place means the movement of a person from a foreign country (or one or more political subdivisions or regions thereof) or place, or series of foreign countries or places, into the United States so as to bring the person into contact with persons in the United States, or so as to cause the contamination of property in the United States, in a manner that the Director determines to present a risk of transmission of a communicable disease to persons or property, even if the communicable disease has already been introduced, transmitted, or is spreading within the United States;

(2) *Serious danger of the introduction of such communicable disease into the United States* means the potential for introduction of vectors of the communicable disease into the United States, even if persons or property in the United States are already infected or contaminated with the communicable disease; and

(3) The term *Place*” includes any location specified by the Director, including any carrier, as that term is defined in 42 CFR 71.1, whatever the carrier’s nationality.

(c) In any order issued under this section, the Director shall designate the foreign countries (or one or more political subdivisions or regions thereof) or places; the period of time or circumstances under which the introduction of any persons or class of persons into the United States shall be suspended; and the conditions under which that prohibition on introduction, in whole or in part, shall be effective, including any relevant exceptions that the Director determines are appropriate.

(d) Before issuing any order under this section, the Director may coordinate with State and local authorities and other Federal departments or agencies as he deems appropriate in his discretion.

(1) If the order will be implemented in whole or in part by State and local authorities who have agreed to do so under 42 U.S.C. 243(a), then the Director may explain in the order the procedures and standards by which those authorities are expected to aid in the enforcement of the order.

(2) If the order will be implemented in whole or in part by designated customs officers (including officers of the Department of Homeland Security with U.S. Customs and Border Protection, who exercise the authorities of customs officers) or Coast Guard officers under 42 U.S.C. 268(b), or another Federal department or agency, then the Director shall, in coordination with the Secretary of Homeland Security or other applicable Federal department or agency head,

explain in the order the procedures and standards by which any authorities or officers or agents are expected to aid in the enforcement of the order, to the extent that they are permitted to do so under their existing legal authorities.

(e) This section does not apply to members of the armed forces of the United States and associated personnel for whom the Secretary of Defense provides assurance to the Director that the Secretary of Defense, through measures such as quarantine, isolation, or other measures maintaining control over such individuals, is preventing the risk of transmission of a communicable disease into the United States.

(f) This section shall not apply to U.S. citizens and lawful permanent residents.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.

[FR Doc. 2020-06238 Filed: 3/20/2020 4:15 pm; Publication Date: 3/24/2020]

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

EXHIBIT B

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**ORDER SUSPENDING INTRODUCTION OF
CERTAIN PERSONS FROM COUNTRIES
WHERE A COMMUNICABLE DISEASE EXISTS**

I. Purpose and Application

I issue this order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and their implementing regulations, which authorize the Director of the Centers for Disease Control and Prevention (CDC) to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

This order applies to persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry (POE) or Border Patrol station at or near the United States borders with Canada and Mexico, subject to the exceptions detailed below. The danger to the public health that results from the introduction of such persons into congregate settings at or near the borders is the touchstone of this order.

This order is necessary to protect the public health from an increase in the serious danger of the introduction of Coronavirus Disease 2019 (COVID-19) into the land POEs, and the Border Patrol stations between POEs, at or near the United States borders with Canada and Mexico. Those facilities are operated by U.S. Customs and Border Protection (CBP), an agency within the U.S. Department of Homeland Security (DHS). This order is also necessary to protect the public health from an increase in the serious danger of the introduction of COVID-19 into the interior of the country when certain persons are processed through the same land POEs and Border Patrol stations and move into the interior of the United States.

There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the United States land borders with Canada and Mexico. Those persons are subject to immigration processing in the land POEs and Border Patrol stations. Many of those persons (typically aliens who lack valid travel documents and are therefore inadmissible) are held in the common areas of the facilities, in close proximity to one another, for hours or days, as they undergo immigration processing. The common areas of such facilities were not designed for, and are not equipped to, quarantine, isolate, or enable social distancing by persons who are or may be infected with COVID-19. The introduction into

congregate settings in land POEs and Border Patrol stations of persons from Canada or Mexico increases the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of such persons into the United States.

The public health risks of inaction are stark. They include transmission and spread of COVID-19 to CBP personnel, U.S. citizens, lawful permanent residents, and other persons in the POEs and Border Patrol stations; further transmission and spread of COVID-19 in the interior; and the increased strain that further transmission and spread of COVID-19 would put on the United States healthcare system and supply chain during the current public health emergency.

These risks are troubling because POEs and Border Patrol stations were not designed and are not equipped to deliver medical care to numerous persons, nor are they capable of providing the level of care that vulnerable populations with COVID-19 may require. Indeed, CBP typically transfers persons with acute presentations of illness to local or regional healthcare providers for treatment. Outbreaks of COVID-19 in land POEs or Border Patrol stations would lead to transfers of such persons to local or regional health care providers, which would exhaust the local or regional healthcare resources, or at least reduce the availability of such resources to the domestic population, and further expose local or regional healthcare workers to COVID-19.^[1] The continuing availability of healthcare resources to the domestic population is a critical component of the Federal government's overall public health response to COVID-19. Action is required.

As stated above, this order applies to persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land POE or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. Additionally, this order does not apply to persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

DHS has informed CDC that persons who are traveling from Canada or Mexico (regardless of their country of origin), and who must be held longer in congregate settings in POEs or Border Patrol stations to facilitate immigration processing, would typically be aliens seeking to enter the United States at POEs who do not have proper travel documents, aliens whose entry is otherwise contrary to law, and aliens who are apprehended near the border seeking to unlawfully enter the United States between POEs. This order is intended to cover all such aliens.

^[1] An outbreak of COVID-19 among CBP personnel in land POEs or Border Patrol stations would impact CBP operations negatively. Although not part of the CDC public health analysis, it bears emphasizing that the impact on CBP could reduce the security of U.S. land borders and the speed with which cargo moves across the same.

For simplicity, I shall refer to the persons covered by this order as “covered aliens.” I suspend the introduction of all covered aliens into the United States for a period of 30 days, starting from the date of this order. I may extend this order if necessary to protect the public health.

II. Factual Basis for Order¹

1. COVID-19 is a global pandemic that has spread rapidly

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan, Hubei Province, People’s Republic of China (China).²

COVID-19 appears to spread easily and sustainably within communities.³ The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may also transfer through contact with surfaces or objects contaminated with these droplets.⁴ There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms.⁵ The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.⁶

Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure.⁷ Manifestations of severe disease have included severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure.⁸ According to the WHO, approximately 3.4% of reported COVID-19 cases have resulted in death globally.⁹ This

¹ Given the dynamic nature of the public health emergency, CDC recognizes that the types of facts and data set forth in this section may change rapidly (even within a matter of hours). The facts and data cited by CDC in this order represent a good-faith effort by the agency to present the current factual justification for the order.

² Centers for Disease Control and Prevention, Situation Summary (Mar. 15, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html>.

³ Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (Mar. 10, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

⁴ *Id.*

⁵ Centers for Disease Control and Prevention, Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (Mar. 7, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

⁶ Ariana Eunjung Cha, Washington Post, Spiking U.S. Coronavirus Cases Could Force Rationing Decisions Similar to Those Made in Italy, China (Mar. 15, 2020), available at <https://www.washingtonpost.com/health/2020/03/15/coronavirus-rationing-us/>.

⁷ Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19) (Mar. 16, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>.

⁸ *Supra*, note 4.

⁹ WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19 (Mar. 3, 2020), available at

mortality rate is higher among older adults or those with compromised immune systems.¹⁰ Older adults and people who have severe chronic medical conditions like heart, lung, or kidney disease are also at higher risk for more serious COVID-19 illness.¹¹ Early data suggest older people are twice as likely to have serious COVID-19 illness.¹²

As of March 17, 2020, there were over 179,112 cases of COVID-19 globally in 150 locations, resulting in over 7,426 deaths; more than 4,226 cases have been identified in the United States, with new cases being reported daily and over 75 deaths due to the disease.¹³

Unfortunately, at this time, there is no vaccine against COVID-19, nor are there any approved therapeutics available for those who become infected. Treatment is currently limited to supportive care to manage symptoms. Hospitalization may be required in severe cases and mechanical respiratory support may be needed in the most severe cases. Testing is available to confirm suspected cases of COVID-19 infection. Testing requires specimens collected from the nose, throat or lungs; specimens can only be analyzed in a laboratory setting. At present, results are typically available within three to four days.¹⁴ There is currently no rapid test for COVID-19 that can provide results at the time of sample collection, although efforts are underway to develop such a test.

On January 30, 2020, the Director General of the WHO declared COVID-19 to be a Public Health Emergency of International Concern under the International Health Regulations.¹⁵ The following day, the Secretary of Health and Human Services (HHS) declared that COVID-19 is a public health emergency under the Public Health Service Act (PHSA).¹⁶ On March 11, 2020, the

<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020>.

¹⁰ *Supra*, note 4.

¹¹ *Id.*

¹² *Id.*

¹³ Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Cases in U.S. (Mar. 17, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html; World Health Organization, Coronavirus disease 2019 (COVID-19) Situation Report – 57 (Mar. 17, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_2, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_2.

¹⁴ Centers for Disease Control and Prevention, Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) (Mar. 13, 2020), available at <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>.

¹⁵ World Health Organization, Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (January 30, 2020), [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

¹⁶ U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Determination that a Public Health Emergency Exists (January 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

WHO officially classified the global COVID-19 outbreak as a pandemic.¹⁷ On March 13, 2020, the President issued a Presidential Declaration that COVID-19 constitutes a National Emergency.¹⁸ Likewise, all U.S. states, territories, and the District of Columbia have declared a state of emergency in response to the growing spread of COVID-19.¹⁹

Global efforts to slow the spread of COVID-19 have included sweeping travel limitations. Countries such as Japan, Australia, Israel, Russia, and the Philippines have imposed stringent restrictions on travelers who have recently been in China, the epicenter of the pandemic. Similar travel restrictions have since been imposed on individuals from places experiencing substantial outbreaks, including the Islamic Republic of Iran (Iran), South Korea, and Europe. In many countries, individuals are being asked to self-quarantine for 14 days—the outer limit of the COVID-19’s estimated incubation period—following return from a foreign country with sustained community transmission.²⁰

In the United States, the President has suspended the entry of most travelers from China (excluding Hong Kong and Macau), Iran, the Schengen Area of Europe,²¹ the United Kingdom (excluding overseas territories outside of Europe), and the Republic of Ireland, due to COVID-19.²² CDC has issued Level 3 Travel Health Notices recommending that travelers avoid all nonessential travel to China (excluding Hong Kong and Macau), Iran, South Korea, and most of Europe.²³ The U.S. Department of State has issued a global Level 4 Do Not Travel Advisory advising travelers to avoid all international travel due to the global impact of COVID-19.²⁴ In

¹⁷ World Health Organization, WHO Director-General’s opening remarks at the media briefing on COVID-19 – 11 (March 11, 2020), <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

¹⁸ Message to Congress on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (March 13, 2020) <https://www.whitehouse.gov/briefings-statements/message-congress-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

¹⁹ National Governors Assn., Coronavirus: What You Need to Know, (last updated March 17, 2020) <https://www.nga.org/coronavirus/#states>.

²⁰ James Asquith, [Update] Complete Coronavirus Travel Guide – The Latest Countries Restricting Travel, (March 16, 2020), <https://www.forbes.com/sites/jamesasquith/2020/03/15/complete-coronavirus-travel-guide-the-latest-countries-restricting-travel/#2fdc3b7d715b>.

²¹ For purposes of this order, the Schengen Area comprises 26 European states: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland.

²² Proclamation on the Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus (March 14, 2020) <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-coronavirus-2/>.

²³ Centers for Disease Control and Prevention, Travelers’ Health, COVID – 19 in Europe, Warning – Level 3, Avoid Nonessential Travel – Widespread Ongoing Transmission (March 11, 2020) <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-europe>.

²⁴ U.S. Dept. of State, Bureau of Consular Affairs, Global Level 4 Health Advisory – Reconsider Travel (March 15, 2020) <https://travel.state.gov/content/travel/en/traveladvisories/ea/travel-advisory-alert-global-level-4-health-advisory-issue.html>.

addition, CDC has recommended that travelers, particularly those with underlying health conditions, avoid all cruise ship travel worldwide.²⁵ The U.S. Department of State has similarly issued guidance that U.S. citizens should not travel by cruise ship at this time.²⁶

The Federal government announced guidelines stating that the public should avoid discretionary travel; shopping trips; social visits; gatherings in groups of more than 10 people; and eating or drinking at bars, restaurants, and food courts.²⁷ Numerous states and localitieslocalitieslocalitieslocalitieslocalitieslocalitieslocalities have gone further and shut down restaurants, bars, nightclubs, and theaters. For example, 6 counties surrounding San Francisco, California have issued shelter in place orders impacting nearly 7 million residents.²⁸ Similar measures are being considered in other cities.²⁹

2. COVID-19 exists in Canada and Mexico

i. Persons from Canada and other foreign countries where COVID-19 exists cross into the United States from Canada frequently

As of March 17, 2020, Canada has reported 424 confirmed cases of COVID-19, of which the Canadian government believes 74% are travel-related with an additional 6% being close contacts of travelers.³⁰ This is a 115% increase in confirmed cases in four days.³¹ The provinces of Ontario and British Columbia have reported the most COVID-19 cases, with Ontario reporting a 29% increase in confirmed cases in a single day.³² Canada's Chief Public Health Officer stated that community transmission of COVID-19 is occurring in multiple provinces and Ottawa public

²⁵ Centers for Disease Control and Prevention, Travelers' Health, COVID – 19 and Cruise Ship Travel, Warning – Level 3, Avoid Nonessential Travel (March 17, 2020) <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-cruise-ship>.

²⁶ U.S. Dept. of State, Bureau of Consular Affairs, Current Outbreak of Coronavirus Disease 2019 (March 14, 2020) <https://travel.state.gov/content/travel/en/traveladvisories/ea/covid-19-information.html>.

²⁷ The White House & Centers for Disease Control and Prevention, 15 Days to Slow the Spread (Mar. 15, 2020), available at https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf.

²⁸ Erin Allday, San Francisco Chronicle, Bay Area Orders 'Shelter in Place' Only Essential Businesses Open in 6 Counties (Mar. 18, 2020), available at <https://www.sfchronicle.com/local-politics/article/Bay-Area-must-shelter-in-place-Only-15135014.php>.

²⁹ Noah Higgins-Dunn & William Feuer, CNBC, New Yorkers Should be Prepared for a 'Shelter-In-Place,' Mayor Bill de Blasio says (Mar. 18, 2020), available at <https://www.cnbc.com/2020/03/17/new-yorkers-should-be-prepared-for-a-shelter-in-place-order-mayor-bill-de-blasio-says.html>.

³⁰ Government of Canada, Coronavirus disease (COVID-19): Outbreak update (Mar. 15, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>.

³¹ National Post, The Latest Numbers of COVID-19 Cases in Canada as of March 13, 2020 (Mar. 13, 2020), available at <https://nationalpost.com/pmnn/news-pmn/canada-news-pmn/the-latest-numbers-of-covid-19-cases-in-canada-as-of-march-13-2020>.

