Nos. 20-15398, 20-15399, 20-16045 and 20-35044

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

CITY AND COUNTY OF SAN FRANCISCO, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

COUNTY OF SANTA CLARA, et al., *Plaintiffs-Appellees*,
v.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants-Appellants*.

STATE OF CALIFORNIA, *Plaintiff-Appellee*,
v.
ALEX M. AZAR, et al., *Defendants-Appellants*.

STATE OF WASHINGTON, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

On Appeal from the United States District Courts for the
Northern District of California and the Eastern District of Washington

**SUPPLEMENTAL EXCERPTS OF RECORD**
**VOLUME VI OF X**

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**IN THE UNITED STATES DISTRICT COURT**

**FOR THE NORTHERN DISTRICT OF CALIFORNIA**

| | |
|---|---|
| CITY AND COUNTY OF SAN FRANCISCO,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR II, et al.,<br>Defendants. | No. C 19-02405 WHA<br>*Related to*<br>No. C 19-02769 WHA<br>No. C 19-02916 WHA |
| STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR, et al.,<br>Defendants. | **DECLARATION OF DR. RANDI C. ETTNER, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT** |
| COUNTY OF SANTA CLARA, et al.<br>Plaintiffs,<br>vs.<br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br>Defendants. | |

I, Dr. Randi C. Ettner, declare as follows:

1. I have been retained by counsel for Plaintiffs Trust Women Seattle, Los Angeles LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan LGBT Community Center, Center On Halsted, Hartford Gyn Center, Mazzoni Center, Medical Students For Choice, AGLP: The Association Of LGBTQ+ Psychiatrists, American Association of Physicians for Human Rights d/b/a Glma: Health Professionals Advancing LGBTQ Equality, Colleen Mcnicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey as an expert in connection with the above-captioned matter.

2. I submit this expert declaration based on my personal knowledge.

3. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

## I. BACKGROUND AND QUALIFICATIONS

### Qualifications and Basis for Opinion

4. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

5. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. A true and accurate copy of my curriculum vitae is attached as Exhibit A to this declaration.

6. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1980 to present. I have

published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (1st edition, co-editors Monstrey & Eyler; Rutledge 2007; and 2nd edition, coeditors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

7. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgenderism and Transgender Health*. I am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People* (7th version), published in 2011. The WPATH promulgated *Standards of Care* ("*Standards of Care*") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

8. I chair the WPATH Committee for Institutionalized Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, South America, Europe, and Asia on topics related to gender dysphoria and present grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and GD in Illinois.

9. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases in both state and federal courts as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates and for Centers for Medicare and Medicaid in the state of Illinois.

10. Attached as Exhibit B is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

**Compensation**

11. I am being compensated for my work on this matter at a rate of $375.00 per hour for preparation of declarations and expert reports. I will be compensated $500.00 per hour for any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will receive a flat fee of $2,500.00 for any travel time to attend deposition or trial, and will be reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

**Previous Testimony**

12. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Monroe v. Jeffreys*, No. 3:18-cv-00156-NJR-MAB (S.D. Ill. 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho 2018); *Carillo v U.S. Dep't of Justice Exec.* (Office of

Immig. Rev. 2017); *Broussard v. First Tower Loan, LLC*, 135 F. Supp. 3d 540 (E.D. La. 2016); *Faiella v. American Medical Response of Connecticut, Inc.*, No. HHD-CV15-6061263-S (Conn. Super. Ct.); *Kothmann v. Rosario*, 558 F. App'x 907 (11th Cir. 2014).

## II. EXPERT OPINIONS

### Gender Identity and Gender Dysphoria

13. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectible through karyotyping); gonads and internal reproductive organs (detectible by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); sexual differentiations in brain development and structure (detectible by functional magnetic resonance imaging studies and autopsy); and gender identity.

14. Gender identity is a well-established concept in medicine. Gender identity refers to a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity. All human beings develop this elemental internal view: the conviction if belonging to a particular gender, such as male or female. Gender identity is innate, has biological underpinnings, and is firmly established early in life.

15. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation. Developmentally, it is the overarching determinant of the self-system, influencing personality, a sense of mastery, relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of satisfaction and quality of life. Efforts to change an individual's gender identity are harmful, futile, and unethical.

16. At birth, individuals are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate,

and their birth-assigned sex matches that person's actual sex. However, for transgender individuals, this is not the case.

17. For transgender individuals, the sense of one's self—one's gender identity—differs from the sex they were assigned at birth, giving rise to a sense of being "wrongly embodied."

18. The medical diagnosis for that feeling of incongruence and accompanying distress is gender dysphoria, a serious medical condition, formerly known as gender identity disorder ("GID"). Gender Dysphoria is a diagnosis codified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5"). The critical element of the Gender Dysphoria diagnosis is the presence of symptoms that meet the threshold for clinical impairment. This represents a change from GID, which focused on an individual's *identity* being disordered. This new diagnostic term, Gender Dysphoria, is also an acknowledgment that gender incongruence, in and of itself, does not constitute a mental disorder. As recently as June 16, 2018, the World Health Organization ("WHO") likewise announced it was reclassifying the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because it removes "gender identity disorder" from the chapter on mental and behavioral disorders, recognizing that gender incongruence is not a mental illness, and instead incorporates it within a new chapter dedicated to sexual health.

19. The condition is characterized by incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning that results. Gender dysphoria is manifested by symptoms such as preoccupation with ridding oneself of the primary and/or secondary sex characteristics associated with one's birth- assigned sex. Untreated gender dysphoria can result in significant clinical distress, debilitating depression, and suicidality.

20. The diagnostic criteria for gender dysphoria in adults are as follows:

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 month's duration, as manifested by at least two of the following:

i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
ii. A strong desire to be rid of one's primary and/or secondary sex characteristics.
iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.
iv. A strong desire to be of the other gender.
v. A strong desire to be treated as the other gender.
vi. A strong conviction that one has the typical feelings and reactions of the other gender.

b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

21. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas et al., 2014).

22. Gender dysphoric patients who are assigned a male sex at birth but identify as female and lack access to appropriate care are often so desperate for relief that they may resort to life-threatening attempts at auto-castration—removal of the testicles—in the hopes of eliminating the major source of testosterone that kindles the distress (Brown, 2010; Brown & McDuffie, 2009).

23. Gender dysphoria generally intensifies with age. As gender dysphoric individuals approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley, 2013).

**Treatment of Gender Dysphoria**

24. The standards of care for treating gender dysphoria are set forth in the WPATH *Standards of Care*, first published in 1979. The *Standards of Care* are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world, and in this country. The American Medical Association, the Endocrine Society, the American Psychological Association the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the WPATH standards. *See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); American Psychological Association Policy Statement on Transgender, Gender Identity & Gender Expression Non-discrimination (2008).

25. The Standards of Care identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition)
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize or masculinize the body
- Surgery to alter primary and/or secondary sex characteristics (e.g., breasts, external genitalia, facial features, body contouring)

26. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each

transgender person takes to transition are not identical. Whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

27. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria (Section VIII).

28. **Psychotherapy:** Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

29. **Social Role Transition:** The *Standards of Care* establish the therapeutic importance of changes in gender expression and presentation—the ability to feminize or masculinize one's appearance— as a critical component of treatment. Known as the "real life experience," it requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one's gender identity. This is an appropriate and essential part of identity consolidation. Through this experience, the transgender individual can begin to address the shame some experience of growing up living as a "false self" and the grief of being born in the "wrong body." (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

30. **Hormone Therapy:** For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross sex hormone administration is a well-established and effective treatment modality for gender dysphoria. The American Medical Association, the Endocrine Society, the

American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

31. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with either feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e. those born with insufficient sex steroid hormones). *See Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009).

32. The therapeutic effects of hormone therapy are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, i.e., breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

33. For many patients, hormones alone will not provide sufficient breast development to approximate the female torso. For these patients, breast augmentation has a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus unquestionable therapeutic results.

34. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention. For transgender women, genital confirmation surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains

body congruence resulting from the normal appearing and functioning female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria. Additionally, breast augmentation procedures play the critical role in treatment mentioned in the paragraph immediately above.

35. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH *Standards of Care*, as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017) ("For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

36. Surgeries are considered "effective" from a medical perspective, if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the only effective treatment.

37. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from 12 countries, spanning 30 years. They concluded that "reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" (Pfafflin & Junge 1998).

38. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria, had decreased to such a degree that it had disappeared."

39. As a general matter, patient satisfaction is a relevant measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender confirmation surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al., 1999; Johansson et al., 2010; Hepp et al.; 2002; Ainsworth & Spiegel, 2010; Smith et al., 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith et al., 2005; Weyers et al., 2009); and greater acceptance and integration into the family (Lobato et al., 2006).

40. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo et al., 2009; Klein & Gorzalka, 2009; Jarolim et al., 2009; Smith et al., 2005; Rehman et al., 1999; DeCuypere et al., 2005).

41. Given the decades of extensive experience and research supporting the effectiveness of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not experimental, treatment for gender dysphoria. Therefore, decades of peer-reviewed research and a medical consensus support the inclusion of gender confirmation surgery as a medically necessary treatment in the WPATH *Standards of Care*.

42. In 2016 WPATH issued a "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." ("Position Statement"), affirming a statement originally issued in 2008. As the Position Statement explains, "These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient."

43. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

44. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that Medicare's policy barring coverage for transition-related surgeries was not valid under the "reasonableness standard." The Board found that the ban "was based principally on" a report from 1981 that has been rendered obsolete by numerous "medical studies published in the more than 32 years since issuance of the 1981 report." The Board specifically concluded that transition-related surgeries are "safe and effective and not experimental." As a result, Medicare's exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.

45. The overwhelming scientific evidence indicates that transition-related care, including gender confirmation surgery, is medically necessary for the treatment of gender dysphoria in some patients.

46. Equating treatment gender confirmation surgery that has been prescribed to treat gender dysphoria with sterilization is medically inaccurate. Procedures undertaken for the purpose of sterilization are distinct from medical procedures undertaken for other purposes that incidentally affect reproductive function.

47. For some transgender people who desire children, reproduction may be possible even when such individuals have obtained transition-related medical care. For example, prior to the initiation of cross sex hormones, the preservation of gametes allows for future possible conception. If hormonal treatment for gender dysphoria has been initiated, it can be discontinued, and harvesting to retrieve gametes or stimulation of testicles or ovaries can be utilized for conception. In addition, for transgender men who retain a uterus, the discontinuation of masculinizing hormones may allow for pregnancy and childbirth.

**The Harmful Effects of Denial-of-Care to Transgender People**

48. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-identity formation is a fundamental undertaking for all human beings. Denial of medically indicated care to transgender people based on moral or religious objections signals that such people are "inferior" or "unworthy," and triggers shame. The "Denial of Care Rule" provides a license to discriminate and challenges the legitimacy of identity. In so doing, the Rule erodes resilience and poses lifelong health risks to transgender and gender nonconforming individuals, including depression, posttraumatic stress disorder, cardiovascular and other disease, premature death and suicide.

49. A wealth of research establishes that transgender people suffer from discrimination, stigma and shame. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. The stress process can be both external, *i.e.*, actual experiences of rejection and discrimination (enacted stigma), and as a result of such experiences, internal, *i.e.*, perceived rejection and the expectation of being rejected or discriminated against (felt stigma). A 2015 study of 28,000 transgender and gender nonconforming individuals found that 30% reported being fired, discriminated or otherwise experiencing mistreatment in the workplace. Similarly, 31% of respondents had been mistreated in a public place, including 14% who were denied service, 24% who were verbally harassed and 2% who were physically attacked.

50. This discrimination, often in the form of violence, abuse or harassment, is related to negative health outcomes. A 2012 study of transgender adults found fear of discrimination increased the risk of developing hypertension by 100%, owing to the intersectionality of shame and cardiovascular reactivity. Indeed, a 2012 study of discrimination and implications for health concluded: "living in states with discriminatory policies . . . was associated with a statistically significant increase in the number of psychiatric disorder diagnoses." Another study found transgender adults' access to college bathrooms and housing was related to suicidality.