³² Ryan Rocca, Global News, Coronavirus: Ontario reports 39 new COVID-19 cases, provincial total rises to 142 (Mar. 15, 2020), https://globalnews.ca/news/6679409/ontario-coronavirus-update-march-15/?utm_source=site_banner.

health officials believe that there are at least 1,000 undiagnosed cases in the Canadian capital alone.³³ In an effort to slow the transmission and spread of the virus, the Canadian government banned foreign nationals from all countries except the United States from entering Canada and mandated that returning Canadians self-monitor for COVID-19 symptoms for 14 days following their return, effective March 18, 2020.³⁴

The United States and Canada share the longest international border in the world, spanning approximately 3,987 (largely unfenced) miles with 119 ports of entry.³⁵

In 2017, approximately 33 million individuals crossed the Canadian border into the United States.³⁶ Through February of Fiscal Year (FY) 2020, DHS has processed 20,166 inadmissible aliens at POEs at the U.S.-Canadian border, and CBP has apprehended 1,185 inadmissible aliens attempting to unlawfully enter the United States between POEs.³⁷ These aliens have included not only Canadian nationals, but also 1,062 Iranian nationals, 1,396 Chinese nationals, and 1,326 nationals of Schengen Area countries—all of which currently have COVID-19 outbreaks. Indeed, the United States government has determined that China, Iran, and the countries of the Schengen Area are experiencing sustained person-to-person transmittal of the disease.³⁸ As of March 15, 2020, the WHO reports that China has 81,048 confirmed cases and 3,204 deaths; Iran has 12,729 confirmed cases and 608 deaths³⁹; and the Schengen Area has almost 42,000 confirmed cases.⁴⁰ The total number of COVID-19 infections in these countries is impracticable to quantify due to the inherent limitations of epidemiological surveillance, but are likely higher than the reported number of confirmed cases because COVID-19 can be present in asymptomatic persons.

³³ Adam Miller, Canadian Broadcast Corporation, ‘The Time is Now to Act’: COVID-19 spreading in Canada With no Known Link to Travel, Previous Cases (Mar. 16, 2020), available at <https://www.cbc.ca/news/health/coronavirus-community-transmission-canada-1.5498804>; CBC News, Canadian Broadcast Corporation, Community Spread of COVID-19 in Ottawa Likely, Says OPH (Mar. 15, 2020), available at <https://www.cbc.ca/news/canada/ottawa/5-new-covid-cases-ottawa-1.5498489>.

³⁴ Government of Canada, Coronavirus disease (COVID-19): Canada’s Response, At Canadian Borders (Mar. 16, 2020), available at <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse.html#acb>.

³⁵ Janice Cheryh Beaver, Congressional Research Service, U.S. International Borders: Brief Facts (Feb. 1, 2007), available at https://www.everycrsreport.com/files/20070201_RS21729_514d6fe01555a06aa58c33fd1d8cf34ad1dc50f8.pdf.

³⁶ Les Perreux, The Globe and Mail, Rejection Rate on the Rise for Canadians at U.S. Border (Apr. 14, 2017), available at <https://www.theglobeandmail.com/news/national/rejection-rate-on-the-rise-for-canadians-at-us-border/article34262237/>.

³⁷ Exhibits 2 and 3, attached.

³⁸ The White House, Proclamation—Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus (Mar. 11, 2020), available at <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-2019-novel-coronavirus/>.

³⁹ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 55 (Mar. 15, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200315-sitrep-55-covid-19.pdf?sfvrsn=33daa5cb_8.

⁴⁰ *Id.*

On March 18, 2020, the President announced that the United States “will be, by mutual consent, temporarily closing our Northern Border with Canada to non-essential traffic,” and DHS will be issuing guidance on the implementation of that arrangement, including exceptions for “essential travels.”

ii. Mexico expects community transmission of COVID-19 and has been slower to implement public health measures

According to WHO, as of March 17, 2020, Mexico has only 53 confirmed cases of COVID-19, all found to be travel related, and no deaths.⁴¹ Some Mexican public health experts believe the number of COVID-19 cases in the country is much higher and that Mexico will see widespread community transmission of the virus in the near future.⁴² A Deputy Health Minister in Mexico has attributed Mexico’s low number of confirmed cases to the virus having been first detected in Mexico on February 27, 2020, approximately one month after the first confirmed cases in the United States.⁴³ The same official also stated that, based on the Mexican government’s modeling, Mexico expects community transmission of COVID-19 to begin between 15 and 40 days from the first confirmed case (in other words, as early as March 13, 2020).⁴⁴

Mexico is only now undertaking some of the public health measures to mitigate the spread of the virus.⁴⁵ Schools will be closed from March 20 until April 20, and some large public events are being cancelled.⁴⁶ However, many events, such as professional soccer games, have gone

⁴¹ *Id.* World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 57 (Mar. 17, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_4.

⁴² Andrea Ano, Latin Post, Experts Question Mexico's Coronavirus Preparations (Mar. 15, 2020), available at <http://www.latinpost.com/articles/144156/20200315/experts-question-mexicos-coronavirus-preparations.htm>; Mexico News Daily, One Former Health Minister Critical of Coronavirus Response (Mar. 14, 2020), available at <https://mexiconewsdaily.com/news/former-health-secretary-critical-of-coronavirus-response/>.

⁴³ Mexico News Daily, Why so few Cases of Coronavirus? Deputy Minister Explains In Other Countries the Disease was Detected Earlier (Mar. 13, 2020), available at <https://mexiconewsdaily.com/news/why-so-few-cases-of-coronavirus-deputy-minister-explains/>.

⁴⁴ Mexico News Daily, Business Insider, A Widespread Outbreak of Coronavirus in Mexico is 'Inevitable,' Health Officials Say (Mar. 13, 2020), available at <https://www.businessinsider.com/widespread-outbreak-of-coronavirus-in-mexico-is-inevitable-2020-3>.

⁴⁵ Patrick J. McDonnell, Katie Linthicum, Tracy Wilkinson, L.A. Times, Mexico, Latin America Gear up for Next Phase of Coronavirus Threat (Mar. 14, 2020), available at <https://www.latimes.com/world-nation/story/2020-03-14/mexico-latin-america-gear-up-for-next-phase-of-coronavirus-threat>; *cf* Dave Graham, Reuters, Mexico Government Urges Public to Keep Distance Over Coronavirus; President Embraces Crowds (Mar. 15, 2020), available at <https://www.reuters.com/article/us-health-coronavirus-mexico/mexico-government-urges-public-to-keep-distance-over-coronavirus-president-embraces-crowds-idUSKBN2130A0>.

⁴⁶ Alexis Ortiz & Karla Linares, El Universal, COVID-19: Mexico to Suspend Classes Over Coronavirus Concerns (Mar. 14, 2020), available at <https://www.eluniversal.com.mx/english/covid-19-mexico-suspend-classes-over-coronavirus-concerns>.

forward as planned.⁴⁷ Mexico has not announced any restrictions on persons entering the country from areas with sustained human-to-human transmission of the disease.⁴⁸ There are currently no COVID-19 health screenings at Mexico's international airports, although Mexican officials have announced that some additional screening measures may be implemented.⁴⁹ Medical experts believe that community transmission and spread of COVID-19 at asylum camps and shelters along the U.S. border is inevitable, once community transmission begins in Mexico.⁵⁰

Mexico has fewer health care resources than the United States. Mexico's total expenditure on health care per capita is \$1,122, compared to the United States' \$9,403 per person.⁵¹ On average, there are only 1.38 available hospital beds per every 1,000 inhabitants in Mexico, compared to 2.77 available hospital beds per every 1,000 inhabitants in the United States.⁵² Similarly, there are approximately 2.2 practicing doctors and 2.9 practicing nurses per every 1,000 inhabitants in Mexico, compared to 2.6 practicing doctors and 8.6 practicing nurses per every 1,000 inhabitants in the United States.⁵³ This raises public health concerns, given that Mexico is likely to reach community transmission soon (including in asylum camps and shelters).

While Mexico responded vigorously to the H1N1 pandemic in 2009-2010, Mexico does not appear to be approaching the COVID-19 pandemic with the same dispatch. In 2003, Mexico established the National Preparedness and Response Plan for an Influenza Pandemic, which was first tested during the 2009 outbreak of H1N1 influenza. Mexico helped contain that outbreak, primarily through early detection of the outbreak, followed by the declaration of a "sanitary emergency" that focused on raising public awareness of the need to contain the spread with proper hygiene, school closings, cancellation of large public gatherings, and aggressive surveillance through widespread testing.⁵⁴ Mexico does not appear to have undertaken equivalent measures in

⁴⁷ Kirk Semple, The N.Y. Times, 'We Call for Calm': Mexico's Restrained Response to the Coronavirus (Mar. 15, 2020), available at <https://www.nytimes.com/2020/03/15/sports/soccer/soccer-mexico-coronavirus.html>.

⁴⁸ Wendy Fry, The San Diego Union-Tribune, While Impacts of Coronavirus Remain Mild in Baja California, Mexico Begins Bracing for Outbreak (Mar. 13, 2020), available at <https://www.sandiegouniontribune.com/news/border-baja-california/story/2020-03-13/impacts-of-coronavirus-remain-mild-in-baja-california>.

⁴⁹ *Id.*

⁵⁰ Rick Jervis, USA Today, Migrants Waiting at U.S.-Mexico Border at Risk of Coronavirus, Health Experts Warn (Mar. 17, 2020), available at <https://www.usatoday.com/story/news/nation/2020/03/17/us-border-could-hit-hard-coronavirus-migrants-wait-mexico/5062446002/>; Rafael Carranza, AZ Central, New World's Largest Border Crossing, Tijuana Shelters Eye the new Coronavirus with Worry (Mar. 14, 2020), available <https://www.azcentral.com/story/news/politics/immigration/2020/03/14/tijuana-migrant-shelters-coronavirus-covid-19/5038134002/>.

⁵¹ Compare WHO, Mexico—Statistics, <https://www.who.int/countries/mex/en/>, with WHO, United States of America—Statistics, <https://www.who.int/countries/usa/en/>.

⁵² See Organization for Economic Co-operation and Development ("OECD"), Data—Hospital Beds, <https://data.oecd.org/health/hospital-beds.htm>.

⁵³ Compare The World Bank, Data—Physicians (per 1,000 people), <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS>, with The World Bank, Data—Nurses and Midwives (per 1,000 people), <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS>.

⁵⁴ See Jose A. Cordova-Villalobos et al., The influenza A (H1N1) epidemic in Mexico: Lessons learned, Health Research Policy & Systems 7:21 (Sept. 28, 2009); Gerardo Chowell, Characterizing the Epidemiology of the 2009

response to the COVID-19 pandemic. COVID-19 is more infectious than H1N1, and so CDC expected a more vigorous Mexican response to COVID-19, which has not occurred.

It also bears noting that Mexico struggled to mobilize its strategic stockpile of the antiviral drug Oseltamivir during the 2009-2010 H1N1 outbreak.⁵⁵ The entire strategic stockpile was centrally stored as dry bulk product, and the national pandemic preparedness plan called for the dry bulk to be distributed to and reconstituted by Mexico's 31 state-level public health laboratories.⁵⁶ After the onset of the outbreak, Mexican authorities realized that the network of labs they intended to rely on were not properly equipped or authorized to prepare the antiviral medication, leading to complications in implementing the planned response.⁵⁷ A comparative assessment of national pandemic preparedness plans found that Mexico's plan was missing key annexes regarding case management, surveillance, communication, laboratory sample and transport, public health measures, and plans for private business.⁵⁸ While no public health response is perfect, and testing for COVID-19 has presented global challenges, the experience of Mexican laboratories during the H1N1 outbreak raises concerns about their current capabilities.

The existence of COVID-19 in Mexico presents a serious danger of the introduction of COVID-19 into the United States for these reasons, and because the level of migration across the United States border with Mexico is so high. The U.S.-Mexico border runs an estimated 1,933 miles.⁵⁹ To date in fiscal year (FY) 2020, DHS has processed 34,141 inadmissible aliens at POEs along the border, and U.S. Border Patrol has apprehended 117,305 aliens attempting to unlawfully enter the United States between POEs, almost 110,000 of whom reported Mexican citizenship.⁶⁰ Over 15,000 were nationals of other countries that are now experiencing sustained human to human transmission of COVID-19, including approximately 1,500 Chinese nationals and 6,200 Brazilian nationals.⁶¹

Influenza A/H1N1 Pandemic in Mexico, PLOS Med 8(5): e1000436 (May 24, 2011).

⁵⁵ Luis Meave Gutierrez-Mendoza et al., Lessons from the Field: Oseltamivir storage, distribution and dispensing following the 2009 H1N1 influenza outbreak in Mexico, Bull World Health Organ, 90:782-787 (Aug. 17, 2012).

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ WHO, Comparative Analysis of National Pandemic Influenza Preparedness Plans (Jan. 2011), available at https://www.who.int/influenza/resources/documents/comparative_analysis_php_2011_en/en/.

⁵⁹ *Supra*, note 36.

⁶⁰ Exhibits 2 and 3, attached.

⁶¹ *Id.*

3. Land POEs and Border Patrol stations are congregate settings that present infection control challenges

CBP screens and processes millions of aliens who seek to enter the United States legally each year at POEs, as well as apprehending, screening, and processing the hundreds of thousands of aliens who attempt to unlawfully enter the United States each year by crossing between POEs. *See* Exhibits 2-3 (charts summarizing number of apprehensions and inadmissible aliens in FY 2020, as of Mar. 3, 2020). Apprehended aliens vary significantly by age and health status. At this time, the majority tend to be adults between 25 and 40 years old, and include those with chronic health problems such as diabetes and high blood pressure (which are comorbidities known to increase the health risks associated with COVID-19 infections and, thus, the likelihood of requiring medical intervention after infection).⁶²

i. Covered aliens in land POEs who CBP screens and processes for admissibility spend hours or days in congregate areas

There are 328 land POEs along the northern and southern borders operated by CBP. At land POEs, CBP screens and processes the millions of U.S. citizens, lawful permanent residents, and other aliens who seek to enter the United States from Canada and Mexico every year.

One of the CBP's critical functions at POEs is to screen and process arriving aliens to determine whether they are admissible to the United States. CDC understands from DHS that inadmissible aliens are typically those who do not have proper travel documents to enter or whose entry is otherwise contrary to law, such as those who are interdicted attempting to smuggle contraband into the United States. It takes CBP much longer to screen inadmissible aliens than U.S. citizens, lawful permanent residents, and aliens with valid travel documents, all of whom tend to move quickly into the United States after contact with CBP personnel and other travelers at POEs. This difference is due in part to the fact that inadmissible aliens tend to arrive by foot (not vehicle), and lack documentation. Inadmissible aliens in land POEs may spend hours or days in congregate areas while undergoing processing. During that time, they are in close proximity to CBP personnel and other travelers, including U.S. citizens and other aliens.

The admissibility of each alien is determined by a CBP officer. As part of the current admissibility screening, aliens are subject to an initial set of questions designed to elicit their risk factors for various contagious diseases, including COVID-19. Questions would include recent travel and any physical symptoms they are experiencing. CBP officers also use this initial questioning to visually observe arrivals for any obvious signs of illness. Those whose appearance or responses indicate possible exposure to or infection with COVID-19 are directed to don a surgical mask, and are escorted by a CBP officer (also wearing a surgical mask) for further evaluation and risk assessment by the contract medical staff, which is conducted in a designated area within the POE.

Presently, if CBP determines that an alien may be exposed to or infected with COVID-19, the alien is escorted to a separate, enclosed waiting area (usually a small holding room adjacent to

⁶² *Supra*, note 4.

normal processing areas) while CBP alerts the relevant health authorities. Specifically, CBP notifies the local health department, CDC, and CBP's Senior Medical Advisor. Local health officials and possibly CDC personnel if available, then consult with CBP to determine whether the individual should be tested for COVID-19 and where that testing should occur. CBP follows guidance from CDC and local health officials regarding transport to the testing site. If the alien is sent for testing in an ambulance, a CBP officer will accompany the individual in the ambulance. If CBP vehicles are used for transport, they are disinfected afterwards. In addition, CBP will consult with U.S. Immigration and Customs Enforcement (ICE) officials regarding the transport of the alien outside of the POE, given that the individual leaving the CBP facility does not have a preexisting legal right to enter the United States and must remain in custody while testing and treatment is carried out.