51. Until recently, it was not fully understood that these experiences of shame and discrimination could have serious and enduring consequences. But it is now known that marginalization, stigmatization and victimization are some of the most powerful predictors of current and future mental health problems, including the development of psychiatric disorders. The social problems that young transgender people face actually create the blueprint for future mental health, life satisfaction, and even physical health. A recent study of 245 gender-nonconforming adults found that stress and victimization during childhood and adolescence was associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and

suicidality in adulthood. A 2011 Institute of Medicine (IOM) report concurs: "the marginalization of transgender people from society is having a devastating effect on their physical and mental health." And the American Journal of Public Health recently reported that more than half of transgender women "struggle with depression from the stigma, shame and isolation caused by how others treat them."

52. Conversely, Bauer et al. found a 62% reduction in risk of suicide ideation with the completion of medical transition. That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year.

53. There is a growing body of documentation that structural forms of stigma (policies) harm the health of transgender people. For example, a 2018 study showed that structural stigma affects the health and well-being of LGBTQ people and leads to psychological harm. In other words, stigma—a chronic source of psychological stress—negatively affects health by disrupting physiological pathways, increases disease vulnerability, causes psychological harm, and possibly leads to premature death.

54. Adding to the corpus of research in this area is a relatively new approach to the investigation of the relationship between discrimination and health. Neuroscientists have discovered that, in addition to causing serious emotional difficulties and physical harms, discrimination, harassment and verbal abuse permanently alter the architecture of the brain. Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause cognitive difficulties in individuals who have been routinely subjected to humiliation and ostracism.

55. Transgender individuals currently face significant discrimination in health care settings and barriers to care. Forty percent (40%) fear accessing care, and forego routine screening and preventative care. A 2017 report by the Center for American Progress of 7,500 transgender

adults found 29 % were refused treatment based on their gender identity and 21 % were verbally abused when seeking healthcare. The report also found that transgender individuals often had to travel to other states to find medical providers. A 2018 survey of 6,450 participants found 24% were denied treatment in doctor's offices or hospitals, 13% in emergency rooms, 11% in mental health clinics and 5% for ambulance or emergency medical services. These experiences lead transgender patients to be less likely to advocate on their own behalves out of fear of discrimination and stigma, and to sometimes forego time-sensitive health care. As a result, transgender individuals have poorer health, greater stress, and higher rates of obesity, even when compared to lesbian and gay populations. Indeed, 23% of respondents to a 2015 study did not see a doctor when they needed to because of fear of being mistreated as a transgender person. These findings led to the Association of American Medical Colleges to convene an advisory committee to develop curricula based on competencies for medical education.

56. "The Denial of Care Rule" further endangers the health and well-being of vulnerable individuals by permitting providers to refuse healthcare on the basis of religious or moral objections to transgender individuals' identities. The Rule seeks to create a license to discriminate, posing a serious risk to transgender people. The harms that will befall transgender people are predictable and dire: the exacerbation of symptoms of gender dysphoria, grave damage to mental and physical health, and the undermining of clearly established, evidence based treatment protocols.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 8 day of September, 2019.

Respectfully submitted,

Dr. Randi C. Ettner

Dr. Randi C. Ettner

# EXHIBIT A

*Curriculum Vitae*

**RANDI ETTNER, PHD**
**1214 Lake Street**
**Evanston, Illinois 60201**
**847-328-3433**

## POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

## EDUCATION

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|---|---|
| PhD, 1979 | Northwestern University (with honors) Evanston, Illinois |
| MA, 1976 | Roosevelt University (with honors) Chicago, Illinois |
| BA, 1969-73 | Indiana University<br>Bloomington, Indiana<br>Cum Laude<br>Major: Clinical Psychology; Minor: Sociology |
| 1972 | Moray College of Education<br>Edinburgh, Scotland<br>International Education Program |
| 1970 | Harvard University<br>Cambridge, Massachusetts<br>Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes |

## CLINICAL AND PROFESSIONAL EXPERIENCE

| | |
|---|---|
| 2016-present | Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery<br>Consultant: Walgreens; Tawani Enterprises<br>Private practitioner |
| 2011 | Instructor, Prescott College: Gender-A multidimensional approach |
| 2000 | Instructor, Illinois Professional School of Psychology |
| 1995-present | Supervision of clinicians in counseling gender non conforming clients |
| 1993 | Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota |
| 1992 | Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy |
| 1983-1984 | Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois |
| 1981-1984 | Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology |
| 1976-1978 | Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry |
| 1975-1977 | Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry |
| 1971 | Research Associate, Department of Psychology, Indiana University |
| 1970-1972 | Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University |
| 1969-1971 | Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University |

## LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

*Mental health issues in transgender health care,* American Medical Student Association, webinar presentation, 2019

*Sticks and stones: Childhood bullying experiences in lesbian women and transmen,* Buenos Aires, 2018

*Gender identity and the Standards of Care,* American College of Surgeons, Boston, MA, 2018
*The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery,* American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

*Navigating Transference and Countertransference Issues,* WPATH global education initiative, Portland, OR; 2018

*Psychological aspects of gender confirmation surgery* International Continence Society, Philadelphia, PA 2018

*The role of the mental health professional in gender confirmation surgeries,* Mt. Sinai Hospital, New York City, NY, 2018

*Mental health evaluation for gender confirmation surgery,* Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

*Transitioning; Bathrooms are only the beginning,* American College of Legal Medicine, Charleston, SC, 2018

*Gender Dysphoria: A medical perspective,* Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

*Multi-disciplinary health care for transgender patients,* James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

*Psychological and Social Issues in the Aging Transgender Person,* Weiss Memorial Hospital, Chicago, IL, 2017.

*Psychiatric and Legal Issues for Transgender Inmates,* USPATH, Los Angeles, CA, 2017

*Transgender 101 for Surgeons,* American Society of Plastic Surgeons, Chicago, IL, 2017.

*Healthcare for transgender inmates in the US,* Erasmus Medical Center, Rotterdam, Netherlands, 2016.

*Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet*- WPATH symposium, Amsterdam, Netherlands, 2016.

*Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment:* WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017,

Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

*Pre-operative evaluation in gender-affirming surgery*-American Society of Plastic Surgeons, Boston, MA, 2015

*Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care*-Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

*Adult development and quality of life in transgender healthcare*- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

*Healthcare for transgender inmates*- American Academy of Psychiatry and the Law, 2014

*Supporting transgender students: best school practices for success*- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

*Addressing the needs of transgender students on campus*- Prescott College, 2014

*The role of the behavioral psychologist in transgender healthcare* – Gay and Lesbian Medical Association, 2013

*Understanding transgender*- Nielsen Corporation, Chicago, Illinois, 2013

*Role of the forensic psychologist in transgender care*; *Care of the aging transgender patient*-University of California San Francisco, Center for Excellence, 2013

*Evidence-based care of transgender patients*- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

*Children of Transsexuals*-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

*Gender and the Law*- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

*Gender Identity, Gender Dysphoria and Clinical Issues* –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World

Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

*Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients*- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

*Psychonueroimmunology and Cancer Treatment*- St. Francis Hospital, Evanston, Illinois, 1984

*Psychosexual Factors in Women's Health*- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

*Sexual Dysfunction in Medical Practice*- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

*Sleep Apnea* - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

*The Role of Denial in Dialysis Patients* - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

**PUBLICATIONS**

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transmen. *Journal of Child and Adolescent Psychiatry*.

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin*, 1997.

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin*, 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

## PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

## AWARDS AND HONORS

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018
*The Randi and Fred Ettner Transgender Health Fellowship*-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

**LICENSE**

Clinical Psychologist, State of Illinois, 1980

# EXHIBIT B

*Bibliography*

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C19-02405 WHA
No. C19-02769 WHA
No. C19-02916 WHA

**DECLARATION OF MARK GHALY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, Mark Ghaly, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Secretary of the California Health & Human Services Agency (CHHS). The California Health & Human Services Agency (CHHS) is the state's largest agency. The Secretary of CHHS is a member of the Governor's Cabinet. CHHS oversees twelve departments and five offices that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians from all walks of life. More than 33,000 people work for departments in CHHS at state headquarters in Sacramento, regional offices throughout the state, state institutions and residential facilities serving the mentally ill and people with developmental disabilities.

3. I was appointed Secretary of CHHS by Governor Newsom in April 2019. I am a Secretary in Governor Newsom's cabinet. My duties as Secretary of CHHS include supervising the CHHS departments and offices in administering and overseeing state programs for health care and social services. CHHS departments are instrumental in implementing Governor Newsom's goal of achieving universal coverage in the state and expanding access to care.

4. Before my appointment as Secretary of CHHS, I served for over a decade in various health care programmatic and policy leadership roles in county government. Most recently, since April 2018, I served as the Director for Health & Social Impact at the Los Angeles County Chief Executive Office, where I spearheaded and supported a number of health care, housing, and employment initiatives for the County. From 2011 until April 2018, I was the Deputy Director for Community Health and Integrated Programs for the Los Angeles County Department of Health Services. In that role, I directed clinical services for county correctional facilities; the Los Angeles County Whole Person Care Pilot Program; and created and developed a program for individuals facing chronic illnesses and homelessness to obtain permanent housing and appropriate treatment. Before my appointment in Los Angeles County, I served for five years in the City and County of San Francisco as the Medical Director for Southeast Health Center, a

public health clinic located in the Bayview-Hunters Point community. As Medical Director, I supervised clinic operations and promoted community-based initiatives to improve population health. In 1996, I earned a Bachelor of Arts degree in Biology and Biomedical Ethics from Brown University. In 2002, I earned a Doctorate of Medicine from Harvard Medical School, as well as a Masters in Public Health from the Harvard School of Public Health. And in 2006, I completed my residency training in Pediatrics at the University of California, San Francisco.

5. CHHS oversees the Department of Aging, the Department of Child Support Services, the Department of Community Services & Development, the Department of Developmental Services, the California Emergency Medical Services Authority, the Department of Health Care Services, the Department of Managed Health Care, The Department of Public Health, the Department of Rehabilitation, the Department of Social Services, the Department of State Hospitals, the Office of Health Information Integrity, the Office of Law Enforcement Support, the Office of Statewide Health Planning and Development, the Office of Systems Integration, and the Office of the Patient Advocate.

6. I am familiar with the rule Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (HHS) on May 2, 2019, and published in the Federal Register on May 21, 2019 (Rule).

7. The Rule will impose an immediate cost on CHHS and the departments and offices it oversees due to its notice, assurance and certification, recordkeeping, and reporting requirements. Although the Rule indicates that the notice requirements are voluntary, the Rule also states that adherence to the notice requirements will be taken into consideration when assessing whether an agency is in compliance.

8. The Rule potentially places at risk all federal funds CHHS receives from the U.S. Department of Health and Human Services. For fiscal year 2019-2020, CHHS expects $77.6 billion in total federal funds in a total budget of $163 billion. Federal funds make up much of CHHS's budget, and a substantial portion of those federal funds come from appropriations subject to the Rule. Loss of this funding would have a devastating impact on California. State programs and local programs that depend on pass-through funding would be unable to absorb

such a loss of funding without cutting staff and services. The state and local governments would be unable to make up this shortfall in funding, and the programs would need to be cut as a consequence.