These infection control procedures are not easily scalable for large numbers of aliens. Moreover, an influx of infected, asymptomatic aliens would present significant infection control challenges for CBP, as the screening of such an aliens may not prompt testing. The aliens would remain in congregate areas in the POE while CBP finishes the screening and processing. During that time, the alien could infect CBP personnel or other aliens with COVID-19.

ii. Border Patrol stations present greater infection control challenges than POEs because they often have less space and fewer resources

In addition to the 328 POEs, CBP operates a network of Border Patrol stations to apprehend, process, and temporarily hold aliens seeking to unlawfully enter the United States *between* POEs. CBP has a total of 136 Border Patrol stations along the land and coastal borders, and many Border Patrol stations, particularly along the Southwest border, are in remote locations.

Border Patrol stations vary significantly in terms of size and layout, but generally have several congregate holding areas where covered aliens are divided based on demographic factors such as age, gender, and family status, as required by law. A typical Border Patrol station is designed to temporarily hold a maximum of 150 to 300 people standing shoulder-to-shoulder, and has between two to five separate holding areas that can be used to segregate adult males, adult females, unaccompanied children, and family units, with possible further subdivision for female- and male-led family units. The subdividing of aliens is crucial to maintaining order and safety inside the Border Patrol stations because the experience of CBP is that certain cohorts of covered aliens are antagonistic towards one another. On average, a covered alien apprehended between POEs will spend approximately 78 hours in a Border Patrol station before transfer to ICE.

Only 46 of the 136 Border Patrol stations offer any medical services. The services that are offered are administered by contract medical support and are limited to glucose, pregnancy, influenza testing, and basic emergency care. The 46 facilities are all located on the southwest border with Mexico.

As discussed more fully below, the infection control challenges in Border Patrol stations can be greater than the challenges in POEs, especially when the Border Patrol stations are at or near capacity. This is because covered aliens are in close proximity with one another and CBP

personnel, and there is typically no suitable space for quarantining, isolating, or engaging in social distancing with aliens.

iii. The United States Public Health Service (USPHS) observed infection control challenges during a site visit to El Paso del Norte POE

On March 12-13, 2020, a USPHS Scientist officer conducted an observational visit to the El Paso del Norte POE (El Paso PDN). The USPHS Scientist officer viewed directly the areas within the POE that CBP uses to screen and process aliens for admissibility. (Exhibit 1).

El Paso PDN is one of the country's busiest border crossings, with more than 10 million people entering the United States from Mexico every year. It receives a constant, heavy inflow of pedestrian and vehicular traffic, consisting of approximately 12,000 pedestrians and 6,000 vehicles per day. El Paso PDN operates 24/7, with a 3-4 person team of contract medical staff who work 12 hour shifts and provide 24/7 coverage. The medical team is typically led by a nurse practitioner or physician assistant, with the remaining team members consisting of emergency medical technicians (EMT) or registered nurses.

El Paso PDN adheres to the general process for screening and processing covered aliens described in § II.3.i above. In terms of medical capabilities, El Paso PDN performs on-site testing only for pregnancy, blood glucose levels, and Influenza A/B. Any other testing or treatment is performed by nearby medical providers. El Paso PDN is representative of other POEs in that it is heavily reliant on local and regional hospitals and EMT services to care for aliens. El Paso PDN has several small waiting rooms that are used to isolate individuals suspected of exposure to or infection with a contagious disease. Each room can fit approximately 6-7 people, and is equipped with windows to permit observation of the rooms' occupants, and locks to prevent them from leaving.

Facility staff indicated they have been fit-tested for N95 respirators, receive biannual N95 training, and that the facility has an approximately 30-day regular use supply of N95 respirators for use by CBP personnel. El Paso PDN has not encountered any suspected COVID-19 cases, but does not currently perform COVID-19 testing.

The site was selected by CBP because it is one of CBP's largest and best equipped POEs on the Southwest Border. Other POEs have fewer capabilities.

The USPHS Scientist officer observed that even at El Paso PDN, covered aliens would present infection control challenges during processing and screening in congregate areas.

III. The introduction into DHS facilities of persons from countries with COVID-19 would increase the already serious danger of COVID-19 in the facilities

1. POEs and Border Patrol stations are not structured or equipped to effectively mitigate the risks presented by COVID-19

The time required to test for COVID-19 dictates, at least in part, the infection control measures that DHS would have to implement at POEs and Border Patrol stations to effectively mitigate the public health risks presented by covered aliens suspected of harboring or being infected with COVID-19. At this time, there is no available COVID-19 test that yields results at the time of sample collection, such as the rapid testing available for certain influenza strains that yields results in as little as 15 minutes. Nor is there a COVID-19 test that has been cleared for use in a non-clinical setting such as a POE or a Border Patrol station lacking isolation capabilities. Rather, current COVID-19 testing would require the collection of samples from aliens suspected of infection and the mailing of the samples to a laboratory for analysis, with results available within 3-4 days. In theory, to mitigate public health risks, CBP would have to transport aliens in their custody suspected of COVID-19 infection to a nearby medical site for sample collection and testing, and then implement containment protocols (i.e., quarantine or isolation) in their facilities while awaiting test results. CDC would not have the resources or personnel required to house in quarantine or isolation or monitor dozens, much less hundreds or thousands of aliens. The burden would shift to state and local governments, and it seems equally unlikely to CDC that they could collectively implement such a massive public health initiative under current conditions.

POEs and Border Patrol stations are not structured or equipped to implement quarantine, isolation, or social distancing protocols on site for COVID-19 for even small numbers of aliens, much less dozens or hundreds of them together with CBP personnel. In particular, POEs and Border Patrol stations were designed for the purpose of short-term holding in a congregate setting. The vast majority of those facilities lack the areas needed to effectively quarantine or isolate aliens for COVID-19 while test results are pending. Moreover, the process for screening and ultimately quarantining or isolating aliens suspected of COVID-19 infection would require the alien to move throughout various sections of the facility, creating a risk of exposure to all nearby—including DHS personnel and other aliens.⁶³

Because POEs and Border Patrol stations are not structured or equipped for quarantine or isolation for COVID-19, DHS's alternative would be to try to conduct some type of social distancing in congregate holding areas. The numbers of aliens and the size and capacity of the congregate holding areas are not at all conducive to effective social distancing, which requires individuals to maintain a distance of at least six feet from each other, and to avoid contact with shared surfaces. The typical dimensions of the congregate areas at POEs and Border Patrol stations would not provide sufficient space if more than a handful of individuals were present in congregate areas (which is typically the situation). Such an approach would be fraught with public health risks for not only the aliens but also DHS personnel nearby.

⁶³ The use of congregate holding areas for quarantine or isolation would present a significant risk of transmitting COVID-19 for obvious reasons. Even if a congregate holding area were used to try to quarantine or isolate a single alien, it would significantly limit the facility's overall holding capacity, and potentially increase the public health risks in other congregate holding areas (if any space were left at all, after subdividing demographics).

CDC also has a public health tool called conditional release, which involves the release of potentially infected individuals from federal custody subject to conditions calculated to mitigate the risk of disease transmission, such as mandatory self-isolation and CDC monitoring at home. Conditional release is not a viable solution in this context because many aliens covered by this order may lack homes or other places in the United States where they can self-isolate, and CDC lacks the resources and personnel necessary to effectively monitor such a large number of persons. Reliance on the conditional release mechanism in this context would jeopardize, not protect, the public health.

2. POEs and Border Patrol stations are not structured or equipped to safely house or care for aliens infected with COVID-19

POEs and Border Patrol stations would lack the capacity to provide the medical monitoring and care that would be needed by covered aliens confirmed to be infected with COVID-19. Only a few facilities offer medical services directly, and the medical services that are provided are limited to care for minor ailments, basic emergency care, or the on-site administration of prophylaxis for seasonal influenza (i.e., Tamiflu). The facilities are heavily reliant on local and regional hospitals and emergency medical system (EMS) resources.

Moreover, many of the facilities are geographically remote and far from the major medical centers or hospital systems equipped to handle COVID-19 outbreaks. Infected covered aliens would either have to be transported tens or hundreds of miles to the nearest appropriately equipped medical center, or brought to smaller local providers who might lack the resources or capacity to accept COVID-19 cases involving covered aliens. Indeed, U.S. states along the border with Mexico have some of the lowest number of hospital beds per 1,000 inhabitants in the United States.⁶⁴ Arizona, California, and Texas also have some of the largest numbers of residents living in primary care shortage areas of any U.S. states or territories.⁶⁵ The shift of healthcare resources to large numbers of infected, covered aliens would divert the same resources away from the domestic population, which would undermine the Federal response to COVID-19. It would also increase the risk of exposure to COVID-19 for domestic healthcare workers. Such a scenario is not tenable given the current nationwide public health emergency.

IV. Determination and Implementation

Based on the foregoing, I find there is a serious danger of the introduction of COVID-19 into the POEs and Border Patrol stations at or nearby the United States borders with Canada and Mexico, and the interior of the country as a whole, because COVID-19 exists in Canada, Mexico,

⁶⁴ Arizona has 1.9 hospital beds per 1,000 inhabitants; California has 1.8; New Mexico has 1.8, and Texas has 2.3. Kaiser Family Foundation, State Health Facts: Hospitals Per 1,000 Population by Ownership Type (2018), available at <https://www.kff.org/other/state-indicator/beds-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%22,%22sort%22:%22asc%22%7D>.

⁶⁵ Kaiser Family Foundation, State Health Facts: Primary Care Health Professional Shortage Areas (HPSAs) (Sept. 30, 2019), available at <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20Need%20Met%22,%22sort%22:%22asc%22%7D>.

and the countries or places of origin of the covered aliens who migrate to the United States across the land borders with Canada and Mexico. I also find that the introduction into POEs and Border Patrol stations of covered aliens increases the seriousness of the danger to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

It is necessary for the public health to immediately suspend the introduction of covered aliens. The immediate suspension of the introduction of these aliens requires the movement of all such aliens to the country from which they entered the United States, or their country of origin, or another location as practicable, as rapidly as possible, with as little time spent in congregate settings as practicable under the circumstances. The faster a covered alien is returned to the country from which they entered the United States, to their country of origin, or another location as practicable, the lower the risk the alien poses of introducing, transmitting, or spreading COVID-19 into POEs, Border Patrol stations, other congregate settings, and the interior.

My determinations are based on information provided to CDC by DHS personnel regarding DHS border operations and facilities; the report of the observational visit to the El Paso PDN conducted by the USPHS Scientist officer; figures on the numbers of apprehensions at the United States borders with Canada and Mexico of aliens from countries where COVID-19 exists; information from the public domain; and my own personal knowledge and experience.

I consulted with DHS before I issued this order, and requested that DHS implement this order because CDC does not have the capability, resources, or personnel needed to do so. As part of the consultation, CBP developed an operational plan for implementing the order. Accordingly, DHS will, where necessary, use repatriation flights to move covered aliens on a space-available basis, as authorized by law. The plan is generally consistent with the language of this order directing that covered aliens spend as little time in congregate settings as practicable under the circumstances. In my view, it is also the only viable alternative for implementing the order; CDC's other public health tools are not viable mechanisms given CDC resource and personnel constraints, the large numbers of covered aliens involved, and the likelihood that covered aliens do not have homes in the United States.⁶⁶

This order is not a rule within the meaning of the Administrative Procedure Act (APA). In the event this order qualifies as a rule under the APA, notice and comment and a delay in effective date are not required because there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date. Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this order. In addition, because this order concerns the ongoing discussions with Canada and Mexico on how

⁶⁶ CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. CDC lacks the resources, manpower, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for use in quarantines or isolation. Certain soft-sided facilities may be inappropriate for use in quarantines or isolation. DHS would need at least 90 days (likely more) to build and start bringing hard-sided facilities online. Such an approach would not help address the current public health emergency presented to the Federal government today.

best to control COVID-19 transmission over our shared border, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

This order shall remain effective for 30 days, or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is shorter. I may extend or modify this order as needed to protect the public health.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Atlanta, Georgia, this 20th day of March, 2020.

A handwritten signature in black ink, reading "Robert R. Redfield MD". The signature is written in a cursive, flowing style.

Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

EXHIBIT 1

Date: March 14, 2020

To: RADM Sylvia Trent-Adams, Principal Deputy Assistant Secretary for Health, Office of the Assistant Secretary for Health (OASH)

RADM Erica Schwartz, Deputy Surgeon General, Office of the Surgeon General, OASH

From: CAPT Mehran S. Massoudi, Regional Health Administrator, Region VI, OASH

RE: Report of Observational Visit to the DHS El Paso *Paso del Norte* Port of Entry

Mission: Observe normal work flow process and personnel traffic at the El Paso *Paso del Norte* Port of Entry and assess possible public health risks or vulnerabilities posed by the Coronavirus Disease (COVID-19) at Department of Homeland Security (DHS) border facilities.

On March 12-13, 2020, I traveled to El Paso *Paso del Norte* (PDN) Port of Entry and met with Port Director Good, Watch Commander Alvarez, Watch Commander Gomez, and Supervisor Officer Rivas.

The site I visited was selected by the Customs and Border Patrol (CBP) Senior Medical Advisor Dr. Tarantino. It was intended to serve as an example of one of CBP's largest and best-equipped Ports of Entry (POEs) on the Southwest Border, not a representative of other POEs across the country.

The El Paso PDN is one of the country's busiest border crossings, and sees approximately 10 million people entering the United States from Mexico annually. The El Paso PDN processes a flow of approximately 12,000 pedestrians and approximately 6-8,000 vehicles per day. Field statistics for FY19 and Jan. 2020 were supplied by the Public Affairs and Community Liaison Director, El Paso Field Office and are attached to this report, as Attachments A and B, respectively. The location is staffed by CBP officers 24/7 working 8 hour shifts. In addition, the facility has 24/7 coverage by a third party contracted Medical Team comprised of 3-4 members, led by a nurse practitioner or physician assistant, with the rest of the team comprised of emergency medical technicians or Registered Nurses.

There are two points of entry into PDN: a pedestrian and vehicular mode. Both are staffed by the same CBP officers from El Paso. Each person seeking entry to the United States at PDN is asked a series of questions upon encountering the CBP officer, including the travel-related COVID-19 screening questions. Officers use visual cues as well as responses to the screening questions to determine the level of risk of COVID-19 infection. If CBP officers suspect any level of risk or signs/symptoms of illness, they put on a surgical mask (CBP officers wear gloves as a normal practice) and give a surgical mask to the individual as well. The officer would then escort the individual to an area where the officer would first inspect the individual for anything that could be used as a weapon, and then fingerprint the individual (if applicable). The individual would then be triaged to an area where they would be administered a 13-part

questionnaire, with a series of questions added about COVID-19 by the third party contract Medical Team. The questionnaire is attached as Attachment C.

If an individual is determined to be at risk of COVID-19, the individual is escorted to one of several small waiting rooms, each with a window and locked door, while the local health department, Centers for Disease Control and Prevention (CDC), and CBP's Senior Medical Advisor are notified. Local health officials and/or CDC would then be consulted to determine next steps with respect to testing and/or treatment for COVID-19.

If testing is recommended, then CBP will follow guidance from CDC and local health officials about which third party hospital to transport the individual. If the individual is sent for testing in an ambulance, a CBP officer will accompany the individual inside the ambulance. In addition, CBP will consult with Immigration and Customs Enforcement (ICE) officials if the individual leaving the CBP facility has not yet been processed and so must remain in custody.