9. Federal funding comes to the departments CHHS oversees from appropriations acts approved by Congress and signed by the president. The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Public Law 115-245, which was enacted September 28, 2018, makes appropriations for the following programs (among others), which provide funding to CHHS and the departments and offices it oversees:

- Title XIX of the Social Security Act, to operate and make payments for Medicaid which provides healthcare coverage for low-income adults, families and children, pregnant women, the elderly, and people with disabilities;
- The Child Support Enforcement and Family Support Programs for child support enforcement and family support programs;
- The Social Security Block Grant Program to assist states in delivering social services by helping reduce dependency, increase self-sufficiency, prevent abuse and neglect, and limit institutional care, if possible;
- The Older Americans Act of 1965 for programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities; ;
- The 21st Century Cures Act, section 1003(c), and the State Opioid Response Grants Program to assist state response to the opioid crisis;
- The Ryan White HIV/AIDS Program to provide primary medical care and essential support for people with HIV/AIDS; and
- The Rehabilitation Act of 1973 to ensure that individuals with disabilities have access to programs and activities that are funded by federal agencies and to federal employment.

10. In developing its annual budget, CHHS did so with the expectation that it would receive the federal funds to which it is entitled to under its existing agreements under the

aforementioned federal programs—these funds are now being placed at risk under the Rule. Under the regulatory language of the Rule, however, it is now unclear how HHS will implement and enforce monetary consequences for noncompliance with the Rule given the new and broader definitions, number of laws that now fall within the ambit of the Rule, and expanded enforcement tools. Also, the Rule makes CHHS departments liable for the actions of third parties in a manner that is unprecedented in CHHS' experience and unworkable in practice.

11. In California, county and local partners administer the vast majority of health and human services programs, often as sub-recipients of federal funding that flows through CHHS departments. Counties and local partners are independent legal entities and make compliance determinations independently from CHHS. If a sub-recipient is deemed to be in violation of the Rule and federal funding is withheld from these programs, local communities statewide will suffer devastating consequences. A sudden disruption in anticipated federal funds would create budgetary chaos for CHHS, the departments and offices it oversees, and the many entities that receive pass-through federal funding.

12. Already, State officials and I have discussed how the administration can comply with the Rule's requirements while simultaneously abiding by California laws. For example, representatives of the Department of Managed Health Care and I have discussed how to ensure that licensed plans abide by California law that requires health plans to provide basic, non-discriminatory health care services while not running afoul of this Rule and jeopardizing billions of dollars in federal funding.

13. It is estimated that the Department of Health Care Services, which administers California's Medicaid program, known as Medi-Cal, and other federally funded health care programs, will receive more than $60.3 billion in federal funding for services and operations in Fiscal Year 2018-2019. Much of this funding is expended by the state in expectation of reimbursement from the federal government.

14. The loss of federal Medicaid or Children's Health Insurance Program funding in California would largely end the delivery of basic health care services to more than 13 million low income, elderly and pregnant individuals, as well as individuals with disabilities. Numerous

studies have shown that not having access to coverage leads individuals to postpone or forgo needed medical treatment, including both preventive treatment as well as treatments for major acute or chronic conditions. Lack of access to timely treatment leads to increased emergency room use and hospitalizations, and a decline in health. Additionally, when uninsured individuals ultimately undergo medical treatment, as everyone eventually must, they often receive unaffordable medical bills, causing serious financial harms. These can include medical debt and bankruptcy.

15. The Department of Social Services estimates that it will receive nearly $2.93 billion in federal funding for various child welfare and refugee assistance programs and over $7.87 billion in federal funding for the In-Home Supportive Services program during Fiscal Year 2018-2019.

16. If federal dollars are reduced or eliminated pursuant to implementation of the Rule, additional social services programs would be impacted, resulting in significant reductions or potentially termination of crucial supports and services that include, but are not limited to: programs for foster care placements and the prevention of child abuse awarded under Titles IV-E and IV-B; the Adoption Assistance Program, which provides financial and medical support to promote the adoption of children who otherwise would remain in long-term foster care; the Kinship Guardianship Program, which promotes permanency for foster children living with an approved relative caregiver; the In-Home Supportive Services Program, which provides services to the elderly and individuals with disabilities to remain safely within in community settings as opposed to institutional placement; and the Refugee and Entrant Assistance Program, which coordinates the delivery of benefits and services to refugees and entrants in the state.

17. Approximately 218,000 households are served in California under the Low-Income Home Energy Assistance Program (LIHEAP). Of the households served, 162,000 are considered a vulnerable population such as elderly, individuals with disabilities, or households with children under five. LIHEAP is the primary source of financial assistance for the eligible low-income households in California to manage and meet their immediate home heating and/or cooling needs. LIHEAP also provides emergency assistance to help low-income households

avoid the loss of home energy services and those facing life-threatening energy-related emergencies created by a natural disaster. The weatherization component of LIHEAP provides energy efficiency upgrades for low-income households, helping to reduce utility costs, while improving the health and safety of the occupants. The heating, cooling, and weatherization services LIHEAP helps to provide can mean the difference between life and death for recipients. Loss of federal funding for this program would deprive thousands vulnerable Californians of the support they need to keep their homes safe for habitation.

18. The California Department of Public Health's (CDPH) Immunization Branch receives substantial annual funding and support under the federal Health and Human Services appropriation, totaling almost $581 million annually. Approximately $537 million supports the Vaccines for Children program, an entitlement program allocated through the Centers for Medicare and Medicaid (CMS) which supplies vaccines for all children in the Medi-Cal program. About $8.7 million in direct assistance provides vaccines for uninsured and underinsured adults being immunized in local health departments and 500 federally qualified health center sites, as well as for outbreak containment. Of the remaining $35.4 million (financial assistance), half of this funding is CDPH support and half is provided through CDPH to all 61 local health departments around the state. If this $581 million in federal support is jeopardized or lost, the local health departments and federally qualified health clinics would be severely limited in their ability to provide immunizations to protect California communities against dangerous diseases, and the state Medicaid program would need to make up a $537 million shortfall in vaccine funding for its pediatric members.

19. CDPH's STD Control Branch receives approximately $8.8 million in annual federal funding. This funding is critical for STD control programs, and enables CDPH to monitor STDs, provide information about STD trends to the public and policy makers, identify effective strategies to control STDs based on the groups and regions most at risk, provide expert consultation and training to front line local disease prevention staff, and leverage partnerships with health care systems and others to prevent disease. Losing this funding would increase the

likelihood of further accelerating the rate of STD transmission at a time when STD rates, particularly syphilis and gonorrhea rates, are already rising in the state.

20. The Public Health Emergency Preparedness Program at CDPH coordinates preparedness and response activities for public health emergencies and supports surge capacity in health care and public health systems during emergencies. This program receives approximately $52.7 million in federal HHS funding annually, without which the state's emergency health care system could be unequipped to handle a public health crisis. These funds provide a whole community approach to emergency response for events ranging from communicable disease outbreaks like the current national measles outbreak to the catastrophic wildfires faced by California over the last few years. The funds provide for advanced planning and preparedness at the state and local level to handle the laboratory and epidemiology skills necessary to stop a communicable disease outbreak. The funds also provide for the safe evacuation of healthcare facilities and emergency medical transport, medical care in evacuation shelters, and the safe repopulation and return to normal operations of the medical and health infrastructure following an event.

21. In addition to the individual and public health harms that would occur if federal funding to these programs is terminated, the Rule will confuse health care consumers about which providers will perform what services and will unduly burden consumers as they try to navigate the health care delivery system. For example, if a consumer's primary care provider refuses to perform certain medically necessary services, such as sterilizations, and the provider refuses to provide the enrollee with a referral to another provider, the consumer may not be aware that the health plan must find another provider to perform the services. In such instances, the consumer may simply forgo the service and suffer serious consequences as a result. Additionally, health plans may be unaware that certain providers will refuse to perform certain services, which will add to the difficulties consumers may face as they try to find providers to perform medically necessary services.

I declare under penalty of perjury under the laws of the United States and the State of

California that the foregoing is true and correct to the best of my knowledge.

Executed on August 26, 2019 in Sacramento, California.

Mark Ghaly, MD, MPH
Secretary
California Health & Human Services Agency

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF DEBRA HALLADAY, INTERIM CHIEF EXECUTIVE OFFICER OF VALLEY HEALTH PLAN, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, DEBRA HALLADAY, declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Interim Chief Executive Officer of Valley Health Plan. In this role I oversee all health plan operations. I have held this position since July of 2019. I have also served as the Chief Operating Officer for Valley Health Plan since May of 2018. Prior to my current roles at Valley Health Plan, I served as the Director of Planning, Business Development and Managed Care as well as the Director of System Integration and Transformation for the County of Santa Clara Health & Hospital System. Prior to my work with the County, I also worked with several managed care organizations in executive roles. I have served in health care for 30 years.

3. Valley Health Plan is a health maintenance organization ("HMO") owned and operated by the County of Santa Clara since 1985. Our mission is to provide affordable healthcare to a wide spectrum of Santa Clara County residents and community members, and to improve the overall health and wellbeing of Santa Clara County and our members. As an HMO, Valley Health Plan offers a set of different healthcare coverage plans that give enrolled members access to a range of medical services from physicians and other healthcare providers with whom Valley Health Plan contracts. The health plan member, or the entity paying for the member's coverage, selects a plan and pays a predetermined fee in exchange for securing the member's access to a set of covered healthcare services, including access to a network of primary and specialty care providers, nationwide pharmacy locations, and in-state laboratory locations, as well as other health care providers for behavioral health, substance abuse, chiropractic, acupuncture, and related services. Many of our provider partners are primarily focused on safety-net populations and our partnership with them provides them with an alternate and steady stream of payments that can help enable their work with safety net populations.

4. We serve a variety of populations, and many of our members have their healthcare plans with us paid for in whole or in part by the federal government:

a. **Commercial members**: For these members, an employer secures healthcare coverage through Valley Health Plan for its employees. Approximately 22,686 people obtain healthcare through our commercial memberships, and many Santa Clara County employees receive healthcare coverage through this option.

b. **Medi-Cal**: The Santa Clara Family Health Plan (Family Health Plan) is an independent Health Authority created by the County in 1996 that works with the State to provide coverage to Medi-Cal and Healthy Kids enrollees. The Family Health Plan delegates to Valley Health Plan the responsibility for connecting a large portion of its Medi-Cal and Healthy Kids enrollees to covered healthcare services. Thus, Valley Health Plan provides administrative services, including access to its extensive provider network, to the Family Health Plan's Medi-Cal and Healthy Kids enrollees. The Family Health Plan is compensated by the State for providing coverage, and the Family Health Plan in turn compensates Valley Health Plan for its services. Valley Health Plan's current enrollment of Medi-Cal Managed Care and Healthy Kids members is approximately 119,924. Were we to be disqualified from receiving federal funds passed through the Department of Health and Human Services we would no longer be able to offer services to the Medi-Cal Managed Care members.

c. **Covered California Health Exchange Program**: Valley Health Plan is a Qualified Health Plan Issuer for Covered California, the California Health Benefit Exchange. Covered California is the state marketplace for health insurance, established following the enactment of the Patient Protection and Affordable Care Act (ACA). Under the ACA, each state is tasked with creating a marketplace for health insurance plans. The federal government subsidizes these plans for individuals who meet income-based eligibility requirement. Thus, through the Covered California marketplace, Valley Health Plan offers subsidized health insurance plans to eligible persons. There are approximately 16,816 members enrolled in Valley Health Plan through Covered California.

d. **Individual and Family Plans**: Valley Health Plan offers an off-exchange product for individuals and families that allows those who don't qualify for subsidies to obtain insurance under the same terms as those offered through the Covered California exchange. There

are 347 members enrolled in Valley Health Plan's direct family and individual plans.

5. When Valley Health Plan enters into a contract with a provider, Valley Health Plan requires that the provider inform us of the entire range of specific services they provide. A sample of our standard provider agreement is attached as **Exhibit A**. We also require that a provider inform us if the scope of the services it offers is about to change or has changed. Exhibit A at 2.1(l). Without this information, we cannot match our members to providers who can appropriately care for them. For example, an obstetrician/gynecologist is required to list whether they provide abortion and sterilization care as part of the provider contract, and once that provider is part of the VHP network, the provider must provide those services or timely inform us that they no longer offer such services. See Exhibit A at 2.1(l). If providers were to not provide us with accurate information about the care they provide, it could delay or bar members from receiving the healthcare to which they are entitled.