CBP personnel informed me that the same basic process described above would be applied to those who arrived on foot or by vehicle—provided the individual provided a response to the screening questions indicative of COVID-19 exposure/infection or appeared to exhibit signs/symptoms of the disease requiring a medical consult for further evaluation and possible testing.

Key Observations:

- All CBP officers are fit-tested twice a year for N-95 respirators, but when asked and observed, only surgical masks were identified for use. I was told that the N-95 respirators would be used when there is a declaration of a pandemic or when they are told to use them. Leadership at the site said that they have approximately a 30-day supply of N-95 respirators on hand at the PDN sites. I observed that all CBP officers had a box of gloves and a box of N-95 respirators by their feet behind their workstations.
- The CDC Quarantine Station in El Paso makes routine visits to stop by and answer any questions and provide any updates as needed for the CBP officers. The CBP officers carry a small, two-sided laminated card with key evaluation criteria. The card is attached as Attachment D.
- Observed color-posters of CDC COVID-19 awareness messaging on walls throughout the facility.
- The third party contract Medical Team performs only a small number of tests on-site (rapid Influenza A/B, pregnancy, and glucose). Tests for other conditions, particularly other contagious diseases like measles, are performed off-site at a third part medical facility.
- If an individual is suspected of having an infectious disease or needs to be held for a short period of time, they are put in a small room with a window and a locked door, adjacent to the CBP officers' work-area. This is not an isolation room because the HVAC system is shared with the rest of the facility, and does not have adequate capabilities to contain COVID-19 (i.e., negative pressure, HEPA filtration). Escorting a contagious individual

to and from this room, as well as holding them there, poses a significant risk of exposing nearby CBP personnel.

- If an individual actually infected with COVID-19 were subject to the above screening processes, they would be maneuvered throughout various sections of the POE, creating a significant risk of COVID-19 exposure to other aliens and CBP officers in the POE.

[Attachment A: FY 2019 Field Statistics]

U.S. Department of Homeland Security
9400 Viscount
El Paso, TX 79925



U.S. Customs and Border Protection

January 21, 2019

To: Stakeholders and interested parties

From: Ruben Jauregui
Director, Communication Management Office
Public Affairs and Community Liaison
El Paso Field Office
El Paso, Texas

Subject: El Paso Field Office Traffic Summary Report January-December 2019

January 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	642	228,341	0	0	0	376,229
El Paso	Bridge of Americas	24,576	719	332,330	116	5,387	2,817	104,379
El Paso	Ysleta Bridge	46,518	0	238,762	0	0	0	116,175
El Paso	Stanton St DCL	0	0	119,715	0	0	0	0
El Paso	Ysleta DCL	0	0	101,452	0	0	0	0
Presidio		823	114	62,393	0	0	0	19,563
Boquillas		0	0	0	0	0	0	144
Serna/Tornillo		0	0	24,750	0	0	0	3,124
Serna/Tornillo	Ft Hancock	0	0	8,002	0	0	0	162
Columbus	Columbus	863	0	26,777	0	0	0	23,158
Columbus	Antelope Wells	0	*120	1,163	0	0	0	0
Santa Teresa		9,733	19	46,230	0	0	0	10,132

*Antelope Wells numbers are for passenger vans processed

February 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	793	208,026	0	0	0	347,742
El Paso	Bridge of Americas	22,159	539	296,190	116	6,503	2,487	93,721
El Paso	Ysleta Bridge	43,800	0	213,097	0	0	0	115,133
El Paso	Stanton St DCL	0	0	114,954	0	0	0	0
El Paso	Ysleta DCL	0	0	96,686	0	0	0	0
Presidio		707	77	53,410	0	0	0	15,362
Boquillas		0	0	0	0	0	0	2,385
Serna/Tornillo		0	0	24,503	0	0	0	3,284
Serna/Tornillo	Ft Hancock	0	0	7,792	0	0	0	143
Columbus	Columbus	418	0	24,635	0	0	0	21,340
Columbus	Antelope Wells	0	*76	793	0	0	0	0
Santa Teresa		9,116	15	42,335	0	0	0	7,413

*Antelope Wells numbers are for passenger vans processed

March 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	759	225,206	0	0	0	408,028
El Paso	Bridge of Americas	23,832	684	305,090	109	5,751	3,180	115,579
El Paso	Ysleta Bridge	45,152	0	221,472	0	0	0	136,788
El Paso	Stanton St DCL	0	0	124,712	0	0	0	0
El Paso	Ysleta DCL	0	0	106,205	0	0	0	0
Presidio		791	105	62,810	0	0	0	20,473
Boquillas		0	0	0	0	0	0	4,362
Serna/Tornillo		0	0	28,181	0	0	0	3,061
Serna/Tornillo	Ft Hancock	0	0	9,908	0	0	0	224
Columbus	Columbus	377	0	28,673	0	0	0	21,951
Columbus	Antelope Wells	0	*103	972	0	0	0	0
Santa Teresa		9,903	24	52,541	0	0	0	9,898

*Antelope Wells numbers are for passenger vans processed

April 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	750	155,983	0	0	0	380,366
El Paso	Bridge of Americas	18,973	670	200,817	112	6,932	3,211	154,135
El Paso	Ysleta Bridge	38,449	0	140,421	0	0	0	173,111
El Paso	Stanton St DCL	0	0	130,521	0	0	0	0
El Paso	Ysleta DCL	0	0	92,139	0	0	0	0
Presidio		829	123	55,708	0	0	0	35,469
Boquillas		0	0	0	0	0	0	2,875
Serna/Tornillo		0	0	28,326	0	0	0	4,361
Serna/Tornillo	Ft Hancock	0	0	11,545	0	0	0	339
Columbus	Columbus	608	0	28,117	0	0	0	24,299
Columbus	Antelope Wells	0	*127	1,302	0	0	0	0
Santa Teresa		10,187	29	45,852	0	0	0	20,355

*Antelope Wells numbers are for passenger vans processed

May 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	882	168,894	0	0	0	379,532
El Paso	Bridge of Americas	20,390	705	242,474	134	8,308	3,239	147,259
El Paso	Ysleta Bridge	47,835	0	169,580	0	0	0	168,443
El Paso	Stanton St DCL	0	0	138,374	0	0	0	0
El Paso	Ysleta DCL	0	0	108,888	0	0	0	0
Presidio		875	0	58,129	0	0	0	23,072
Boquillas		0	0	0	0	0	0	1,563
Serna/Tornillo		0	118	29,010	0	0	0	3,571
Serna/Tornillo	Ft Hancock	0	0	11,630	0	0	0	216
Columbus	Columbus	1,030	0	30,660	0	0	0	24,365
Columbus	Antelope Wells	0	*125	1,135	0	0	0	0
Santa Teresa		13,221	13	49,834	0	0	0	14,221

*Antelope Wells numbers are for passenger vans processed

June 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	934	158,621	0	0	0	372,565
El Paso	Bridge of Americas	14,620	789	224,054	121	7,820	3,116	154,368
El Paso	Ysleta Bridge	48,564	0	181,356	0	0	0	161,103
El Paso	Stanton St DCL	0	0	123,047	0	0	0	0
El Paso	Ysleta DCL	0	0	104,499	0	0	0	0
Presidio		643	117	55,964	0	0	0	29,194
Boquillas		0	0	0	0	0	0	1,007
Serna/Tornillo		0	0	26,625	0	0	0	1,506
Serna/Tornillo	Ft Hancock	0	0	9,443	0	0	0	334
Columbus	Columbus	1,204	0	29,661	0	0	0	15,392
Columbus	Antelope Wells	0	*127	992	0	0	0	0
Santa Teresa		11,843	30	50,672	0	0	0	16,847

*Antelope Wells numbers are for passenger vans processed

July 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	862	146,360	0	0	0	369,293
El Paso	Bridge of Americas	15,711	883	217,658	126	8,741	2,660	182,378
El Paso	Ysleta Bridge	51,922	0	305,414	0	0	0	178,969
El Paso	Stanton St DCL	0	0	123,123	0	0	0	0
El Paso	Ysleta DCL	0	0	107,296	0	0	0	0
Presidio		830	162	58,934	0	0	0	37,779
Boquillas		0	0	0	0	0	0	934
Serna/Tornillo		0	0	33,967	0	0	0	1,510
Serna/Tornillo	Ft Hancock	0	0	9,456	0	0	0	385
Columbus	Columbus	1,808	0	32,455	0	0	0	22,959
Columbus	Antelope Wells	0	*152	1,473	0	0	0	0
Santa Teresa		12,915	19	56,495	0	0	0	26,487

*Antelope Wells numbers are for passenger vans processed

August 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	981	163,806	0	0	0	349,842
El Paso	Bridge of Americas	16,129	812	240,369	124	10,404	4,487	152,466
El Paso	Ysleta Bridge	53,240	0	198,831	0	0	0	166,014
El Paso	Stanton St DCL	0	0	133,379	0	0	0	0
El Paso	Ysleta DCL	0	0	108,208	0	0	0	0
Presidio		806	130	56,539	0	0	0	25,946
Boquillas		0	0	0	0	0	0	709
Serna/Tornillo		0	0	28,161	0	0	0	3,093
Serna/Tornillo	Ft Hancock	0	0	9,508	0	0	0	273
Columbus	Columbus	2,138	0	31,132	0	0	0	25,529
Columbus	Antelope Wells	0	*121	950	0	0	0	0
Santa Teresa		11,922	22	49,664	0	0	0	16,532

*Antelope Wells numbers are for passenger vans processed

September 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	930	183,319	0	0	0	341,846
El Paso	Bridge of Americas	15,080	675	252,480	127	8,223	3,086	131,396
El Paso	Ysleta Bridge	50,428	0	221,684	0	0	0	156,242
El Paso	Stanton St DCL	0	0	134,221	0	0	0	0
El Paso	Ysleta DCL	0	0	107,839	0	0	0	0
Presidio		833	125	56,328	0	0	0	20,988
Boquillas		0	0	0	0	0	0	1,001
Serna/Tornillo		0	0	25,901	0	0	0	3,654
Serna/Tornillo	Ft Hancock	0	0	9,581	0	0	0	268
Columbus	Columbus	2,054	0	30,609	0	0	0	24,870
Columbus	Antelope Wells	0	*98	938	0	0	0	0
Santa Teresa		11,377	16	43,162	0	0	0	12,113

*Antelope Wells numbers are for passenger vans processed

October 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	839	191,494	0	0	0	361,221
El Paso	Bridge of Americas	16,498	697	265,834	115	7,278	2,571	147,038
El Paso	Ysleta Bridge	55,251	0	214,485	0	0	0	159,779
El Paso	Stanton St DCL	0	0	146,029	0	0	0	0
El Paso	Ysleta DCL	0	0	115,628	0	0	0	0
Presidio		1,054	142	56,209	0	0	0	19,401
Boquillas		0	0	0	0	0	0	1,700
Serna/Tornillo		0	0	27,883	0	0	0	4,021
Serna/Tornillo	Ft Hancock	0	0	9,676	0	0	0	268
Columbus	Columbus	2,890	0	30,318	0	0	0	23,592
Columbus	Antelope Wells	0	*0	931	0	0	0	0
Santa Teresa		12,672	13	42,174	0	0	0	11,661

*Antelope Wells numbers are for passenger vans processed

November 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	742	175,505	0	0	0	330,171
El Paso	Bridge of Americas	12,839	760	259,756	112	7,202	2,346	134,592
El Paso	Ysleta Bridge	52,063	0	203,584	0	0	0	149,073
El Paso	Stanton St DCL	0	0	133,865	0	0	0	0
El Paso	Ysleta DCL	0	0	105,061	0	0	0	0
Presidio		1,022	142	54,667	0	0	0	21,686
Boquillas		0	0	0	0	0	0	3,498
Serna/Tornillo		0	0	26,583	0	0	0	3,128
Serna/Tornillo	Ft Hancock	0	0	9,664	0	0	0	242
Columbus	Columbus	1,868	0	27,981	0	0	0	21,435
Columbus	Antelope Wells	0	*95	1,070	0	0	0	0
Santa Teresa		10,924	20	43,748	0	0	0	12,416

*Antelope Wells numbers are for passenger vans processed

December 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	1,007	190,826	0	0	0	325,436
El Paso	Bridge of Americas	11,379	978	284,027	97	5,258	2,826	154,034
El Paso	Ysleta Bridge	46,744	0	221,027	0	0	0	161,469
El Paso	Stanton St DCL	0	0	135,170	0	0	0	0
El Paso	Ysleta DCL	0	0	108,080	0	0	0	0
Presidio		985	182	58,203	0	0	0	38,527
Boquillas		0	0	0	0	0	0	2,467
Serna/Tornillo		0	0	29,660	0	0	0	3,099
Serna/Tornillo	Ft Hancock	0	0	10,279	0	0	0	262
Columbus	Columbus	1,490	0	30,398	0	0	0	22,675
Columbus	Antelope Wells	0	*121	1,551	0	0	0	0
Santa Teresa		10,113	20	53,942	0	0	0	23,104

*Antelope Wells numbers are for passenger vans processed

[Attachment B: Jan. 2020 Field Statistics]

U.S. Department of Homeland Security
9400 Viscount
El Paso, TX 79925



U.S. Customs and Border Protection

February 25, 2020

To: Stakeholders and interested parties

From: Ruben Jauregui
Director, Communication Management Office
Public Affairs and Community Liaison
El Paso Field Office
El Paso, Texas

Subject: El Paso Field Office Traffic Summary Report January 2020

January 2020

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	1,047	186,475	0	0	0	294,921
El Paso	Bridge of Americas	13,612	810	279,016	91	4,090	1,481	127,497
El Paso	Ysleta Bridge	53,785	0	219,982	0	0	0	137,015
El Paso	Stanton St DCL	0	0	134,574	0	0	0	0
El Paso	Ysleta DCL	0	0	104,067	0	0	0	0
Presidio		967	128	56,535	0	0	0	25,047
Boquillas		0	0	0	0	0	0	2,585
Serna/Tornillo		0	0	24,937	0	0	0	2,929
Serna/Tornillo	Ft Hancock	0	0	9,246	0	0	0	169
Columbus	Columbus	1,032	0	28,629	0	0	0	24,479
Columbus	Antelope Wells	0	*118	1,254	0	0	0	0
Santa Teresa		11,886	31	46,478	0	0	0	14,731

*Antelope Wells numbers are for passenger vans processed

[Attachment C: 13-part Screening Questionnaire]



LoyalSource
Government Services

BSFAU SOP: 010
28 Oct 2019

Attachment 3



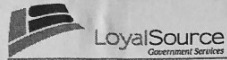
LoyalSource
Government Services

13 Scripted Questions for Detainee Intake

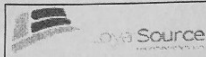
1. Do you have a history of current medical or mental health issues?
Tiene o ha tenido problemas medicos o condiciones de enfermedad mentales?
2. Are you taking any medications (prescription or OTC)? If yes, do you have it with you?
Esta tomando medicamento recetadas?
3. Do you have any allergies (food or medicine)?
Tiene alergias a cualquier medicamento o comida?
4. Are you a drug user?
Usa drogas?
5. (If female) Are you pregnant? If yes, how many months?
Esta embarazada? Cuantos meses/semanas?
6. (If female) Are you nursing?
Estas amamantando?
7. Are you currently injured or do you have significant pain?
Esta erido or tiene dolor en algun lugar?
8. Do you have a skin rash?
Tiene una condicion en la piel?
9. Do you have a contagious disease?
Tiene una enfermedad contagiosa?
10. Are you thinking about hurting yourself or others?
Esta pensando lastimarte a ti mismo o alguien mas?
11. Do you feel feverish or do you feel that you have a fever?
Te sientes febril o tiene fiebre?
12. Do you have a cough or difficult breathing?
Tiene tos o problemas respirando?
13. Do you have nausea, vomiting, or diarrhea?
Tiene nausea, vomitos or diarea?

Detainee Initial Health-Intake Requirements V2.1

Page 6

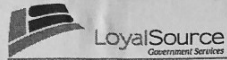
BSFAU SOP: 010
28 Oct 2019

Attachment 3

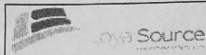


13 Scripted Questions for Detainee Intake

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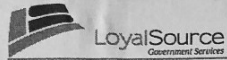
BSFAU SOP: 010
28 Oct 2019

Attachment 3

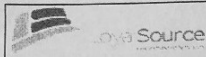


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BSFAU SOP: 010
28 Oct 2019

Attachment 3



13 Scripted Questions for Detainee Intake

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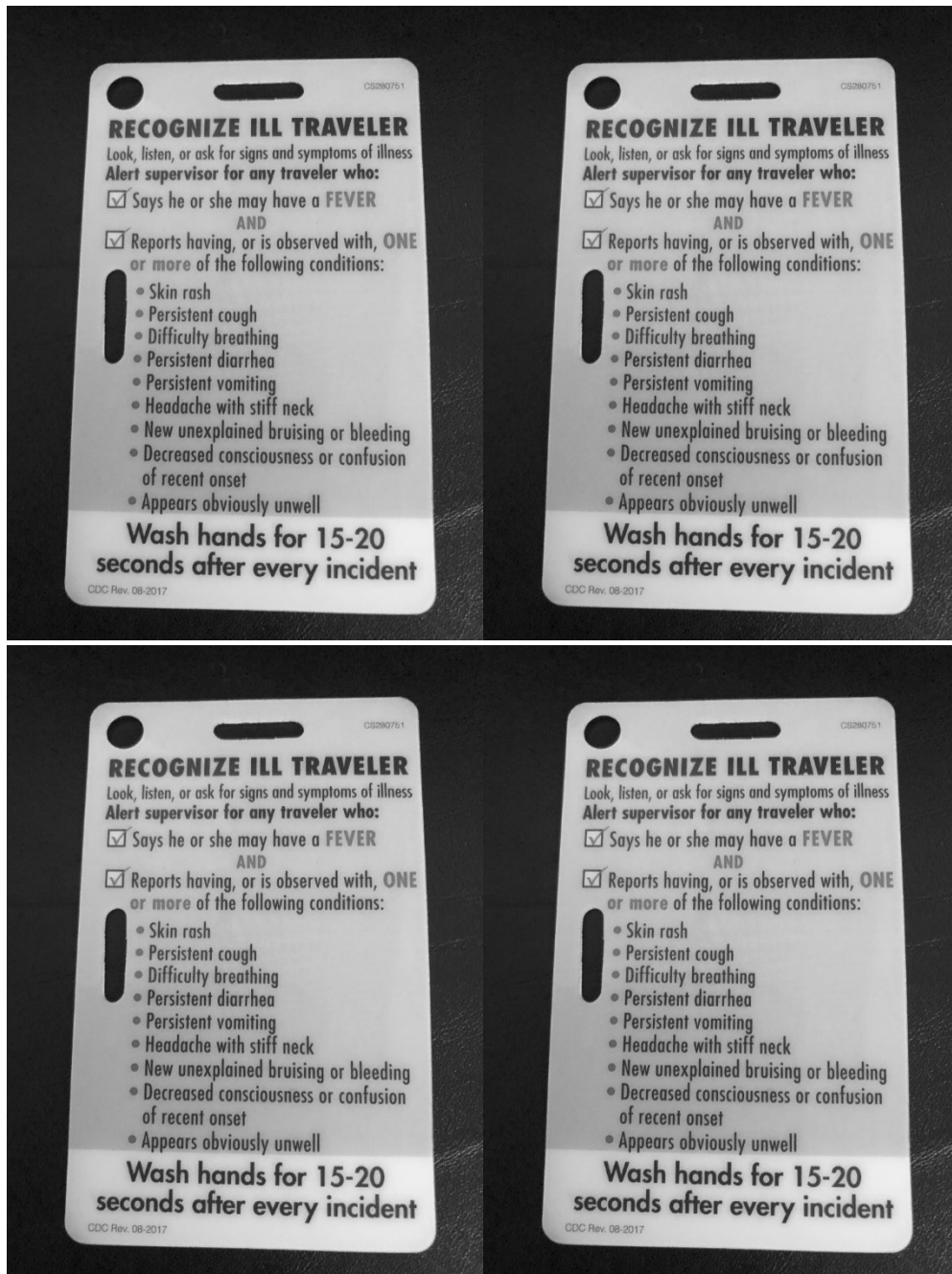
[Attachment D: RING Card]

(front)





(back)



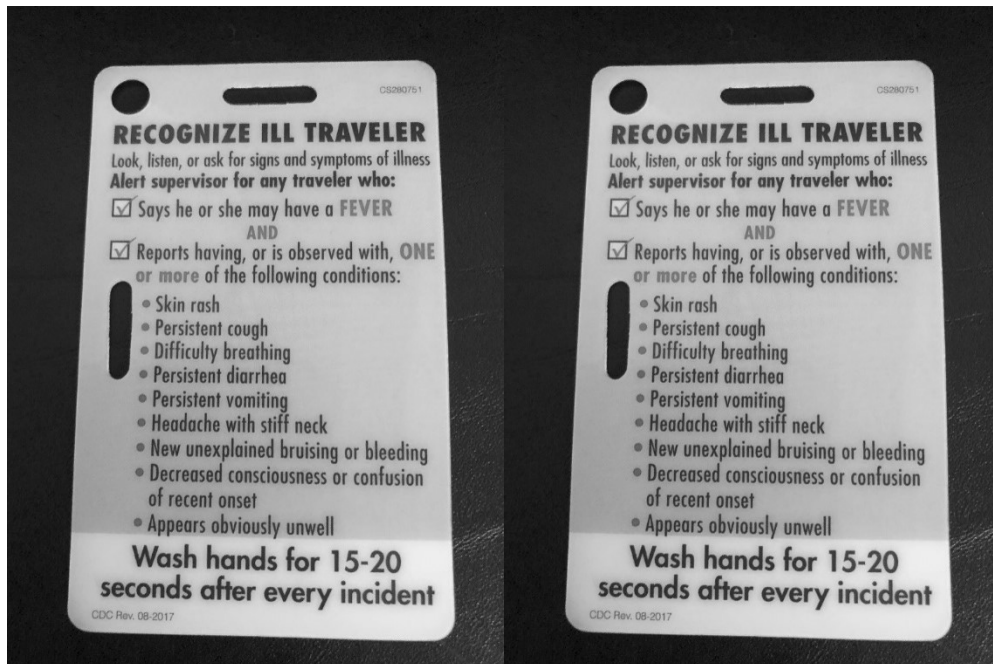


EXHIBIT 2

U.S. Border Patrol (USBP) - Apprehensions (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
ALBANIA	12	1
ALGERIA	0	1
ARGENTINA	4	2
ARMENIA	1	0
BANGLADESH	420	1
BELGIUM	0	1
BOLIVIA	10	1
BRAZIL	6,248	11
BULGARIA	1	1
BURKINA FASO	1	1
CAMBODIA	0	1
CAMEROON	20	0
CANADA	2	33
CHILE	341	0
CHINA (PEOPLE'S REPUBLIC OF)	1,157	18
COLOMBIA	204	35
COSTA RICA	21	0
DEM REP OF THE CONGO	149	0
DOMINICAN REPUBLIC	160	12
ECUADOR	7,027	35
FRENCH GUIANA	1	0
GERMANY	0	1
GUADELOUPE	2	0
HONDURAS	19,493	87
INDIA	805	111
INDONESIA	1	1
IRAN	5	1
IRAQ	1	1
IRELAND	2	0
ISRAEL	4	3
ITALY	6	1
JAMAICA	1	7
JAPAN	0	1
JORDAN	7	3
KOREA	0	1
KUWAIT	1	0
MALAYSIA	1	1

U.S. Border Patrol (USBP) - Apprehensions (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
MEXICO	80,130	707
MOLDOVA	0	1
NEPAL	77	0
NIGERIA	9	8
NORWAY	0	1
PAKISTAN	61	3
PANAMA	11	1
PARAGUAY	1	1
PERU	295	1
PHILIPPINES	0	3
POLAND	0	3
ROMANIA	151	43
RUSSIA	6	0
SENEGAL	1	1
SINGAPORE	1	0
SOUTH AFRICA	2	2
SOUTH KOREA	1	8
SPAIN	5	7
SRI LANKA	196	3
SWEDEN	1	0
THAILAND	0	1
TOGO	2	1
TUNISIA	0	1
TURKEY	46	1
UKRAINE	2	3
UNITED KINGDOM	2	10
VIETNAM	197	2
TOTAL	117,305	1,185

Source: End of Month Report

EXHIBIT 3

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
AFGHANISTAN	0	23
ALBANIA	0	13
ALGERIA	0	349
ANDORRA	0	1
ARGENTINA	4	7
ARMENIA	108	1
AUSTRALIA	4	53
AUSTRIA	1	6
AZERBAIJAN	8	9
BANGLADESH	3	79
BELARUS	11	5
BELGIUM	15	39
BHUTAN	0	9
BOLIVIA	3	2
BOSNIA-HERZEGOVINA	0	6
BRAZIL	152	318
BULGARIA	1	14
BURKINA FASO (UPPER VOLTA)	10	20
CAMBODIA	0	3
CAMEROON	1,025	69
CANADA	25	9,693
CHILE	21	47
CHINA (PEOPLE'S REPUBLIC OF)	500	1,378
TAIWAN	0	21
COLOMBIA	83	151
COSTA RICA	8	3
CROATIA	0	10
CYPRUS	0	4
CZECH REPUBLIC	1	7
DEMOCRATIC REPUBLIC OF CONGO (ZAIRE)	171	29
DENMARK	1	16
DOMINICAN REPUBLIC	4	25
ECUADOR	156	14

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
EGYPT	2	124
ESTONIA	0	1
FINLAND	0	5
FRANCE	6	802
GEORGIA	59	2
GERMANY	1	88
GREECE	1	19
HONDURAS	1,343	32
HONG KONG, PRC	0	8
HUNGARY	1	16
INDIA	22	2,135
INDONESIA	1	17
IRAN	3	1,061
IRAQ	2	63
IRELAND	0	27
ISRAEL	5	58
ITALY	6	50
JAMAICA	24	120
JAPAN	2	33
JORDAN	1	28
KUWAIT	3	1
LATVIA	1	1
LEBANON	2	54
LITHUANIA	2	8
LUXEMBOURG	0	2
MACAO (MACAU), PRC	0	1
MACEDONIA (SKOPJE)	0	2
MALAYSIA	0	9
MALTA AND GOZO	0	2
MEXICO	29,713	245
MOLDOVA	0	9
MOROCCO	1	350
NEPAL	0	6
NETHERLANDS	0	17

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
NEW ZEALAND	0	20
NIGERIA	0	182
NORWAY	3	7
OMAN	1	2
PAKISTAN	5	160
PANAMA	4	1
PARAGUAY	0	2
PERU	46	15
PHILIPPINES	0	554
POLAND	1	66
PORTUGAL	0	57
REPUBLIC OF CONGO (BRAZZAVILLE)	40	9
REPUBLIC OF SOUTH AFRICA	6	21
ROMANIA	9	39
RUSSIA	340	101
SAUDI ARABIA	4	14
SENEGAL	5	56
SERBIA	0	4
SINGAPORE	0	6
SLOVAKIA	0	2
SLOVENIA	0	2
SOUTH KOREA	12	178
SPAIN	19	66
SRI LANKA	0	28
SWEDEN	0	27
SWITZERLAND	1	20
THAILAND	0	6
TOGO	6	20
TUNISIA	0	274
TURKEY	38	50
UKRAINE	70	130
UNITED ARAB EMIRATES	1	2
UNITED KINGDOM	7	148
VIETNAM	7	77

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
TOTAL	34,141	20166

Source: SBO Data via End of Month Report; NBO Data via CBP Data Warehouse as of
3/3/2020

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

EXHIBIT C

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**EXTENSION OF ORDER SUSPENDING INTRODUCTION OF CERTAIN PERSONS
FROM COUNTRIES WHERE A COMMUNICABLE DISEASE EXISTS**

I am extending the Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists issued on March 20, 2020 until 11:59 p.m. EDT on May 20 or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is sooner. I may further amend or extend the March 20, 2020 Order as needed to protect the public health.

I issued the March 20, 2020 Order pursuant to §§ 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and the Act's implementing regulations, which authorize the Director of the Centers for Disease Control and Prevention (CDC) to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States, and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

The March 20, 2020 Order suspended introduction of certain "covered aliens" into the United States for a period of 30 days. The March 20, 2020 Order defined "covered aliens" as follows:

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry ("POE") or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE.

In addition, the March 20, 2020 Order did not apply to "persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests."

The March 20, 2020 Order was based on the following determinations:

- COVID-19 is a communicable disease that poses a danger to the public health;
- COVID-19 is present in numerous foreign countries, including Canada and Mexico;
- There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the land borders with Canada and Mexico;
- But for a suspension-of-entry order under 42 U.S.C. § 265, covered aliens would be subject to immigration processing at the land POEs and Border Patrol stations, and during that processing many of them (typically aliens who lack valid travel documents and are therefore inadmissible) would be held in the common areas of the facilities, in close proximity to one another, for hours or days; and
- Such introduction into congregate settings of persons from Canada or Mexico would increase the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

COVID-19 has continued to spread since the March 20, 2020 Order. Canada and Mexico continue to see increasing numbers of COVID-19 infections and deaths. In addition, the United States has seen many states experience exponential growth in the number of confirmed COVID-19 cases, which has strained the healthcare system and prompted dramatic public health responses at the local, state, and Federal levels. Millions of Americans are now complying with local and state stay-at-home orders, engaging in social distancing, and taking other precautions calculated to slow the spread of, and protect others from, COVID-19. At the Federal level, the U.S. Departments of Health and Human Services (HHS) and Homeland Security (DHS) are working with public and private stakeholders to rapidly procure, distribute, and increase the supply of scarce medical and healthcare resources such as personal protective equipment (PPE), ventilators, and therapeutics for the American public. The entire country has mobilized to save lives by limiting face-to-face contact and reserving medical and healthcare resources for those who need them most. At a time when these domestic efforts are ongoing and effective, it would be counterproductive and dangerous to undermine those efforts by permitting the introduction of persons from outside the United States who pose a risk of transmission of COVID-19 within DHS facilities or the U.S. interior.

Further, the determinations made in support of the March 20, 2020 Order remain correct. If anything, they have become more compelling. I therefore conclude that the March 20, 2020 Order should remain in effect until 11:59 p.m. EDT on May 20.

COVID-19 is Continuing to Spread in Canada, Mexico, and the United States

Since the March 20, 2020 Order, the number of COVID-19 cases globally, including in Canada, Mexico, and the United States, has continued to increase.