6. We require each provider to sign a nondiscrimination provision stating that it "will not differentiate or discriminate in its provision of Covered Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and . . . will render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other Clinic patients." Exhibit A at 2.1(k). Were our providers allowed to refuse to provide care to specific members on the basis of a member's identity or a connection between a member's identity and the care they were seeking, it would obstruct members' access to healthcare to which they are entitled, undercut our relationship with our members, and endanger member health. We strive to run an inclusive organization, and without the ability to enforce this policy, we would not be able to ensure access to healthcare services.

7. When a member is seeking healthcare services they call Member Services to be connected with a provider who can meet their needs. If one of our representatives responsible for answering calls through Member Services objected to connecting a member with care on the basis of the representative's cultural values, ethics, or religious beliefs, this could delay or bar a member's access to the healthcare to which they are entitled. For example, if a Member Services

representative told a member that they could not connect them with services—without noting that this was because of the representative's own provider's cultural values, ethics, or religious beliefs—then that member might be left with the impression that Valley Health Plan would not cover the service the member was seeking. And, while a limited subset of calls are recorded, Valley Health Plan would largely be left entirely unaware that a member sought certain care and was turned away be a Member Services representative.

8. Further, a Valley Health Plan nurse or doctor must review and approve a request for services before a member can obtain certain services. Valley Health Plan's medical management follows national clinical guidelines for determining medical necessity and whether to approve a specific clinical service. It would undermine our review system if a reviewing nurse or doctor—based on their own cultural values, ethics, or religious beliefs—rejected or ignored a request for service that should have been approved under Valley Health Plan's guidelines, particularly if they did so without informing anyone that the denial or non-action was due to their cultural values, ethics, or religious beliefs. Indeed, if the member did not appeal the ruling, Valley Health Plan might never learn that a nurse or doctor had rejected the request based on their cultural values, ethics, or religious beliefs. And as a result, that member might never get the medically indicated care to which they were entitled.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on September 6, 2019 in San José, California.

DEBRA HALLADAY
Interim Chief Executive Officer

# EXHIBIT A

**PROVIDER AGREEMENT**
**BY AND BETWEEN**
**THE COUNTY OF SANTA CLARA, dba VALLEY HEALTH PLAN**
**AND**
**PROVIDER_CONTRACT_NAME**

This agreement, effective as of **Effective_Date** ("Effective Date"), is made and entered into by and between **Provider_Contract_Name** ("Provider"), and the County of Santa Clara, a subdivision of the state of California, ("County") doing business as Valley Health Plan ("VHP") for **Type_of_Services** ("Agreement"). Provider and Plan may be referred to individually as "Party" and collectively as "Parties".

## RECITALS

WHEREAS, County operates VHP ("Plan"), a Health Care Service Plan licensed pursuant to the Knox-Keene Health Care Service Act of 1975, as amended ("Knox-Keene Act");

WHEREAS; VHP arranges for the provision of Covered Services to Members (as hereinafter defined) of Plan;

WHEREAS, such Members may from time to time require the services of a health care Provider**,** or services at a location, which County is unable to provide, and Plan wishes to insure the provision of such services to Members;

WHEREAS, **Provider_Contract_Name** is a health care Provider duly licensed by the State of California to provide the services under this Agreement and Provider has the authority, applicable knowledge, and expertise to provide **Type_of_Services** at Provider's medical offices located at **«Address», «City», «State» «Zip».**

## AGREEMENT

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, and for the good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

## ARTICLE I

## DEFINITIONS

In addition to the definitions elsewhere in this Agreement, the following capitalized terms shall have the meanings set forth below:

**1.1 "Accrediting Agency"** means a nationally recognized agency invested in the assurance of quality care to patients, which helps organizations meet regulatory requirements, as well as, distinguish themselves from non-accredited competition. An Accrediting Agency (i) completes initial and periodic assessments of an organization, (ii) evaluates against a defined set of standards, and (iii) determines and issues an official

recognition of accreditation to organizations meeting those set standards. VHP's Accrediting Agency(s) are identified on the Valley Health Plan's website at www.valleyhealthplan.org.

**1.2 "Applicable Requirements"** means, to the extent applicable to the terms and conditions of this Agreement and the duties, rights and privileges hereunder, the requirements set forth in: (i) the Provider Manual, the VHP Language Assistance Program, and any other policies and procedures of VHP including the Quality Management Programs; (ii) federal and state laws and regulations and any amendments or updates thereto, including the Knox-Keene Act; (iii) the applicable Evidence of Coverage; (iv) Medicare and Medi-Cal laws and regulations or Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) instructions and reporting requirements, including certification requirements; (v) the California Department of Managed Health Care (DMHC); (vi) the California Health Benefit Exchange; and (vii) VHP's Accrediting Agency standards.

**1.3 "Authorization"** means the written approval by Plan, to be obtained by a Provider, making a Referral or providing certain Covered Services (other than Emergency Services) to any Member, in accordance with Applicable Requirements. Covered Services approved by Plan, as applicable, in accordance with the foregoing are "Authorized".

**1.4 "Clean Claim"** means a billing form (e.g. UB-04, CMS 1500, or any subsequent form issued by CMS, or applicable electronic claim) submitted by Provider to VHP that (i) identifies the Member; (ii) identifies the items and services with codes listed in this Agreement, including Exhibits, or, if not specifically listed, identifies the items and services provided utilizing codes published in the Current Procedural Terminology ("CPT"), Healthcare Common Procedure Coding System ("HCPCS"), or other industry-standard codes utilized by Provider; (iii) if applicable, contains or attaches a required authorization or form as specified in this Agreement, and (iv) follows all industry standard clean claim practices.

**1.5 "Contracted Services"** Covered Services that are within Provider's scope of practice provided to a Member pursuant to the Evidence of Coverage in effect at the time services are rendered and compensated in accordance with this Agreement.

**1.6 "Coordination of Benefits" ("COB")** means the determination of order of financial responsibility that will apply when two (2) or more payors provide coverage of services for an individual Member. When the primary and secondary benefits are coordinated, determination of financial responsibility shall be in accordance with Applicable Requirements.

**1.7 "Co-payment"** means the amount due from Member for Covered Services that is in accordance with Applicable Requirements and is disclosed and provided for in the Member's Evidence of Coverage. The reference to "Co-payments" may include copayments, deductibles, and co-insurance charges or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

**1.8 "Covered California"** shall mean Covered California, California Health Benefit Exchange, the independent entity established within the government of the State of California and authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010) and Chapter 659, Statutes of 2010) ("California Affordable Care Act") to selectively contract with health insurance issuers in order to make available to enrollees of the exchange health care coverage choices available to qualified individuals, employers and employees.

**1.9 "Covered Services"** means all of the health care services and supplies: (i) that are Medically Necessary; (ii) that are generally available from provider; (iii) that provider is licensed to provide to Members; and (iv) that are covered under the terms of the Member's Evidence of Coverage at the time service is rendered. Plan shall retain the right and sole responsibility to determine whether a service is a Covered Service.

**1.10 "Emergency Medical Condition"** as set forth in Title 22, California Code of Regulations ("CCR"), section 51056, and California Health and Safety Code section 1317.1, means those services required for alleviation of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

**(a)** Placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

**(b)** Serious impairment to bodily functions; or

**(c)** Serious dysfunction of any bodily organ or part.

**1.11 "Emergency Services"** means those medical and psychiatric services required that are (i) furnished by a physician qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

**1.12 "Evidence of Coverage" ("EOC")** means the Plan handbook issued to a Member that describes coverage and benefits known as the Combined Evidence of Coverage and Disclosure Form as may be amended, modified, replaced, or supplemented from time to time and issued to Members by Plan pursuant to Title 28 of the California Code of Regulations § 1300.63.2.

**1.13 "Language Assistance Program"** means the language assistance program established by VHP in compliance with the requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq.

**1.14 "Medically Necessary"** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury as determined by a Physician, or, as appropriate, by another Provider under supervision of a Physician, in accordance with accepted medical and surgical practices and standards prevailing at the

time of treatment and in conformity with the professional and technical standards adopted by VHP, as applicable.

**1.15 "Member"** means each VHP Employer Group, Covered California, Individual and Family Plan, Medi-Cal, Healthy Kids enrollee or other individual included in the products reflected in the exhibits attached to and incorporated by reference to this Agreement.

**1.16 "Physician(s)"** means each duly licensed and qualified physician who has satisfied Plan's credentialing criteria and is under contract, directly or indirectly, with Plan to provide specified Covered Services to Members.

**1.17 "Practitioner(s)"** mean the other health care Providers that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

**1.18 "Provider(s)"** means the hospitals, community clinics, primary care and specialty care physicians, skilled nursing facilities, home health agencies, and other health care providers (including institutional, ancillary, behavioral health, and participating Physicians) that have entered or will enter into a written agreement, directly or indirectly, with Plan to provide certain Covered Services in return for a negotiated rate of compensation.

**1.19 "Primary Care Physician(s)" ("PCP")** means the Physician responsible for supervising, coordinating, and providing initial and primary care to each Member who selects or is assigned to such physician. The PCP is responsible for: managing the delivery of all health and medical care services; for initial referrals for specialist care; and for maintaining the continuity of patient care to such Members. PCP includes physicians practicing in the area of internal medicine, general and family practice, or pediatrics; and may also include physicians in other areas of practice, as applicable, to the extent permitted by VHP and Applicable Requirements.

**1.20 "Provider Manual"** means, collectively, VHP's standards, protocols, policies and procedures, guidelines, manuals, and related written materials. The Provider Manual(s) are incorporated into this Agreement and may be revised or replaced from time to time, in accordance with the terms of this Agreement. The Provider Manual can be located on Valley Health Plan's website at www.valleyhealthplan.org. If any provisions in the Provider Manual or any amendments thereto are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

**1.21 "QHP Contract"** shall mean the Qualified Health Plan contract between Plan and Covered California through which Plan is authorized to enroll individuals as Covered California Members.

**1.22 "Quality Management Programs"** shall include both Quality Improvement and Utilization Management Programs and means VHP policies, procedures, protocols and functions designed to monitor and ensure the quality and appropriate utilization of Covered Services provided to Members. The Quality Management Programs are described in the Provider Manual.

**1.23 "Santa Clara Family Health Plan" ("SCFHP")** means the health care service plan licensed pursuant to the Knox-Keene Act and governed by the Santa Clara County Health Authority.

**1.24 "Surcharge"** means an additional fee that is charged to a Member for Covered Services, which is not permitted under applicable legal requirements, and is neither disclosed nor provided for in the Member's Evidence of Coverage.

## ARTICLE II

## PROVIDER OBLIGATIONS

**2.1 Services.**

**(a)** Provider will provide the **Type_of_Services** services ("Contracted Services") to Members included in the product(s) identified in the exhibits attached to and incorporated by reference to this Agreement.

**(b)** The Provider(s) must submit an application and be approved pursuant to all applicable credentialing procedures, before he or she may provide medical services pursuant to this Agreement.

**(c)** Provider will maintain a current list of its Providers who are eligible in accordance with Section 2.9 of this Agreement, to provide medical services hereunder. Provider shall provide an updated list of any changes monthly.

**(d)** Provider agrees to follow treatment guidelines equivalent to those required by the state in which Provider renders services or as outlined by Provider's specialty.

**(e)** Providers will accept, diagnose, and treat those Members referred to Provider by Plan in accordance with the terms of this Agreement and consistent with accepted principles of medical practice and ethics.

**(f)** Except for Emergency Services as defined herein and unless otherwise authorized, Provider will make best efforts to use Physicians and a contracted Providers for those Members requiring additional professional and Covered Services.

**(g)** Subject to other provisions in this Agreement, the Provider will determine the method, details, and means of performing Contracted Services pursuant to this Agreement. Provider acknowledges that all VHP's decisions, policies and procedures regarding the provision of Covered Services to Members apply solely to Provider's rights to compensation, and will not be construed as interference with, or direction or substitution of, Provider's due diligence and judgment in the provision of Covered Services.

**(h)** Provider will maintain adequate personnel and facilities to meet its responsibilities under this Agreement. Provider will supervise all personnel employed by it. Provider's personnel, equipment and facilities will be licensed or certified to the extent required by law. Plan or its designee(s), the DHCS, the DMHC or other regulatory agencies may conduct periodic site visits to assess the adequacy of personnel and facilities maintained by Provider. If any of the personnel and/or facilities maintained at any site is found to be inadequate, Plan must be notified, and Provider must develop and implement a plan of correction in accordance with Plan's Quality Management Programs and applicable state and federal laws.

**(i)** Provider will be responsible, at its sole cost and expense, for providing licensed persons or technicians to assist in the performance of Contracted Services hereunder.

**(j)** Provider will comply with Plan's drug formularies and treatment protocols, subject to generally accepted medical practice standards. Provider will comply with Title 22, CCR, section 53214, and with DHCS standards for the appropriate use, storage and handling of pharmaceutical items.

**(k)** Provider will not differentiate or discriminate in its provision of Contracted Services to Members hereunder, because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or use of medical services, and Provider will render services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to Provider's other patients.

**(l)** Provider will notify the Plan of a pending or actual change in scope of service available, or any other factors which might materially affect the Provider's ability to provide services and carry out all other provisions under this Agreement.

**(m)** Provider agrees to comply with Plan's Language Assistance Program Requirements as outlined in **Exhibit F** that is attached to and incorporated herein by this reference and any other Applicable Requirements.

**(n)** Provider agrees to comply with Plan's Timely Access Standards as outlined in **Exhibit G** that is attached to and incorporated herein by this reference.

**(o)** Provider agrees to comply with the Covered California Requirements as specified in **Exhibit H** that is attached to and incorporated herein by this reference.

**2.2 Continuity of Care.** The completion of Covered Services shall be provided by a terminated Provider to a Member who at the time of the contract's termination was receiving services from that Provider as required by law.

**2.3 Standard of Care.** Provider shall ensure that Covered Services furnished by Provider to Member are (i) Medically Necessary; (ii) provided in accordance with the standard of care prevailing within the medical community at the time of treatment; (iii)

provided in coordination with appropriate health prevention and education measures; and (iv) in consultation with Plan.

**2.4 Improvement Programs.** Provider shall establish and maintain quality improvement and utilization management programs to monitor the quality and utilization of Covered Services rendered to members within and across the healthcare organization, settings, and all levels of care. Provider shall fully cooperate with and participate in Plan's Quality Improvement (QI) and Utilization Management (UM) Programs, as applicable. Provider will operate a QI program that is compliant and responsive to public health initiatives, federal, state, and local regulators and accreditation bodies. Provider's QI program shall include a system for monitoring and evaluating accessibility of care. Provider shall support the Plan's ongoing efforts to improve clinical care and services through activities including, but not limited to safe clinical practices, assessment and improvement of clinical care as necessary, measuring quality of services and member experience, and efficient utilization of resources. Provider agrees to implement any reasonable change required by Plan regarding any Provider or problem identified by Plan's Quality Improvement and/or Utilization Management Programs. Provider shall permit Plan personnel to review medical records of Members and Provider shall furnish copies of such pertinent sections of Members' medical records, as may be required, consistent with applicable confidentiality requirements as set forth in this Agreement. Provider agrees to provide to Plan, monthly, all Member data necessary for Plan to maintain and operate its QI and UM Programs and comply with all encounter data submission requirements imposed by Plan and/or any government regulatory agency.

**(a)** Provider shall designate experienced Utilization Management staff, capable of effectively coordinating the provision of Covered Services to Members. The UM staff shall, among other duties, assist Provider and Plan with respect to implementing Covered Service authorizations, approval of Member referrals, and such other duties as Provider shall designate from time to time. Prior authorization is required for all Covered Services except as determined by DMHC policy. Contacts for prior authorization of Covered Services are referenced in **Exhibit D** which is attached to and incorporated herein by this reference.

**(b)** Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet their regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

**(c)** Provider shall cooperate with Plan and/or any external peer review organization in the conduct of QI functions and in solving problems which includes potential quality issues. Provider shall provide Plan with information and reports as are reasonably necessary for Plan to conduct, or, if applicable, monitor Provider's delegated conduct of quality improvement functions. Provider shall also provide Plan with information and reports as are necessary for Plan to maintain compliance with DMHC, CMS, Covered California and Accrediting Agency requirements and/or state and federal law.

**2.5 Member Transfer or Termination.** Provider shall not ask Plan to terminate a Member or transfer a Member to another Provider because of a Member's medical condition or need for, or utilization of Covered Services. However, Plan and Provider may determine that the transfer of certain Members to another Provider may be Medically Necessary. Such determination shall be based on the following: (i) the Member's medical condition; (ii) the standard of care prevailing within the applicable medical community at the time of treatment; (iii) Provider's clinical capabilities, expertise and resources regarding the medical condition and standard of care under review; and (iv) the clinical capabilities, expertise and resources of another Provider under consideration to assume the care of such Member.

**2.6 Eligibility Verification**. Provider shall obtain from Plan verification of the eligibility of all Members who receive Covered Services pursuant to this Agreement. If eligibility verification is not possible prior to the provision of Covered Services, Provider shall request such verification at the earliest possible opportunity thereafter, prior to billing Plan; provided, however, that Provider shall not be required to obtain Plan's approval prior to rendering Emergency Services to Members. Plan agrees to provide access to eligibility verification twenty-four (24) hours per day, seven (7) days per week. If Provider fails to verify eligibility which results in Provider rendering services to ineligible patients, Plan shall have no financial responsibility to reimburse Provider for any such services rendered to such ineligible patients.

**2.7 Authorization Requirements.** Provider agrees to comply with VHP's authorization procedures and shall obtain prior authorization from Plan for all Covered Services, as required herein and in the Provider Manual. Additionally, Provider agrees to obtain prior authorization from Plan before providing any item or service not included in the original referral. If prior approval for additional items or services is not obtained, payment for services will be denied. Plan's contacts for prior authorization are set forth in **Exhibit D** to this Agreement.

**(a)** Upon request, Provider must promptly provide Plan with all information and documentation to enable Plan to determine whether to authorize services. Provider agrees to comply with the prior authorization process as set forth in the Provider Manual, and as required by Plan's Utilization Management Department.

**(b)** Provider will provide a report to referring physician within three (3) working days, unless a significant finding warrants immediate reporting.

**(c)** Provider acknowledges that nothing in this contract should be constructed to prevent Provider from freely communicating with patients about treatment options, including medication treatment options, regardless of benefit coverage limitations.

**2.8 Member Grievances.** Provider shall cooperate with Plan in resolving Member grievances related to the provision of Covered Services in accordance with Plan's Grievance and Appeals Procedures. Provider agrees to make available to Members copies of Plan's Grievance and Appeals Procedures and shall notify Plan within forty-eight (48) hours of the time it becomes aware of any Member grievances. Provider shall investigate all

Member grievances within the time frames specified by Plan and use its best efforts to assist Plan in resolving grievances in a fair and equitable manner.

**2.9 Credentialing; Quality Assessment/Improvement; Grievance**

**(a)** Provider must submit an application to Plan in accordance with Plan's credentialing procedures and must provide Plan with any requested information, records, summaries of records and statistical reports specific to Provider including, but not limited to, utilization profiles pertinent to Provider's provision of medical services, professional qualifications, licensing and credentialing information. Provider will not be permitted to provide services to Plan members until they have been notified by Plan that their Credentialing Process is complete and has been approved. Provider will execute any releases requested by Plan to permit credentialing, re-credentialing, discipline, utilization management, and quality assessment and improvement determinations to be made with respect to Provider. Provider must provide such information for all location(s) and/or individual Provider(s) containing the information set forth in **Exhibit C** of this document, which is attached hereto and incorporated herein by reference. Provider will cooperate and assist with site visits required for regulatory, quality assessment or credentialing purposes.

**(b)** Provider agrees to be bound by and shall fully comply with all Applicable Requirements. Provider shall review the Provider Manual including Plan's Quality Management Programs prior to or promptly following the execution of this Agreement. Provider shall fully comply and cooperate with Plan's Provider Manual requirements including the Quality Management Programs and with any subsequent changes thereto.

**(c)** Prior to execution of this Agreement and thirty (30) days prior to implementing any change, Provider must provide Plan with the information described in **Exhibit C**, including a list of Providers licensed and/or credentialed employees, Provider sites, addresses and operating hours. Provider will maintain a current list of its Providers who are eligible to provide medical services hereunder. Provider shall provide an updated list specifying any changes of Providers to Plan monthly.

**(d)** The Parties acknowledge and agree that Plan or another contracting health plan committee that reviews the quality of medical services rendered to Members will act in the capacity of a "peer review committee" for purposes of applicable law. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence and Health and Safety Codes will apply to any such committee when performing the function described herein.

**(e)** Provider acknowledges that Plan is accredited. Provider's performance under this Agreement must comply with applicable Plan and Accrediting Agency standards. Provider certifies that personnel who are to provide

services to Plan Members maintain appropriate skills, competency, and continuing education commensurate with their current job descriptions. Upon request, Provider will provide Plan with documentation evidencing that the aforementioned standards have been met. Further, Provider agrees to cooperate with and/or participate in any Accrediting Agency review or survey as requested by the Plan and/or Accrediting Agency.

**(f)** Under Plan's direction, Provider agrees to cooperate in the resolution of all Member medical disputes in accordance with the procedures of, and within the timeframes designated by Plan in its Provider Manual.

**(g)** Provider acknowledges that Plan has independent obligations with respect to quality management under the Knox-Keene Act. Plan shall be responsible for developing and operating a quality assurance and improvement program in connection with Covered Services.

**(h)** Provider shall fully comply with Plan's Quality Management Programs and with any changes thereto. Upon request, Provider agrees to furnish Plan with Provider's performance data for quality improvement activities including compiling and comparing the performance data for display to our Members in order for Plan to meet regulatory or accreditation requirements. Information requested must be readily available and requested within a reasonable time frame.

**2.10 Reporting Requirements.** Provider agrees to provide and timely submit to Plan all reports as may be required under this Agreement and/or by federal, state, and local standard regulations and accreditation bodies. Provider agrees to support and promote Plan's Quality Improvement Programs to sustain and/or improve quality of care, safety, efficiency, and continuity and coordination of services, including behavioral health services when applicable. Provider agrees to maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety, and efficiency of clinical care, and quality of service. Provider reports must reveal trends or patterns and identified opportunities for improvement that are based on current scientific knowledge, and evidence-based clinical practice guidelines recognized in the industry. Provider reports must be structured to produce statistically valid performance measures for care and services rendered. Provider shall exercise ongoing efforts supported by concrete data or evidence(s) to improve structural and organizational performance measures. Provider agrees to re-evaluate and determine the effectiveness of measures implemented based on significant statistical findings against organizational goals or benchmarks set. Provider agrees to establish collaborative partnerships with the Plan to implement interventions or service needs of the Plan's Members throughout the entire continuum of care to improve and achieve desired health outcomes. The Plan has the duty to conduct UM, QI, and fraud prevention detection activities in accordance with Plan policies, federal, state, and local regulations, unless Plan delegated those duties. Provider shall cooperate with Plan in the conduct and oversight of those functions and provide Plan with information as is reasonably necessary for Plan to perform its functions.

## ARTICLE III

## PLAN OBLIGATIONS

**3.1 Plan Operations.** Plan agrees to conduct the day-to-day administrative operations of a health care service plan for which it is responsible under state and federal law.

**3.2 Compensation.** Plan shall pay Provider for Contracted Services provided to Members as set forth in Article IV of this Agreement at the rates agreed to in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached to and incorporated herein by this reference, less Co-payments, as applicable.