Canada

As of April 13, 2020, Canada has reported 24,804 confirmed cases of COVID-19, and a total of 734 deaths. Canada has tested 422,200 people for COVID-19.¹ The Public Health Agency of Canada estimates that 72% of infections are the result of community transmission. Canadian modeling indicates that, with the use of strong epidemic controls resulting in a 2.5% infection rate, Canada could see 940,000 people with infections, 73,000 hospitalizations, and 23,000 people requiring intensive care over the course of the COVID-19 pandemic.²

Canada has implemented and maintained robust public health measures to slow the spread of COVID-19, including closures of public schools and cancelation of public events.³ Non-essential businesses have been closed across the country.

Mexico

As of April 12, 2020, Mexico has reported 3,844 confirmed cases of COVID-19 and 233 deaths.⁴ Nevertheless, based on public health surveillance, Mexico estimates that its current case count is 26,519. Mexico's modeling, based on World Health Organization (WHO) reporting from China, assumes a 0.2% infection rate with 250,656 infected people during the acceleration phase of the pandemic.⁵ Of those people, 70% (175,459) are anticipated to seek medical care.⁶ Among people seeking medical care, it is projected that 80% (140,367) will be ambulatory patients, 14% (25,564) will need to be hospitalized without intensive care, and 6% (10,528) will require intensive care.⁷

¹ Government of Canada, Coronavirus disease (COVID-19): Outbreak Update (Apr. 13, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html?topic=tilelink#a2>.

² Public Health Agency of Canada, COVID-19 in Canada: Using Data and Modeling to Inform Public Health Action (Apr. 9, 2020), available at <https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/using-data-modelling-inform-eng.pdf>.

³ See generally Kristin Rushowy, The Star, Ontario Schools Will Remain Closed Until at Least May 4. But Kids Can Expect Marks (Mar. 31, 2020), <https://www.thestar.com/politics/provincial/2020/03/31/ontario-schools-wont-open-until-at-least-may.html>; Ryan Rocca, Global News, Coronavirus: City of Toronto Cancels Events Through June 30, including Pride Parade (updated Apr. 1, 2020), <https://globalnews.ca/news/6758350/coronavirus-toronto-cancels-events-pride-parade/>.

⁴ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 83 (Apr. 12, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200412-sitrep-83-covid-19.pdf?sfvrsn=697ce98d_4.

⁵ Secretaria De Salud, COVID-19: Comunicado Tecnico Diario (Mar. 17, 2020), available at https://www.gob.mx/cms/uploads/attachment/file/541879/COVID-19_-_Presentacion_Comunicado_Tecnico_Diario_2020.03.17.pdf.pdf.

⁶ *Id.*

⁷ *Id.*

On March 30, 2020, Mexico's General Health Council declared a "State of Health Emergency" and suspended all non-essential activities in the public and private sectors until April 30, 2020.⁸ The order granted full authority to the Secretariat of Health to take action to address the pandemic across Mexico. The central guidance of the Mexican health authorities is to maximize social distancing and that people should only leave their homes for essential activities, such as to procure food or medical care.⁹ State and local authorities in several Mexican states also are enforcing non-essential business closures and self-quarantine measures.

United States

As of April 13, 2020, the United States has reported 554,849 confirmed cases of COVID-19 across the United States and 21,942 deaths.¹⁰ Community transmission of COVID-19 is occurring in many locations across the United States. Several cities and states have experienced widespread, sustained community transmission to the extent that their healthcare and public health systems are at risk of being overwhelmed. This includes parts of states and territories at or near borders of the United States which are reporting large increases in new COVID-19 cases since the March 20, 2020 Order.¹¹

In addition to practicing rigorous hygiene and social distancing and limiting non-essential travel,¹² CDC's guidance to the general public has expanded to include the recommendation that individuals wear face coverings when out in public.¹³ CDC expects widespread transmission of COVID-19 in the United States will occur and, in the coming months, most of the U.S. will be exposed to COVID-19.¹⁴ Nevertheless, not all areas of the United States are currently experiencing high rates of infection or numbers of confirmed cases. Generally speaking, COVID-19 is currently concentrated along the East, West, and Gulf Coasts and in the Great Lakes region;

⁸ U.S. Department of State, U.S. Embassy and Consulates in Mexico, Health Alert – Mexico COVID-19 Update (Apr. 10, 2020), <https://mx.usembassy.gov/health-alert-mexico-covid-19-update-04-10-2020/>.

⁹ *Id.*

¹⁰ CDC, Cases in U.S. (updated Apr. 13, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

¹¹ The New York Times, Coronavirus in the U.S.: Latest Map and Case Count (Apr. 13, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>; *see also* CDC, Coronavirus Disease 2019 (COVID-19): Cases in U.S.: States Reporting Cases of COVID-19 to CDC (Apr. 14, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html#cumulative>.

¹² CDC, COVID-19: How to Protect Yourself and Others (last reviewed Apr. 8, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>.

¹³ CDC, COVID-19: How to Wear a Cloth Face Covering (last reviewed Apr. 9, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>.

¹⁴ CDC, Testing for COVID-19 (Mar. 21, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html>.

there are significantly fewer cases in the interior of the United States.¹⁵ Limiting the spread of COVID-19 in these less affected areas is a critical component of the overall U.S. strategy to “flatten the curve,” which requires limiting the number of foci, or infected individuals, who may enter these areas.

Joint Efforts

On March 20, 2020, the United States and Canada jointly decided to restrict all non-essential travel across the U.S.-Canadian border for 30 days, with limited exceptions for U.S. citizens and others entering Canada for essential business, provided these individuals have not been outside Canada or the United States in the 14 days prior to requesting entry into Canada. Foreign nationals, excluding those arriving from the U.S., will not be allowed into Canada, subject to certain exceptions.¹⁶ The Canadian government is requiring individuals returning home to Canada to self-isolate for 14 days upon their return.¹⁷ Individuals exhibiting symptoms of COVID-19 are not permitted to enter Canada, except for Canadian citizens or permanent residents.¹⁸

Similarly, on March 20, 2020, the United States and Mexico announced a joint initiative temporarily restricting all non-essential travel across their border in an effort to combat the spread of COVID-19.¹⁹

Availability of Rapid COVID-19 Testing

Since the March 20, 2020 Order, rapid testing for COVID-19 has been developed that can provide results in approximately 15 minutes and manufacturers are currently ramping up production and distribution of rapid COVID-19 testing.²⁰ Although rapid COVID-19 testing could

¹⁵ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>.

¹⁶ See Notification of Temporary Travel Restrictions Applicable to Land Ports of Entry and Ferries Service Between the United States and Canada, 85 Fed. Reg. 16548 (Mar. 24, 2020).

¹⁷ Government of Canada, Coronavirus disease (COVID-19): Canada’s Response, <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse.html?topic=tilelink>

¹⁸ *Id.*

¹⁹ U.S. Department of Homeland Security, Joint Statement on U.S.-Mexico Joint Initiative to Combat the COVID-19 Pandemic (Mar. 20, 2020), available at <https://www.dhs.gov/news/2020/03/20/joint-statement-us-mexico-joint-initiative-combat-covid-19-pandemic>.

²⁰ For instance, on March 27, 2020, Abbott received emergency use authorization from the U.S. Food and Drug Administration (“FDA”) for the fastest available point-of-care test for COVID-19. Abbott, “Detect COVID-19 in as Little as 5 Minutes” (Mar. 27, 2020), <https://www.abbott.com/corpnnewsroom/product-and-innovation/detect-covid-19-in-as-little-as-5-minutes.html>; see generally U.S. Food and Drug Administration, Emergency Use Authorizations, <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd>. Rapid COVID-19 testing will significantly reduce the time needed to confirm a suspected diagnosis of COVID-19, which currently may take as long as three to four days. See CDC, Order Suspending Introduction of Certain Persons from Countries where a Communicable Disease Exists (Mar. 20, 2020), available at https://www.cdc.gov/quarantine/pdf/CDC-Order-Prohibiting-Introduction-of-Persons_Final_3-20-20_3-

ameliorate some of the public health concerns associated with congregate detention in DHS border facilities, rapid COVID-19 testing is not yet widely available, and demand outstrips supply. Moreover, once it is available, rapid COVID-19 testing should be prioritized to certain key locations, such as hospitals treating high numbers of COVID-19 patients, where the ability to quickly determine whether doctors and nurses have been infected with COVID-19 could increase the availability of care providers by eliminating the need for these individuals to self-isolate while awaiting test results.

Determination and Implementation

Based on the foregoing, I find that the global presence of COVID-19, including in Canada, Mexico, still presents a danger of further introduction of COVID-19 into the United States. This is true notwithstanding the community transmission of COVID-19 in many locations across the United States. There are many locations in the United States near our borders with Canada and Mexico that have not yet experienced widespread community transmission. The on-going COVID-19 pandemic, including in Canada and Mexico, remains a serious danger to such locations.

In the March 20, 2020 Order, I found the risks troubling partly because outbreaks of COVID-19 in POEs or Border Patrol stations would lead U.S. Customs and Border Protection to transfer persons with acute presentations of illness to local or regional healthcare providers for treatment, which would exhaust the local or regional healthcare resources or at least reduce the availability of such resources to the domestic population, and further expose local or regional healthcare workers to COVID-19. Millions of Americans are complying with local and state stay-at-home orders, engaging in social distancing, and taking other precautions calculated to slow the spread, protect others, and relieve the strain on the healthcare system. Their efforts would be significantly undermined if outbreaks of COVID-19 in land POEs or Border Patrol stations crippled the DHS workforce and local or regional healthcare systems.

I consulted with DHS before issuing this Order and requested that DHS continue to implement the March 20, 2020 Order because CDC does not have the capability, resources, or personnel needed to alternatively issue quarantine or isolation orders.²¹

p.pdf; see also CDC, Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) (updated Apr. 8, 2020), <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>. When a case of COVID-19 is suspected, the sooner that confirmatory test results are available, the more quickly treatment and isolation and quarantine measures can be implemented, lowering the risk of infecting others. See CDC, Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) (updated Mar. 24, 2020), <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>.

²¹ As previously discussed in the March 20, 2020 Order, CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. See 42 U.S.C. § 268(b) (requiring customs officers to aid in the enforcement of quarantine regulations). CDC lacks the resources, staffing, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for purposes of quarantine or isolation.

The March 20, 2020 Order shall remain in effect until 11:59 p.m. EDT on May 20, or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is sooner. I may further amend or extend the March 20, 2020 Order as needed to protect the public health.

This Order is not a rule subject to notice and comment under the Administrative Procedure Act (APA). In the event this order qualifies as a rule subject to notice and comment, a delay in effective date are not required because there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date.²² Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this order. In addition, because this order concerns ongoing discussions with Canada and Mexico on how to best control COVID-19 transmission over our shared borders, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

The March 20, 2020 Order shall remain in effect until 11:59 p.m. EDT on May 20, 2020.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, D.C., this 19th day of April, 2020.

A handwritten signature in black ink, reading "Robert R. Redfield MD". The signature is fluid and cursive, with the letters "R" and "M" being particularly large and stylized.

Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

²² See 5 U.S.C. §§ 553(b)(B) and (d)(3).

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

EXHIBIT D

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**AMENDMENT AND EXTENSION OF ORDER SUSPENDING INTRODUCTION OF
CERTAIN PERSONS FROM COUNTRIES WHERE A COMMUNICABLE DISEASE
EXISTS**

I. Introduction

I am amending the Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists, issued on March 20, 2020 (hereinafter, March 20, 2020 Order or Order) and extended on April 20, 2020 (hereinafter, April 20, 2020 Extension or Extension), to clarify that it applies to all land and coastal Ports of Entry (POEs) and Border Patrol stations¹ at or near the United States' border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting. I am extending the duration of the Order until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and continuation of the Order is no longer necessary to protect the public health. Every 30 days, the Centers for Disease Control and Prevention (CDC) shall review the latest information regarding the status of the COVID-19 pandemic and associated public health risks to ensure that the Order remains necessary to protect the public health. Upon determining that the further introduction of COVID-19 into the United States is no longer a serious danger to the public health necessitating the continuation of this Order, I will publish a notice in the Federal Register terminating this Order and its Extensions.

II. History of Order

A. March 20, 2020 Order

I issued the March 20, 2020 Order pursuant to sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and the Act's implementing regulations, which authorize the Director of CDC to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States, and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

The March 20, 2020 Order suspended introduction of certain "covered aliens" into the United States for a period of 30 days. The March 20, 2020 Order described "covered aliens" as follows:

¹ As explained below, air POEs are excluded from the Amended Order and Extension because they do not present the same public health risk as land and coastal POEs.

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry (POE) or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE.

The March 20, 2020 Order also did not apply to “persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests.”

The March 20, 2020 Order was based on the following determinations:

- COVID-19 is a communicable disease that poses a danger to the public health;
- COVID-19 is present in numerous foreign countries, including Canada and Mexico;
- There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States’ borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the land borders with Canada and Mexico;
- But for a suspension-of-entry order under 42 U.S.C. § 265, covered aliens would be subject to immigration processing at the land POEs and Border Patrol stations, and during that processing many of them (typically aliens who lack valid travel documents and are therefore inadmissible) would be held in the common areas of the facilities, in close proximity to one another, for hours or days; and
- Such introduction into congregate settings of persons from Canada or Mexico would increase the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

B. April 20, 2020 Extension

On April 20, 2020, I extended the March 20, 2020 Order until 11:59 p.m. EDT on May 20, 2020. The April 20, 2020 Extension found that the determinations of the March 20, 2020 Order remain correct, and further determined that the suspension of introduction of covered aliens should continue for another 30 days based on the increasing numbers of COVID-19 infections in Canada, Mexico, and the United States, and the highly dynamic domestic health care landscape.

As detailed below, the Order has proven effective in reducing the risk of COVID-19 within POEs and Border Patrol stations, and the latest information on the status of the pandemic in Canada, Mexico, and the United States justifies issuing this Amendment and Extension until I determine that the serious danger of further introduction of COVID-19 into the United States has ceased to be a danger to the public health.

III. The Order has reduced the risk of COVID-19 transmission in POEs and Border Patrol stations

Recent DHS data indicates the March 20, 2020 Order and April 20, 2020 Extension have significantly mitigated the specific public health risk identified in the initial Order by significantly reducing the population of covered aliens held in congregate settings in POEs and Border Patrol stations, thereby reducing the risk of COVID-19 infection among DHS personnel and others within these facilities.

DHS has provided CDC with statistical information on the impact of the Order and Extension, which supports my decision to further extend the suspension. For example, following issuance of the March 20, 2020 Order, DHS data on operational encounters with covered aliens demonstrate that the population of covered aliens held in POEs and Border Patrol stations was reduced by 88 percent. Specifically, in the 46-day period preceding the March 20, 2020 Order (i.e., February 3, 2020 to March 20, 2020), there was a daily average of 3,249 covered aliens in custody at POEs and Border Patrol stations. In the 47-day period following the March 20, 2020 Order (i.e., March 21, 2020 to May 6, 2020), there was a daily average of 395 covered aliens in custody, with approximately 100 aliens in CBP facilities at any given time. By significantly reducing the number of covered aliens held in POEs and Border Patrol stations, the Order and Extension have reduced the density of covered aliens held in congregate custody within these facilities, which reduces the risk of exposure to COVID-19 for DHS personnel and others in POEs and Border Patrol stations.

IV. Conditions in Canada, Mexico, and the United States warrant continued implementation of the Order

Since the April 20, 2020 Extension, COVID-19 has continued to spread. Canada and Mexico continue to see increasing numbers of COVID-19 infections and deaths. In the United States, many states continue to experience growth in the number of confirmed COVID-19 cases, as more states enter the acceleration phase of the pandemic. Although certain early hotspots are beginning to see improvement, and certain areas of the country are beginning a phased reopening of their communities, millions of Americans continue to comply with stay-at-home orders and practice social distancing, most schools and businesses remain closed, and health care providers across the country continue to strive to meet the demand for COVID-19-related care. Epidemiologically speaking, the United States as a whole remains in the acceleration phase of the

pandemic.² Accordingly, there remains a serious risk to the public health that COVID-19 will continue to spread to unaffected communities within the United States, or further burden already affected areas. At this critical juncture, it would be counterproductive to undermine ongoing public health efforts by relaxing restrictions on the introduction of covered aliens who pose a risk of further introducing COVID-19 into the United States.