**3.3 Quality and Utilization of Covered Services.** Plan shall monitor the quality and utilization of Covered Services provided to Members in accordance with the policies and procedures of Plan's Quality Improvement Programs and Utilization Review Programs established by Plan. Plan shall monitor and evaluate accessibility of care and address problems that develop. Plan shall review, at least annually, Provider's compliance with standards established by Plan.

**(a) Quality Reviews.** The Parties acknowledge and agree that Plan reviews the quality of medical services rendered to Members and shall act in the capacity of a "peer review committee" for purposes of Applicable Requirements. For purposes of this section, "quality of medical services" includes, without limitation, matters involving utilization management and compliance with requirements, rules or regulations relating to the delivery, cost, quality or appropriateness of medical care provided to Members. Except as otherwise provided by law, the immunities and protections provided to peer review committees under applicable provisions of the California Civil, Evidence, and Health and Safety Codes will apply to any such committee when performing the function described herein.

**(b) Quality Improvement Services.**

i. Plan shall perform quality improvement services.

ii. Plan shall establish a Quality Improvement (QI) Plan and apply criteria and methodologies to review and measure the quality of professional, ancillary and inpatient professional services.

iii. Plan shall conduct, or require a designee to conduct, meetings at least quarterly, pursuant to a set agenda, to review and measure the quality of health care services provided or arranged by Provider or its subcontractors.

iv. Plan shall on a periodic basis, conduct clinical quality improvement evaluations of the care rendered to members, to comply with DMHC requirements, Applicable Requirements and/or Plan policies.

**3.4 Provider Manual(s).** VHP Provider Manual can be located at www.valleyhealthplan.org. Plan shall make available to Provider a Provider Manual(s) which shall include all administrative policies and procedures of Plan. Plan shall provide forty-five (45) business days' prior written notice to Provider of any amendments to the Provider Manual(s). Such amendments shall become effective upon expiration of the forty-five (45)

business day notice period unless Provider determines that such amendment adversely affects a material duty or responsibility of Provider and/or has detrimental economic effect upon Provider and Provider provides Plan with written notice of such determination within forty-five (45) business days of receiving notice of the applicable amendment from Plan. Plan and Provider shall attempt to agree to a written amendment to the Agreement which addresses the adverse effects of the amendment on Provider. If such an agreement cannot be reached by Provider and Plan, the amendment shall not be effective and shall have no force or effect on Provider and Provider shall have a right to terminate the Agreement in accordance with California Health and Safety Code Section 1375.7(b) prior to the implementation of the amendment.

## ARTICLE IV

## COMPENSATION

**4.1 Billing.** Provider shall submit Clean Claims to Plan for all Contracted Services rendered to a Member, within the timeframes established in **Exhibits A-1, A-2, A-3, A-4, A-5 and A-6,** attached to and incorporated herein by this reference.

**4.2 Payment.**

**(a)** Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6** of this Agreement minus the Member's Co-payment. Plan will pay Provider for Covered Services rendered to Member within forty-five (45) business days of receipt of Provider's undisputed, Clean Claim. A Clean Claim must include the information required by of this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

**(b)** Provider will be responsible for the collection of Coordination of Benefit payments for Members, and Plan will pay in accordance with Article 5 of this Agreement.

**(c)** Balance Billing. Except for applicable Co-payment, Provider shall not invoice or balance bill Plan's Member for the difference between Provider's billed charges and the reimbursement paid by Plan for any Covered Service rendered.

**4.3 Denying, Adjusting or Contesting a Claim and Reimbursement for the Overpayment of Clean Claims.**

**(a)** Denying, Adjusting or Contesting a Clean Claim. For each claim that is either denied, adjusted or contested, Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes as specified in §1300.71(g) and (h) of the Department of Managed Health Care ("DMHC") Regulations.

**(b)** Time for Contesting, Adjusting or Denying Claims. Plan may contest or deny a claim, or portion thereof, by notifying Provider in writing, that the claim is

contested or denied, within forty-five (45) working days after the date of receipt of the claim by Plan.

**(c) Reimbursement for Overpayment of Clean Claim.** If Plan determines it has overpaid a Clean Claim, it shall notify Provider in writing through a separate Notice clearly identifying the claim, the name of the patient, date of service and including a clear explanation of the basis upon which Plan believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

i. If Provider contests Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider, within thirty (30) working days of the receipt of the notice of overpayment of a Clean Claim, shall send written Notice to Plan to state the basis upon which Provider believes that the Clean Claim was not overpaid. Plan shall receive and process the contested notice of overpayment of a Clean Claim as a dispute pursuant to this Agreement and applicable DMHC Regulations.

ii. If Provider does not contest Plan's notice of reimbursement of the overpayment of a Clean Claim, Provider shall reimburse Plan within thirty (30) working days of the receipt by Provider of the notice of overpayment of a Clean Claim.

iii. Plan may only offset an uncontested notice of reimbursement of the overpayment of a Clean Claim against Provider's current Clean Claim submission when: (i) Provider fails to reimburse Plan within the timeframe specified above; and (ii) this Agreement specifically authorizes Plan to offset an uncontested notice of overpayment of a Clean Claim from Provider's current Clean Claim submissions. If an overpayment of a Clean Claim(s) is offset against Provider's current Clean Claim(s) pursuant to this section, Plan shall provide a detailed written explanation to Provider, identifying the specific overpayment or overpayments that have been offset against the specific current Clean Claim(s).

**4.4 Non-Covered Services.** If Provider renders services to Members that are not Covered Services per the Member's EOC in effect at the time service is rendered, Provider may seek payment for such service(s) from the Member as allowed by law. Provider shall refrain from billing and/or collecting from a Member any charges in connection with services provided to the Member that are Non-Covered Services, unless Provider has first obtained a written acknowledgment of financial responsibility from the Member or the Member's legal representative. Such acknowledgement must be obtained in advance of rendering the Non-Covered Services.

## ARTICLE V

## COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

**5.1 Coordination of Benefits.** Certain claims for Contracted Services rendered to Members are claims for which another payor may be primarily or secondarily responsible

under Coordination of Benefit rules. For purposes of this Agreement, "Coordination of Benefits" or "COB" shall mean a method of sequentially assigning responsibility for the payment of Covered Services rendered to a Member among two (2) or more insurers or payors (e.g. Medicare). Plan and Provider shall cooperate to exchange information relating to Coordination of Benefits with regard to any Member for whom Provider has provided Contracted Services. In addition, Provider shall comply with the following requirements in such situations:

**(a) Plan as Primary Payor.** When Plan is the primary payor, Provider shall accept the amount set forth in this Agreement as payment in full for Contracted Services from Plan. However, Provider shall have the right to collect Co-payments and payments for Non-Covered Services from Members and shall have the right to pursue and retain COB revenue from any secondary payor.

**(b) Plan as Secondary Payor.** When Plan is the secondary payor, Provider shall promptly bill and take reasonable steps to collect payment from the primary payor. Plan shall pay Provider the difference between the amount collected from the primary payor and one hundred percent (100%) of the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, of this Agreement.

**5.2 Compliance with Law.** Notwithstanding any other provisions of this Agreement to the contrary, Provider shall, in all instances, collect from a Member, or from those who are financially responsible for such Member, the entire amount of such Member's Co-payment obligation(s) that are required to be collected in accordance with applicable state and federal laws.

**5.3 Collection of Charges from Third-Parties.** If a Member is entitled to payment from a third-party, Plan shall have no objection to Provider engaging in collection of any claims or demands against such third parties for amounts due for Contracted Services, so long as Provider gives Plan prior written notice of its intent to pursue such collection.

**5.4 COB Obligations of Plan.** Plan shall provide COB information to Provider by supplying available data from the Member at the point of enrollment and supplying such data to Provider when available.

**5.5 Assignment of Third-Party Liability Payments.** If Provider collects any third-party liability payments for Contracted Services provided to a Member and has also previously received payments for such Contracted Services from Plan, Provider shall reimburse Plan the amount paid by Plan for said Member.

## ARTICLE VI

## COMPLIANCE WITH DMHC REGULATORY REQUIREMENTS

**6.1 Records Maintenance.** Provider shall, with respect to services provided under this Agreement, cooperate fully with Plan by, among other things, maintaining and making available to Plan and the Director of the DMHC, all records necessary: (i) to ensure

continuity and quality of care for Members; (ii) to fulfill Plan's obligations under the Knox-Keene Act and implementing regulations; and (iii) for Plan to verify Provider's compliance with any of the terms and conditions of this Agreement. Provider shall maintain medical records, including without limitation their confidentiality as required under federal HIPAA law, and the Confidentiality of Medical Information Act, California Civil Code Section 56 *et seq.*, in a manner consistent with the requirements of Applicable Requirements. Provider shall not allow unauthorized persons to view confidential records and shall have safeguards to prevent unauthorized viewing of confidential files. Provider agrees to maintain all books and records in a form in accordance with the general standards applicable to such books and records at Provider's place of business or at such other mutually agreeable location in California. Provider agrees to maintain all books and records provided for in this Section 6.1 for ten (10) years, or as may be otherwise required under Applicable Requirements, or CMS requirements, and such obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

**6.2 Access to Records; Inspection.** Plan shall have access, at all reasonable times upon reasonable demand, to the books, records and papers of Provider, (including but not limited to patient medical records,) relating to Covered Services provided to Members under this Agreement, to the cost thereof and to payments received by Provider from Members. Provider agrees to permit the DHCS, DMHC, the California Department of Public Health, or their authorized representatives, to conduct a site evaluation of Provider facilities and/or to inspect, examine or copy, at all reasonable times, upon reasonable demand, all such books and records described in this Section 6.2. Provider agrees to cooperate with all regulatory and governmental agencies in all aspects of the inspection process.

**6.3 Knox-Keene Act.** Provider understands and acknowledges that Plan is subject to the provisions of the Knox-Keene Act (Chapter 2.2 of Division 2 of the Health and Safety Code) and implementing regulations (Chapter 1 of Division 1 of Title 28 of the California Code of Regulations) ("Regulations"). Any provision required to be in this Agreement by either of the above shall bind Plan whether or not provided in this Agreement. Provider shall comply with any and all Applicable Requirements imposed upon Plan and Provider under the Knox-Keene Act and Regulations.

**6.4 No Surcharges.** In no event, including but not limited to nonpayment by Provider or Plan, Provider's or Plan's insolvency or breach of this Agreement, shall any Member be liable for any sums owed to Provider by Plan, and Provider shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any Surcharge upon, a Member or other person acting on a Member's behalf. This provision shall not prohibit collection of Co-payments or COB revenues from secondary carriers by which the Member is covered. In the event Plan receives notice that a Member has been surcharged by Provider, Plan shall notify Provider in writing within ten (10) working days of the receipt of said notice and Plan shall take appropriate action. In the event Plan and Provider mutually determine, in writing, that Member has been Surcharged by Provider, Plan may refund the Surcharge to the Member and deduct the amount of such Surcharge from compensation due Provider pursuant to this Agreement. In the event there is a dispute regarding whether Provider has Surcharged a Member, Provider and Plan agree to meet to discuss said dispute no later than ten (10) calendar days following the receipt of a written request by the

other party. Should the Parties fail to mutually resolve said dispute, said dispute shall be submitted by the Parties to dispute resolution as provided in Section 10 of this Agreement within ten (10) calendar days following the aforedescribed meeting of the Parties. The obligations set forth in this Section 6.4 shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of a Member, and the provisions of this Section 6.4 shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Member or persons acting on behalf of either of them.

**6.5 Language Assistance Program.** Plan shall maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Members have appropriate access to language assistance while accessing any health care service, pursuant to California Health and Safety Code §§ 1367(e)(3), 1367.04 and 1367.07 and California Insurance Code §§ 10133.8 and 10133.9. Provider shall make best efforts to cooperate and comply, with Plan's Language Assistance Program, which is outlined in **Exhibit F.**

**6.6 Further Amendments.** Plan and Provider acknowledge that the DMHC may require that the parties further amend this Agreement to conform to the Knox-Keene Act. If the DMHC requires such further amendments, Plan shall notify Provider in writing of such amendments. Provider shall then have sixty (60) days from the date of Plan's notice to reject the proposed amendments by written notice to Plan. If Plan does not receive such written notice Plan has the option to terminate this Agreement upon sixty (60) days written notice.

**6.7 Subcontractors.** Without limiting any provision in the Agreement regarding assignment and delegation, Provider agrees to maintain and make available for inspection by Plan and the DMHC, written copies of all contracts between Provider and any of its subcontractors.

**6.8 Filing a Complaint.** Members of the Plan are entitled to the following information regarding the Department of Managed Health Care:

**(a)** "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **408-885-4760 or 1-888-421-8444** (toll-free) and use your health plan's Grievance process before contacting the Department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website

www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

**6.9 Compliance.**

**(a)** Provider certifies that none of its employees or agents providing service under this Agreement (hereafter "Practitioners") have been convicted of a criminal offense related to health care, nor are any listed by any federal or state agency as debarred, excluded or otherwise ineligible for participation in Medicare, Medi-Cal, or any other federal or state funded health care program. Provider certifies that it has performed an appropriate screening of Providers prior to making this certification, that it will screen all new Providers, and that it will monitor the status of existing Providers. Provider certifies that they and their Practitioners possess all licenses required and those said licenses are in good standing. Provider certifies that in providing these Contracted Services, they and their Practitioners are operating within any and all limitations or restrictions of these licenses. Provider further certifies that none of its directors, managing employees, and owners of five percent interest, or more, in Provider's business have been convicted of any health care related offenses nor excluded from Medicare, Medi-Cal, or any other federal or state funded health care program.

**(b)** Provider agrees to notify the Plan immediately should Provider or Practitioner be investigated, charged, or convicted of a health care related offense. During the pendency of any such proceedings, Provider or a Practitioner may, at the request of the Plan, be removed from any responsibility for, or involvement in, the provision of services under this Agreement. It is the Provider's obligation to keep the Plan fully informed about the status of such proceedings and to consult with the County prior to taking any action which will directly impact the County. This Agreement may be terminated immediately by Plan upon the actual exclusion, debarment, loss of licensure, or conviction of Provider or of a Provider of a health care offense.

**(c)** Provider will indemnify, defend, and hold harmless Plan for any loss or damage resulting from the conviction, debarment, or exclusion of Provider, or Practitioners, or subcontractors.

**6.10 Directory Requirements.** Provider agrees to comply with Health and Safety Code Section 1367.27 et seq. Provider agrees to coordinate with VHP to verify and maintain all directory requirements in compliance with HSC § 1367.27. Said requirements shall include; (1) participation in a bi-annual audit to verify the Provider contact information and participating Provider profile(s) information is accurately represented in the VHP Provider Directory, (2) provide an affirmative response to the Provider Directory audit confirming the information represented is current and accurate, and (3) if information is inaccurate, provide VHP with current and accurate information. The Provider Directory audit process shall include a Provider notification informing Providers they have thirty (30) business days to provide VHP with their affirmative response. If a response is not received within 30 business days, VHP shall issue a final notice providing an additional ten (10) business days to receive Providers affirmative response. Provider acknowledges that non-responsive Providers are removed from the VHP Provider Directory until the directory

information is confirmed. Additionally, Provider agrees to timely notify VHP when either of the following occurs:

**(a)** Provider agrees to inform the Plan within five (5) business days when the Provider is not accepting new patients.

**(b)** Provider agrees to inform the Plan within five (5) business days when the Provider changes from not accepting new patients to accepting new patients.

## ARTICLE VII

## MEDICAL RECORDS, HIPAA AND THE HITECH ACT

**7.1 Medical Records.** Provider shall maintain for Members a single standard medical record, containing such accurate, descriptive and timely information and preserved for such time period(s) as required by the rules and regulations of the California Department of Public Health, and The Joint Commission or any other comparable accreditation organization. Unless otherwise specifically agreed by Provider, it is the understanding and agreement of the parties that the records described herein are deemed to meet all record keeping requirements required of Plan pursuant to Applicable Requirements.

**7.2 Member Access to Medical Records.** Provider shall ensure that Members have access to their medical records in accordance with the Applicable Requirements of state and federal laws and regulations.

**7.3 Right to Inspect Medical Records.** The medical records described in Section 7.1 above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with Applicable Requirements and general Provider policies. Plan, regulatory agencies with jurisdiction over Plan's business, and their designated representatives shall have the right to inspect, review, and make copies of such records upon request to facilitate Plan's obligation to conduct quality improvement, utilization monitoring, and peer review activities as required by the Provider Manual and Applicable Requirements.

**7.4 Confidentiality.** Provider and Plan agree to maintain the confidentiality of information contained in the medical records of Members in accordance with Applicable Requirements. Medical records may be disseminated to authorized Plan Physicians or Plan representatives or Review Committees, to Plan itself, or to an appropriate Plan peer review, Quality Improvement or Utilization Management Committee or subcommittee identified by Plan, or as otherwise required by law. Provider shall require that all Providers to comply with Applicable Requirements regarding confidentiality and disclosure of mental health records, medical records and other health and Member information.

**(a)** Provider acknowledges and agrees that all information received from Plan in connection with patients referred to Provider by Plan under this Agreement, including, without limitation, the compensation provisions, Member lists, marketing materials, Quality Management Programs, Provider Manual, telephone numbers, manuals, records, policies and agreements, are proprietary information and trade secrets of Plan. Provider and the officers, employees and agents of Provider will

keep such information confidential, except to the extent that confidentiality may not be maintained as to any such information under Applicable Requirements. Provider will obtain written consent of Plan prior to dissemination of any marketing materials or materials promoting health and wellness activities or other information that refers to Plan.

**7.5 Plan and Governmental Agency Access to Records.** Provider shall cooperate and assist with Plan, agencies of the state and federal government and their designees in maintaining and providing medical, financial, administrative and other records of Members as shall be requested by Plan, or such agencies. Plan and such agencies shall have access at reasonable times upon demand to the books, records and papers of Provider and their Practitioners relating to services provided to Members, the quality, appropriateness, timeliness, cost thereof, and any payments received by Provider or their Practitioners for Covered Services provided to Members.

**7.6 Compliance with HIPAA and the HITECH Act.** The parties hereto agree to comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1966 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), including, but not limited to, the HIPAA Privacy and Security Rules. The parties further agree, if required by HIPAA, or any other Applicable Requirements, to enter into a Business Associate Agreement which complies with the requirements set forth in 45 C.F.R. Sections 164.301, 164.312,164.316, 164.504(e)(2)(i)-(iii) and 42 U.S.C. Sections 17931 and 17935(a).

**7.7 Electronic Protected Health Information.**

**(a) Safeguards.** Provider shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information (as defined at 45 C.F.R. 160.103) that it creates, receives, maintains, or transmits on behalf of Plan as required by Subpart 'C' of Part 164 of Title 45 of the Code of Federal Regulations.

**(b) Agent and Subcontractors.** Provider shall require any agent, including a subcontractor to whom Provider provides Electronic Protected Health Information, to implement reasonable and appropriate safeguards to protect such Electronic Protected Health Information.

**(c) Reporting of Unauthorized Use or Disclosure.** Provider shall report to Plan any Security Incident (as defined at 45 C.F.R. 160.103) of which Provider becomes aware.

**(d) Availability of Records upon Termination.** The obligations contained in this Article XIII shall survive termination of this Agreement.

## ARTICLE VIII

## INSURANCE AND INDEMNITY

**8.1 Insurance and Indemnity Requirements**. Provider will comply with the insurance and indemnity requirements set forth in **Exhibit E**, which is attached to and incorporated herein by this reference. It is understood and agreed that County is self-insured pursuant to the authority granted in California Government Code section 990.4, and that such self-insurance satisfies Plan's and the County's obligations hereunder.

**8.2 Insurance Terms.**

**(a)** Each of the policies required by this Agreement shall provide that, prior to the cancellation, change or amendment thereof; the contracting party shall receive a minimum of thirty (30) days' prior written notice.

**(b)** If the malpractice insurance coverage provided is "claims made," and either party changes carriers or terminates coverage on or after termination of this Agreement, that party shall purchase a policy of "prior acts" or "tail" coverage for a minimum term of five (5) years from the termination of the policy in effect immediately prior to such tail policy. Such "tail" coverage shall have the same policy limits as the primary malpractice insurance coverage required under this Agreement.

**(c)** Either party shall provide the other with certificates evidencing such insurance coverages upon the execution of this Agreement or from time to time thereafter as may be requested.

## ARTICLE IX

## TERM AND TERMINATION

**9.1 Term of Agreement.** The term of this Agreement shall commence on the Effective Date and continue for a period of one (1) year ("Initial Term") and shall automatically renew thereafter for up to four (4) additional consecutive one-year terms, unless earlier terminated as provided herein. This Agreement shall supersede any Letters of Agreement and/or Payment Agreements that were executed by the Parties prior to the Effective Date of this Agreement. For services rendered on or after the Effective Date of this Agreement, this Agreement's terms shall control.

**9.2 Termination without Cause.** This agreement may be terminated by the Plan without cause by giving sixty (60) days prior written notice to Provider.

**9.3 Termination of Agreement with Cause.** Either Plan or Provider may terminate this Agreement for cause as set forth in this Section 9.3, subject to the notice requirement and cure period set forth herein.

**(a) Cause for Termination of Agreement by Provider.** The following shall constitute cause for termination of this Agreement by Provider:

i. **Failure to Maintain Insurance.** Plan fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Plan.** A petition is filed to declare Plan bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Plan's assets, and the insolvency is not cured within thirty (30) days after said event;

iii. **Failure to Maintain Government Approvals.** Plan is unable to secure and maintain in effect any of the necessary governmental licenses required for the performance of its duties under this Agreement, including, but not limited to, its contract with CMS; and

iv. **Breach of Material Term and Failure to Cure.** Plan's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

**(b) Cause for Termination of Agreement by Plan.** The following shall constitute cause for termination of this Agreement by Plan:

i. **Failure to Maintain Insurance.** Provider fails to maintain adequate professional and general liability coverage required under this Agreement or to replace coverage that is cancelled or otherwise terminated;

ii. **Insolvency of Provider.** A petition is filed to declare Provider bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of Provider's assets;

iii. **Failure to Provide Quality Services.** Provider's failure to provide Contracted Services in accordance with the standards set forth in this Agreement, the standards of The Joint Commission or any other comparable accreditation organization and Plan's Quality Improvement and Utilization Management Programs;

iv. **Breach of Material Term and Failure to Cure.** Provider's breach of any material term, covenant or condition of this Agreement, and subsequent failure to cure such breach as prescribed in Section 9.3 (c).

**(c) Notice of Termination and Effective Date of Termination.** The party asserting cause for termination of this Agreement (the "Terminating Party") shall provide written notice of termination to the other party. The notice of termination shall specify the breach or deficiency underlying the cause for termination. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the Terminating Party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the Terminating Party within the Cure Period, or if the breach or deficiency is not curable, this Agreement shall terminate upon the expiration of the Cure Period. Satisfaction of a cure shall not be unreasonably withheld.

**9.4 Termination of Provider.** Notwithstanding anything to the contrary in this Agreement, Plan shall have the right to sanction Provider or terminate this Agreement upon

ten (10) days' prior written notice in the event that Plan, or any federal or State agency reasonably believes that Provider is providing inadequate quality of care and/or Provider fails to comply with Plan's statutory obligations under the Knox-Keene Act or regulations whether the Plan directly manages and/or delegates responsibilities consistent with the Knox-Keene Act or Medicare and Medi-Cal laws and regulations. During said ten (10) day period, Provider shall cease providing Covered Services to Members.