A. Canada

As of May 9, 2020, Canada has reported 66,780 confirmed cases of COVID-19, and a total of 4,628 deaths. Canada has tested 1,067,595 people for COVID-19.³ The Public Health Agency of Canada believes that the COVID-19 pandemic may have reached its peak, but expects that the number of confirmed COVID-19 cases will continue to increase.⁴ The Canadian government estimates that 81 percent of COVID-19 cases are the result of community transmission.⁵ Canadian modeling indicates that, with the use of strong epidemic controls resulting in a 2.5 percent infection rate, Canada could see 940,000 people with infections, 73,000 hospitalizations, and 23,000 people requiring intensive care over the course of the COVID-19 pandemic.⁶ Canada continues to enforce robust public health measures to slow the spread of COVID-19; non-essential businesses and public schools remain largely closed, and public events remain cancelled.⁷

B. Mexico

² CDC, Situation Summary (updated Apr. 19, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html>; see also Dr. Anne Schuchat, MMWR and Morbidity and Mortality Weekly Report, U.S. Dep't. of Health and Human Services, Public Health Response to the Initiation and Spread of Pandemic COVID-19 in the United States, February 24–April 21, 2020 (May 8, 2020), available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e2.htm#suggestedcitation>

³ Government of Canada, Coronavirus disease (COVID-19): Outbreak Update (May 9, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html?topic=tilelink#a2>.

⁴ Government of Canada, Epidemiological Summary of COVID-19 Cases in Canada (May 9, 2020), <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>.

⁵ *Id.*

⁶ Public Health Agency of Canada, COVID-19 in Canada: Using Data and Modeling to Inform Public Health Action (last updated May 3, 2020), <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/covid-19-using-data-modelling-inform-public-health-action.html>.

⁷ Schools in Quebec are scheduled to re-open May 11 with restrictions. See Solarina Ho, CTV News (May 4, 2020) <https://www.ctvnews.ca/health/coronavirus/when-will-school-resume-what-we-know-province-by-province-1.4923667>; see also generally Marc Montgomery, Radio Canada International (May 5, 2020) <https://www.rcinet.ca/en/2020/05/05/covid-19-the-2020-summer-of-fun-events-that-werent/>.

As of May 9, 2020, Mexico has reported 29,616 confirmed cases of COVID-19 and 2,961 deaths.⁸ The Mexican Health Ministry believes that there are approximately 8 additional cases for each confirmed case of COVID-19.⁹ On April 21, 2020, government officials announced that Mexico has entered Phase III of the COVID-19 pandemic, the Mexican government's highest level of public health emergency.¹⁰ As the pandemic continues, there are media reports of hospitals in Mexico City turning away potential COVID-19 cases and fears that Mexico lacks sufficient ventilators.¹¹ Mexico's initial modeling, based on Chinese data reported by the World Health Organization (WHO), assumed a 0.2 percent infection rate with 250,656 people infected during the acceleration phase of the pandemic.¹² Of those people, 70 percent (175,459) are anticipated to seek medical care.¹³ Among people seeking medical care, it is projected that 80 percent (140,367) will be ambulatory patients, 14 percent (25,564) will need to be hospitalized without intensive care, and 6 percent (10,528) will require intensive care.¹⁴ Non-governmental models and estimates indicate that Mexico may have between 620,000 and 730,000 symptomatic COVID-19 cases.¹⁵

C. United States

⁸ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 110 (May 9, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200509covid-19-sitrep-110.pdf?sfvrsn=3b92992c_4.

⁹ Mexico News Daily, New Model Show Highest Number of Virus Cases Will Come Sooner Than Expected (Apr. 24, 2020), <https://mexiconewsdaily.com/news/coronavirus/new-model-shows-virus-cases-will-come-sooner-than-expected/>.

¹⁰ James Pasley, MSN News Insider, Mexico has Moved to “Phase 3” – its Most Serious Level of Coronavirus Alert – and Faces a Looming Outbreak. Here's how it got to this Point (Apr. 23, 2020), <https://www.msn.com/en-us/news/other/mexico-has-moved-to-phase-3-e2-80-94-its-most-serious-level-of-coronavirus-alert-e2-80-94-and-faces-a-looming-outbreak-heres-how-it-got-to-this-point/ss-BB135RGq/>.

¹¹ Andrea Navarro, Bloomberg, Mexico City Top Hospitals Reach Capacity, Reject Virus Patients (Apr. 28, 2020), <https://www.bloomberg.com/news/articles/2020-04-28/mexico-city-top-hospitals-reach-capacity-reject-virus-patients>.

¹² Secretaria De Salud, COVID-19: Comunicado Tecnico Diario (Mar. 17, 2020), available at https://www.gob.mx/cms/uploads/attachment/file/541879/COVID-19_-_Presentacion Comunicado Tecnico Diario 2020.03.17.pdf.pdf.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ See Jorge Galindo, Javier LaFuente, El País, The Magnitude of the Epidemic in Mexico (May 8, 2020), <https://elpais.com/sociedad/2020-05-08/la-magnitud-de-la-epidemia-en-mexico.html>; Juan Montes, The Wall Street Journal, Death Certificates Point to Much Higher Coronavirus Toll in Mexico (May 8, 2020), <https://www.wsj.com/articles/death-certificates-point-to-much-higher-coronavirus-toll-in-mexico-11588957041>; Azam Ahmed, Hidden Toll: Mexico Ignores Wave of Coronavirus Deaths in Capital (May 8, 2020), <https://www.nytimes.com/2020/05/08/world/americas/mexico-coronavirus-count.html>.

As of May 9, 2020, the United States has reported 1,274,036 confirmed cases of COVID-19 and 77,034 deaths.¹⁶ Community transmission of COVID-19 is continuing in many locations across the United States. Public health measures to slow the spread of COVID-19 so as to avoid overwhelming health care systems have, to date, largely proven successful.¹⁷ However, several cities and states, including several located at or near U.S. borders, continue to experience widespread, sustained community transmission that has put their healthcare and public health systems remain at risk of being overwhelmed.¹⁸

CDC continues to recommend that all Americans practice vigorous hand hygiene, engage in social distancing, limit non-essential travel,¹⁹ and wear cloth face coverings when out in public.²⁰ Nevertheless, not all areas of the United States are currently experiencing high rates of infection or numbers of confirmed cases.²¹ Limiting the spread of COVID-19 to un- or less-affected areas, and slowing the spread of COVID-19 in highly impacted areas, involves limiting the number of foci, or infected individuals, who may enter these areas. Such efforts are critical as individual states begin to ease public health restrictions on businesses and public activities in an effort to mitigate the economic and other costs of the COVID-19 pandemic.²²

V. The Order is amended to apply to land and coastal POEs and Border Patrol stations at or near the border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting

¹⁶ CDC, Cases in U.S. (updated May 9, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

¹⁷ Judy Woodruff, Interview with Vice President of the United States Michael Pence, PBS News Hour (Apr. 17, 2020), <https://www.pbs.org/newshour/show/our-health-care-system-has-not-been-overwhelmed-by-covid-19-says-pence>.

¹⁸ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>; see also Letter from Chris D. Van Gorder, President & CEO, Scripps Health, & Daniel L. Gross, Executive Consultant, Sharp HealthCare COVID-19 Strategic Response, to Hon. Alex M. Azar, Secretary of the U.S. Dep't. of Health & Human Services, and Hon. Chad F. Wolf, Acting Secretary of the U.S. Dep't. of Homeland Security (Apr. 28, 2020), available at <https://www.voiceofsandiego.org/wp-content/uploads/2020/04/Border-Concerns-Letter-Scripps-Health-Sharp-HealthCare-4.28.20.pdf>; see also Letter from Hon. Kristin Gaspar, Supervisor, Third District, San Diego County Board of Supervisors, to Hon. Michael Pence, Vice President of the United States (Apr. 19, 2020), available at <https://www.krqe.com/news/border-report/san-diego-county-official-asks-white-house-to-help-mexico-control-covid-19/>.

¹⁹ CDC, COVID-19: How to Protect Yourself & Others (last reviewed May 11, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>.

²⁰ CDC, COVID-19: Use of Cloth Face Coverings to Help Slow the Spread of COVID-19 (last reviewed May 11, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>.

²¹ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>.

²² Executive Office of President and CDC, Guidelines for Opening Up America Again (Apr. 16, 2020), <https://www.whitehouse.gov/openingamerica/>.

As noted above, the March 20, 2020 Order and April 20, 2020 Extension defined “covered alien” in terms of the public health risk associated with permitting individuals who have traveled from Canada or Mexico to be introduced into a congregate holding area “in a *land* Port of Entry (POE) or Border Patrol station at or near the United States borders with Canada and Mexico.” Due to the highly contagious nature of the virus that causes COVID-19 and the mode of transmission, it is determined that the continued introduction of potentially infected individuals into these facilities poses a public health risk given the role of these facilities and their personnel not only in carrying out immigration functions, but also in ensuring safe border crossings for essential goods and persons, and in law enforcement activities such as preventing terrorism and drug trafficking. Because the limited medical capacity in POEs and Border Patrol stations presents a significant obstacle to safely managing the risk of COVID-19 among covered aliens held in these facilities, the public health risk is best addressed by suspending the introduction of covered aliens into land and coastal POEs and Border Patrol stations.²³

After consulting with DHS regarding its various operations and ability to rapidly stand-up the containment measures and medical capacity needed to deal with the COVID-19 pandemic, CDC determined that protecting the public health of the United States necessitated temporarily suspending the introduction of covered aliens into the congregate holding areas of POEs and Border Patrol stations at or near the United States’ border with Canada and Mexico. CDC understands that, at least in theory, it is possible to expand and retrofit POEs and Border Patrol stations with the structural and engineering controls necessary to contain COVID-19, and that DHS personnel could be equipped with the necessary PPE and trained in clinically-informed practices to more safely interact with covered aliens. However, CDC believes such an endeavor would be ill-advised in that it would consume a significant amount of scarce medical resources that could otherwise be used to meet the needs of the domestic population. Nor could such interventions—particularly those involving structural and engineering additions or changes to hundreds of DHS facilities—be implemented quickly enough to mitigate the current risk of allowing covered aliens to be introduced into POEs and Border Patrol stations. As noted above, the Order has effectively reduced the population of covered aliens in POEs and Border Patrol stations at or near the border, thereby significantly reducing the risk COVID-19 spreading within these facilities.²⁴

The intent of the March 20, 2020 Order and April 20, 2020 Extension was to suspend the introduction of individuals who have traveled from Canada or Mexico who would otherwise likely have been held in the congregate holding areas of POEs or Border Patrol stations at or near the border with Canada or Mexico, where they could transmit COVID-19 to the DHS personnel and other individuals in those facilities. The public health risk addressed by the Order and Extension was the risk of transmission in the congregate holding areas of POEs and Border Patrol stations created when individuals who have traveled from Canada or Mexico are held for significant periods of time in these facilities because they lack valid documentation for entry into the United

²³ The various screening and documentation requirements to board an aircraft justify the exclusion of air POEs from the scope of this Order because they do not pose the same public health risk as land and coastal POEs. In addition, DHS has informed CDC that air POEs do not tend to hold large numbers of persons for the more extended processing that occurs at land and coastal POEs.

²⁴ See *supra* Section III.

States. This public health analysis was based, in part, on the operational issues identified by DHS, and on the observations of the United States Public Health Service Scientist Officer who visited the El Paso del Norte POE on March 12-13, 2020. For the purposes of the public health analysis and risk determinations, it is irrelevant whether a particular POE or Border Patrol station is designated by DHS as a “land” or “coastal” facility.²⁵ The relevant factor is whether the facility receives individuals who have traveled from Canada or Mexico and are likely to be held in a congregate setting within a POE or Border Patrol station at or near the border.

DHS has informed CDC that many POEs and Border Patrol stations service both land and coastal borders, such that covered aliens who are apprehended while attempting to enter the United States by a coastal border are held in the same facilities that temporarily hold covered aliens apprehended while crossing into the United States over the land borders with Canada and Mexico.²⁶ These facilities are substantially similar in all respects relevant to the public health analysis. DHS has informed CDC that, like their land-based counterparts, coastal POEs and Border Patrol stations generally have one or more congregate areas where covered aliens are held for processing, and are not structured or equipped to manage covered aliens exposed to or infected with COVID-19, nor to protect DHS personnel and other individuals within those facilities, including other aliens, from exposure to COVID-19. Similarly, covered aliens at coastal POEs and Border Patrol stations spend periods of time (i.e., hours or days) in the congregate holding areas of these facilities while they are processed for immigration purposes that are material from a public health perspective. All POEs and Border Patrol stations lack medical resources sufficient to provide the appropriate level of care required by those infected with COVID-19 and would be forced to rely on local health systems, many of which are straining to meet the medical needs of the domestic population.²⁷

Land and coastal POEs and Border Patrol stations are not structured or equipped to implement recommended COVID-19 screening, isolation/quarantine, or social distancing protocols for even small numbers of covered aliens. As noted in the March 20, 2020 Order, the holding areas of POEs and Border Patrol stations were designed for the purpose of short-term processing and holding in a congregate setting. The vast majority of these facilities lack the areas needed to effectively isolate or quarantine covered aliens while COVID-19 test results are pending. Moreover, the process of screening and isolating/quarantining covered aliens suspected of

²⁵ DHS has advised CDC that “coastal borders” refers to any U.S. border that is adjacent to a waterway, rather than land. DHS has further advised CDC that “waterway” refers to any large body of water (e.g., Pacific Ocean, Atlantic Ocean, and Gulf of Mexico). For the purpose of this Order, “coastal” applies to any waterway from which persons traveling through Canada and Mexico may enter the United States (e.g. Pacific, Gulf of Mexico, Lake Michigan, Rio Grande).

²⁶ Indeed, the DHS enforcement statistics cited in the March 20, 2020 Order included apprehensions of inadmissible aliens who attempted to cross a U.S. coastal border. See Exhs. 2-3, Order Suspending Introduction of Certain Persons from Countries where a Communicable Disease Exists (Mar. 20, 2020), available at https://www.cdc.gov/quarantine/pdf/CDC-Order-Prohibiting-Introduction-of-Persons_Final_3-20-20_3-p.pdf.

²⁷ See CDC, COVID View Weekly Summary (updated May 8, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>.

COVID-19 infection would require covered aliens to move throughout various sections of the facility, creating a risk of exposure to all nearby—including DHS personnel and other aliens.

I hereby amend the March 20, 2020 Order and April 20, 2020 Extension by adding the modifier “coastal” so that this Amended Order and Extension expressly applies to land and coastal POE and Border Patrol stations operated by DHS at or near the border with Canada or Mexico. Accordingly, the definition of “covered alien” is amended as follows:

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land or coastal Port of Entry (POE) or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions.²⁸

This Amendment and Extension does not alter any of the exclusions or exceptions to the March 20, 2020 Order or April 20, 2020 Extension. Like the March 20, 2020 Order and April 20, 2020 Extension, the Amended Order and Extension does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. The Amended Order and Extension also does not apply to persons whom customs officers determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests.²⁹ DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

VI. Extended Duration Subject to Recurring 30 Day Review

As discussed above, the number of confirmed cases of COVID-19 in Canada, Mexico, and the United States continue to increase. The COVID-19 public health emergency determination by the Secretary of HHS has remained in effect since February 4, 2020.³⁰ As individual states in the United States enter different phases of the pandemic, the demand for COVID-19-related care and the challenges of providing that care are rapidly changing. Although some states are beginning to

²⁸ CDC recognizes that in certain limited instances, a fact-based inquiry may be required to determine whether individuals are covered aliens within the meaning of the Amended Order and Extension. For example, it may be unclear whether individuals who arrive at a coastal border by boat departed from Mexico, or another country, such as Haiti. CDC defers to DHS regarding the operational considerations necessary to address such scenarios.

²⁹ In addition to CBP and U.S. Coast Guard officers, customs officers include any agent or other person, including foreign law enforcement officers, authorized by law or designated by the Secretary of Homeland Security to perform the duties of a customs officer. *See* 19 U.S.C. § 1401(i).

³⁰ Determination of Public Health Emergency, 85 Fed. Reg. 7316 (Feb. 7, 2020); *see also* HHS Secretary, “Renewal of Determination That A Public Health Emergency Exists,” April 21, 2020, available at: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-21apr2020.aspx>.

relax restrictions and plan for the reopening of their communities, the reopening process will occur in phases that are closely tied to local infection rates, as well as other considerations. As the United States collectively determines how to best balance protecting public health with resuming normal activities, it is critical that the country continues to adhere to existing containment strategies, where possible—including the suspended introduction of covered aliens.

Furthermore, although stay-at-home orders and social distancing have been an important part of controlling the COVID-19 pandemic and “flattening the curve,” these strategies alone cannot eliminate the risk of COVID-19 in the United States. Lasting protection from COVID-19 will be achieved with a widely-available vaccine that confers immunity to the uninfected, widely-available therapeutics for those who are infected, or some combination of both.³¹ While there is unprecedented collaboration between public and private stakeholders to develop vaccines and therapeutics for COVID-19, a widely available finished product is still months away.

The public health risks that are the basis for this Amended Order and Extension are unlikely to abate in the coming months. Covered aliens cannot be introduced into the congregate holding areas of land and coastal POEs and Border Patrol stations without significantly increasing the risk of infection among DHS personnel and others in those facilities. Accordingly, this Amended Order and Extension shall remain in effect until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health.

CDC shall reassess the Order every 30 days to determine whether the latest relevant information regarding the COVID-19 pandemic warrants continued implementation, or whether the Order should be modified or terminated.

VII. Determination and Implementation

Based on both the foregoing and additional insight gained over the past two months, I find that the determinations underlying the March 20, 2020 Order and April 20, 2020 Extension remain correct, and that the situation in Canada, Mexico, and the United States continues to require suspension of the introduction of covered aliens into land and coastal POEs and Border Patrol stations at or near the border in order to protect the public health from COVID-19.

The March 20, 2020 Order and April 20, 2020 Extension were based on the risk of introduction of individuals who have traveled through Canada and Mexico into the congregate settings of POEs and Border Patrol stations. Because COVID-19 is a contagious disease spreading throughout Canada and Mexico, individuals coming from these countries pose a risk of introducing or spreading COVID-19 into the United States once they enter POEs and Border Patrol stations at or near the border. Because covered aliens lack proper immigration documentation for entering the United States, they would have been likely to spend a material amount of time (i.e., hours or days) in the congregate holding areas of POEs and Border Patrol stations while they undergo immigration processing. POEs and Border Patrol stations have capacity only for short-term processing and holding of inadmissible aliens. They were never intended to provide the medical

³¹ CDC does not consider Remdesivir to be a therapeutic for COVID-19 for the purposes of the Amended Order and Extension because Remdesivir is not currently approved by the Food and Drug Administration to treat COVID-19.

screening, monitoring, and isolation functions needed to contain COVID-19, especially on the scale demanded by the ongoing pandemic. As POEs and Border Patrol stations lack appropriate medical capabilities, any COVID-19-related care of covered aliens would have to be met by local healthcare systems in the United States, which are already straining to respond to the needs of the domestic population.

Moreover, due to their lack of legal immigration status, there is significant uncertainty that covered aliens would be able to effectively self-quarantine, self-isolate, or otherwise comply with existing social distancing guidelines, if they were conditionally released. CDC and local public health jurisdictions simply lack the resources and personnel necessary to effectively monitor covered aliens who would otherwise be conditionally released into the United States but for the Order. Accordingly, covered aliens must be returned to the country from which they entered the United States, to their country of origin, or to another appropriate location.

The statistical information provided by DHS shows the March 20, 2020 Order and April 20, 2020 Extension have significantly reduced the number of covered aliens in custody at POEs and Border Patrol stations, practically eliminating one channel through which COVID-19 can enter the United States. In light of the current lack of a widely-available vaccine or therapeutic for COVID-19, protecting the public health warrants further extending the Order.

Accordingly, I determine that COVID-19 remains a contagious disease that is present in many countries including Canada and Mexico; covered aliens arriving from those countries pose a risk of further introducing or spreading COVID-19 into the United States while they are held in the congregate holding areas of POEs and Border Patrol stations at or near the border; and this risk is serious enough to require suspending the introduction of such covered aliens into all land and coastal POEs and Border Patrol stations at or near the border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting.

I consulted with DHS before issuing this Amended Order and Extension and requested that DHS continue to implement the operational plan developed to carry out the March 20, 2020 Order and April 20, 2020 Extension because CDC does not have the capability, resources, or personnel needed to alternatively issue quarantine or isolation orders.³²

This Amended Order and Extension applies to all persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in any land or coastal POE or Border Patrol station at or near the border with Canada and Mexico, subject to exceptions.

This Amended Order and Extension does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and

³² As previously discussed in the March 20, 2020 Order, CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. *See* 42 U.S.C. § 268(b) (requiring customs and Coast Guard officers to aid in the enforcement of quarantine regulations). CDC lacks the resources, staffing, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for purposes of quarantine or isolation.

associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. Additionally, this Amended Order and Extension does not apply to persons whom customs officers determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

This Amended Order and Extension is not a rule subject to notice and comment under the Administrative Procedure Act (APA). In the event this order qualifies as a rule subject to notice and comment, a delay in effective date is not required because the foregoing discussion shows that there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date.³³ Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this Order. In addition, because this Order concerns ongoing discussions with Canada and Mexico on how to best control COVID-19 transmission over our shared borders, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

This Amended Order and Extension goes into effect at 12:00 a.m. Eastern Daylight Time (EDT) on May 21, 2020 and shall remain in effect until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and the continuation of the Order is no longer necessary to protect the public health. Upon making this determination, I will publish a notice in the Federal Register terminating this Order and its Extensions. CDC shall reassess the Order every 30 days to determine whether current conditions warrant continued implementation, modification, or termination of the Order. I may further amend or extend the Order as needed to protect the public health.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, D.C. this 19th day of May, 2020.



Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

³³ See 5 U.S.C. § 553(b)(B) and (d)(3).

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through his
father and next friend, Carlos Emilio Barrera
Rodriguez,

Plaintiff,

vs.

CHAD WOLF, Acting Secretary of Department
of Homeland Security, et al.,

Defendants.

Case No. 1:20-cv-01509 (CJN)

DECLARATION OF ROBERT DANLEY

I, Robert Danley, pursuant to 28 U.S.C. § 1746, and based upon my personal knowledge and documents and information made known or available to me from official records and reasonably relied upon in the course of my employment, hereby declare as follows, relating to the above-captioned matter:

1. I am an Associate Chief with the United States Border Patrol (USBP) currently serving in the capacity as acting Deputy Directorate Chief of the Law Enforcement Operations Directorate - Operational Programs Division with oversight of all national level USBP operational programs, to include those in the Foreign Operations, Liaison, Special Operations and Specialty Programs Divisions. I have been in this role since November 1, 2019. As Associate Chief, I am the first-line supervisor of the Specialty Programs Division and have been serving in this role since June 9, 2019. I am responsible for

reviewing, coordinating, overseeing, approving and providing recommendations for projects and programs concerning detention, administrative processing, and related activities for USBP at the national level. In my capacity as Associate Chief, I am familiar with, and have oversight of, certain aspects of the processing of aliens apprehended by USBP agents who are subject to the Centers for Disease Control and Prevention (CDC) *Order Suspending Introduction Of Persons From A Country Where A Communicable Disease Exists* (March 20, 2020), 85 Fed. Reg. 17060 (Mar. 26, 2020) (CDC Order).

2. USBP agents have been properly designated as “customs officers” pursuant to Title 19 U.S. Code Section 1401(i). USBP agents can therefore exercise the authority of “customs officers,” as identified in the CDC Order and under 42 U.S.C. § 268(b), to assist with the enforcement of the CDC Order.

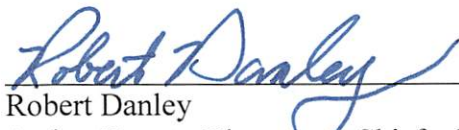
Processing of J.B.B.C.

3. On June 4, 2020, U.S. Customs and Border Protection (CBP) USBP agents encountered J.B.B.C. approximately one mile from the United States/Mexico border near El Paso, Texas after he illegally entered the United States between the Ports of Entry (POEs) without inspection or admission. J.B.B.C., a 16 year-old single minor, is not a United States citizen and admitted to being a Honduran national. J.B.B.C. had not been admitted or paroled into the United States and was not in possession of proper travel documents to allow lawful entry into the United States.
4. USBP determined that J.B.B.C. was subject to the CDC Order, as he was apprehended near the border after unlawfully entering the United States from Mexico between the POEs, and would have otherwise been held in congregate settings in a Border Patrol station to facilitate

immigration processing. J.B.B.C. did not claim any fear of persecution, or torture, or an intent to apply for asylum, while in CBP custody. On June 5, 2020, J.B.B.C. was transferred from CBP to U.S. Immigration and Customs Enforcement custody to be returned to his country of origin, Honduras.

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

Executed this 17th day of June, 2020.

A handwritten signature in blue ink, reading "Robert Danley", is written over a horizontal line.

Robert Danley
Acting Deputy Directorate Chief – Law
Enforcement Operations Directorate

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through his
father and next friend, Carlos Emilio Barrera
Rodriguez,

Plaintiff,

vs.

CHAD WOLF, Acting Secretary of Department
of Homeland Security, et al.,

Defendants.

Case No. 1:20-cv-01509 (CJN)

**DECLARATION OF ACTING ASSISTANT
FIELD OFFICE DIRECTOR DANIELLE
HERNANDEZ**

I, Danielle Hernandez, hereby declare as follows:

1. I am an Acting Assistant Field Office Director at the El Paso Office of Enforcement and Removal Operations (ERO), U.S. Immigration and Customs Enforcement (ICE), within the U.S. Department of Homeland Security (DHS) in El Paso, Texas. I oversee the Non-Detained Unit, which encompasses the Non-Detained Operations Unit, Migrant Protection Protocol Unit and the Field Office Juvenile Coordinators. The Non-Detained Unit is responsible for the detention, release and removal of individuals, family units, and unaccompanied minors in immigration proceedings. I am responsible for a program consisting of approximately 50 employees.

2. In connection with my job responsibilities, I am familiar with this litigation. The following statements are based upon my person knowledge or on information supplied to me in the course of my professional responsibilities.

3. Pursuant to 19 U.S.C. § 1401(i), the Deputy Director and Senior Official

Performing the Duties of the ICE Director exercised his delegated authority to designate the Executive Associate Director (EAD) for ERO as a “customs officer” for purposes of aiding in the enforcement of quarantine rules pursuant to 42 U.S.C. § 268(b). The EAD for ERO then redelegated that authority to all ERO immigration officers. All ERO immigration officers can therefore exercise the authority of “customs officers,” as identified in the Centers for Disease Control and Prevention (CDC) *Order Suspending Introduction Of Persons From A Country Where A Communicable Disease Exists* (March 20, 2020), 85 Fed. Reg. 17060 (Mar. 26, 2020) (CDC Order), and under 42 U.S.C. § 268(b), to help with the enforcement of the CDC Order.

4. On June 4, 2020, ERO was notified that U.S. Customs and Border Protection (CBP) had determined that J.B.B.C. was subject to the CDC Order, and that he should be returned to Honduras. On June 5, 2020, in order to aid the CDC in effectuating the return, ERO requested that ICE contractor MVM transport and supervise J.B.B.C. pending a flight to Honduras that was scheduled for June 10, 2020, which was the next available flight to Honduras.

5. While supervised by MVM, J.B.B.C. has been housed in a hotel as he awaits his return flight to Honduras that was initially scheduled for June 10, 2020. He was transported from his hotel in anticipation of that flight, but in light of this litigation, J.B.B.C. did not complete his return to Honduras via the June 10, 2020 flight. Instead, he returned to a hotel in the El Paso area where he has been housed since.

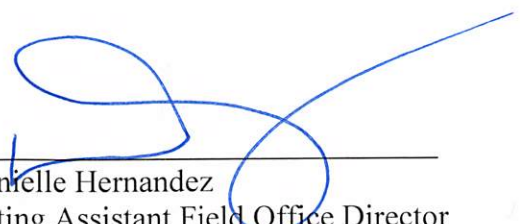
6. On the evening of June 8, 2020, I learned that J.B.B.C. raised a claim for protection under the Convention Against Torture (CAT) through his attorney. I referred the matter to headquarters. On June 10, 2020, I referred J.B.B.C.’s case to the U.S. Citizenship and Immigration Services (USCIS) Houston Asylum Office for an interview to assess his claim. USCIS conducted an assessment of J.B.B.C.’s claim on June 10, 2020. I understand that

screening interviews are conducted by an asylum officer who assesses whether it is more likely than not that the alien will be tortured in the country to which he or she will be sent. I received notice from USCIS on June 10, 2020 that the asylum officer who assessed J.B.B.C.'s claim concluded that J.B.B.C. did not establish a claim for protection under CAT, and that USCIS requested its decision be served on J.B.B.C. The decision was served on J.B.B.C. on the morning of June 11, 2020.

7. In some cases, minors traveling alone from northern triangle countries, including Honduras, are provided temporary housing, often in hotels, for a short period of time while ICE finalizes the logistics for a flight to return them to their native country. While in temporary housing, such minors, including J.B.B.C., are provided basic necessities, including, but not limited to: daily medical visits, frequent temperature checks, issuance of personal protective equipment to include masks and gloves with replacements readily available, access to hand soap and hand sanitizer, daily room cleaning and regular disinfecting, and daily telephone calls (with the option for video calls) with family.

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

Executed in El Paso, Texas on this 17th day of June, 2020.



Danielle Hernandez
Acting Assistant Field Office Director
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement
U.S. Department of Homeland Security

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

J.B.B.C., a MINOR CHILD, by and through
his father and next friend, Carlos Emilio
Barrera Rodriguez,

Plaintiff,

v.

CHAD WOLF, Acting Secretary of
Department of Homeland Security, et al.,

Defendants.

Civil Docket No. 1:20-cv-01509 (CJN)

[PROPOSED] ORDER

Upon consideration of Plaintiff's Emergency Motion for Temporary Restraining Order and all supporting materials, including the amicus briefs filed in this action, as well as Defendants' opposition to that motion, and any reply thereto, it is hereby ORDERED that Plaintiff's motion is DENIED.

SO ORDERED.

Date

CARL J. NICHOLS
United States District Judge

NAMES OF PERSONS TO BE SERVED WITH PROPOSED ORDER

Pursuant to LCvR 7(k), the following attorneys are entitled to be notified of the entry of the foregoing:

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