**9.5 Continuing Care Obligations of Provider.**

**(a) General Obligations.** In the event of termination of this Agreement for any cause or reason, Provider shall continue to provide Contracted Services to Members as required by law, including any Members who become eligible during the termination notice period, for a "Continuing Care Period", Plan shall pay Provider for Contracted Services provided by Provider during the Continuing Care Period at the rates set forth in **Exhibit A-1, A-2, A-3, A-4, A-5 and A-6,** Compensation Schedules, attached hereto.

**(b) Obligations if Plan Ceases Operating or Agreement is terminated for Nonpayment**.

i. Notwithstanding any provisions of this Agreement to the contrary, Provider agrees that in the event Plan ceases operations for any reason, including insolvency, Provider shall continue to provide services as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services provided by Provider after Plan ceases operations.

ii. In the event Plan ceases operations or Provider terminates this Agreement on the basis of Plan's failure to make timely payments in accordance with the terms of this Agreement, Provider shall continue to provide Services to those Enrollees who are under the care at the time Plan ceases operations or Provider terminates this Agreement until such Members are reassigned by Provider, as set forth in Section 9.5 (a) above and shall not bill, charge, collect or receive any form of payment from any Member for Covered Services.

**(c) Survival of Provisions Following Termination.** Provider agrees that the provisions of this Section 9.5 (c) and the obligations of Provider shall survive termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members.

## ARTICLE X

## DISPUTE RESOLUTION

**10.1 Member Grievances and Appeals.** Provider shall review and process all complaints and grievances of Members through Grievance and Appeals Procedures established by Plan. Provider agrees to cooperate fully with Plan in the investigation and resolution of any such Member complaint.

**10.2 Dispute Resolution.** Controversies between Plan and Provider shall be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Provider shall submit disputes to Plan in writing at the address set forth in the Provider Manual(s) and as set forth in this Agreement for resolution pursuant to Plan's dispute resolution procedures described in the Provider Manual(s) to the extent they are not in conflict with the terms and conditions contained herein this Agreement. In the event of any inconsistency between this Agreement and the Provider Manual(s), the terms and conditions of this Agreement shall prevail.

## ARTICLE XI

## GENERAL PROVISIONS

**11.1 Compliance with Applicable Law.** Provider and Plan shall comply with all Applicable Requirements, including any amendments or updates thereto. Any provision required to be in this Agreement according to the Applicable Requirements shall bind Plan and Provider whether or not specifically set forth in this Agreement.

**11.2 Incorporation of Exhibits. Exhibits A-1, A-2, A-3, A-4, A-5, A-6, B (Reserved), C, D, E, F, G, and H** are attached hereto and are hereby expressly incorporated herein by this reference.

**11.3 Waiver.** The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

**11.4 Assignment.** This Agreement shall not be assigned, delegated, or transferred by either Party without the prior written consent of the other Party, except that Plan may assign the Agreement to a parent or affiliate of the Plan that assumes the Plan's obligations as a licensed health care service plan. If required by law, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state or federal agencies.

**11.5 Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

**11.6 Amendment.** Except as set forth below, this Agreement may be modified only upon the mutual written consent of both Parties. Notwithstanding the foregoing, if Plan is required to amend this Agreement to comply with any state or federal law, regulation or instruction from any regulatory agency having jurisdiction over Plan's activities, Plan shall provide at least forty-five (45) days' prior written notice to Provider of such amendment. If Provider fails to accept such amendment within thirty (30) Plan has the option to terminate the Agreement immediately.

**11.7 Governing Law.** This Agreement shall be governed in all respects by the laws of the State of California, and any applicable federal laws.

**11.8 Interruption by Disasters.** In the event the operations of Provider's facilities or any substantial portion thereof, are interrupted by war, fire, and other elements, insurrection, terrorism, riots, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond the control of Provider, the provisions of this Agreement (or such portions hereof as Provider is hereby rendered incapable of performing) may be suspended for the duration of such interruption. Such suspension shall be determined by the mutual written agreement of the Parties and shall include an identification of the necessary adjustments to any provision of this Agreement; provided, however, to the extent that services are provided by Provider, Plan shall compensate Provider for said services in accordance with Article IV herein. Should a substantial part of the services which Provider has agreed to provide hereunder be interrupted pursuant to such event(s) for a period in excess of thirty (30) days, Plan or Provider shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the other party.

**11.9 Headings.** The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

**11.10 Solicitation of Plan Members, Subscribers or Subscriber Groups.** Provider shall not engage in the practice of solicitation of Members, subscribers or subscriber groups without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee of Provider or their respective assignees or successors during the term of this Agreement or during the one (1) year immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members, subscribers or subscriber groups to disenroll from Plan or discontinue their relationship with Plan. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

**11.11 Confidential and Proprietary Information.** Both Parties agree to maintain confidential, (the "Confidential Information") as specified in the Section 11.11 and Section 11.12: (i) eligibility lists and any other information containing the names, addresses and telephone numbers of Members; (ii) the financial arrangements between either Party and any Provider; (iii) any other information compiled or created by either Party that is proprietary to either Party, and that either Party identifies as proprietary in writing. Neither Party shall disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Either Party may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of the other Party upon the effective date of termination of this Agreement, each Party shall promptly return to the other Party the Confidential Information in its possession, upon the other Party's notice. Both Parties shall maintain the confidentiality of the rates and special terms of this Agreement that are unique to the other Party. The obligations contained in this Section 11.11 shall survive the termination of this Agreement.

**11.12 California Public Records Act.** The County is a public agency subject to the disclosure requirements of the California Public Records Act ("CPRA"). If Provider's proprietary information is contained in documents submitted to Plan, and Provider claims

that such information falls within one or more CPRA exemptions, Provider must clearly mark such information "CONFIDENTIAL AND PROPRIETARY," and identify the specific lines containing the information. In the event of a request for such information, the Plan will make best efforts to provide notice to Provider prior to such disclosure. If Provider contends that any documents are exempt from the CPRA and wishes to prevent disclosure, it is required to obtain a protective order, injunctive relief or other appropriate remedy from a court of law in Santa Clara County before the Plan's deadline for responding to the CPRA request. If Provider fails to obtain such remedy within Plan's deadline for responding to the CPRA request, Plan may disclose the requested information.

**11.13 Notices.** All notices, requests, demands and other communications hereunder shall be in writing (hereafter a "Notice"). A Notice shall be deemed given when delivered (i) delivered in person, or (ii) four (4) days after being mailed by certified or registered mail, postage prepaid, return receipt requested, or (iii) one (1) day after being sent by overnight courier such as Federal Express, to the Parties, their successors in interest or their assignees at the following addresses, or at such other addresses as the Parties may designate by written Notice in the manner aforesaid. In addition to the approved delivery methods, a copy of the Notice shall also be sent via secure email or electronic facsimile as follows:

| **Provider:** | **Plan:** |
|---|---|
| Provider Contact Name, Title<br>Provider_Contract_Name<br>«Address»<br>«City», «State» «Zip»<br>Phone_#<br>Email | Bruce Butler, Chief Executive Officer<br>Valley Health Plan<br>2480 North First Street, Suite 160<br>San Jose, CA 95131<br>(408) 885-5780<br><br>And CC:<br>Valley Health Plan<br>Provider Contracts Administration<br>2480 North First Street, Suite 160<br>San Jose, CA 95131<br>ProviderContracts@vhp.sccgov.org<br>Fax: (408) 954-1027 |

**11.14 Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between a Provider and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Provider or Plan regarding coverage of treatment that has been recommended or rendered. Moreover, Provider and Plan agree not to penalize nor sanction any Provider in any way for engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

**11.15 Severability.** If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect.

**11.16 Attorneys' Fees.** Should either party institute any action or procedure to enforce this Agreement or any provision hereof, or for damages by reason of any alleged breach of this Agreement or of any provision hereof, or for a declaration of rights hereunder (including, without limitation, arbitration), each party shall pay its own costs and expenses, including, without limitation, its own attorneys' fees, incurred in connection with such action or proceeding.

**11.17 No Third-Party Beneficiaries.** This Agreement shall not create any rights in any third-parties who have not entered into this Agreement, nor shall this Agreement entitle any such third-party to enforce any rights or obligations that may be possessed by such third-party.

**11.18 Integration of Entire Agreement.** This Agreement contains all the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

**11.19 County No Smoking Policy.** Provider and its employees, agents and subcontractors, shall comply with the County's No Smoking Policy, as set forth in the Board of Supervisors Policy Manual section 3.47 (as amended from time to time), which prohibits smoking: (i) at the Santa Clara Valley Medical Center campus and all County-owned and operated health facilities, (ii) within 30 feet surrounding County-owned buildings and leased buildings where the County is the sole occupant, and (iii) in all County vehicles.

**11.20 Food and Beverage Standards.** Except in the event of an emergency or medical necessity, the following nutritional standards shall apply to any foods and/or beverages purchased by Provider with County funds for County-sponsored meetings or events:

**(a)** If food is to be provided, healthier food options shall be offered. "Healthier food options" include (i) fruits, vegetables, whole grains, and low fat and low-calorie foods; (ii) minimally processed foods without added sugar and with low sodium; (iii) foods prepared using healthy cooking techniques; and (iv) foods with less than 0.5 grams of trans fat per serving. Whenever possible, Provider shall (i) offer seasonal and local produce; (ii) serve fruit instead of sugary, high calorie desserts; (iii) attempt to accommodate special, dietary and cultural needs; and (iv) post nutritional information and/or a list of ingredients for items served. If meals are to be provided, a vegetarian option shall be provided, and the Contractor should consider providing a vegan option. If pre-packaged snack foods are provided, the items shall contain: (i) no more than 35% of calories from fat, unless the snack food items consist solely of nuts or seeds; (ii) no more than 10% of calories from saturated fat; (iii) zero trans-fat; (iv) no more than 35% of total weight from sugar and

caloric sweeteners, except for fruits and vegetables with no added sweeteners or fats; and (v) no more than 360 mg of sodium per serving.

**(b)** If beverages are to be provided, beverages that meet the County's nutritional criteria are (i) water with no caloric sweeteners; (ii) unsweetened coffee or tea, provided that sugar and sugar substitutes may be provided as condiments; (iii) unsweetened, unflavored, reduced fat (either nonfat or 1% low fat) dairy milk; (iv) plant-derived milk (e.g., soy milk, rice milk, and almond milk) with no more than 130 calories per 8 ounce serving; (v) 100% fruit or vegetable juice (limited to a maximum of 8 ounces per container); and (vi) other low-calorie beverages (including tea and/or diet soda) that do not exceed 40 calories per 8 ounce serving. Sugar-sweetened beverages shall not be provided.

**11.21 Assignment of Clayton Act, Cartwright Act Claims.** Provider hereby assigns to the Plan all rights, title, and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, materials, or services by the Provider for sale to the Plan pursuant to this Agreement.

**11.22 Compliance with All Laws, Including Nondiscrimination, Equal Opportunity, and Wage Theft Prevention.**

**(a)** Compliance with All Laws. Provider shall comply with all applicable Federal, State, and local laws, regulations, rules, and policies (collectively, "Laws"), including but not limited to the non-discrimination, equal opportunity, and wage and hour Laws referenced in the paragraphs below.

**(b)** Compliance with Non-Discrimination and Equal Opportunity Laws: Provider shall comply with all applicable Laws concerning nondiscrimination and equal opportunity in employment and contracting, including but not limited to the following: Santa Clara County's policies for Providers on nondiscrimination and equal opportunity; Title VII of the Civil Rights Act of 1964 as amended; Americans with Disabilities Act of 1990; the Age Discrimination in Employment Act of 1967; the Rehabilitation Act of 1973 (Sections 503 and 504); the Equal Pay Act of 1963; California Fair Employment and Housing Act (Gov. Code § 12900 et seq.); California Labor Code sections 1101, 1102, and 1197.5; and the Genetic Information Nondiscrimination Act of 2008. In addition to the foregoing, Provider shall not discriminate against any subcontractor, employee, or applicant for employment because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political belief, organizational affiliation, or marital status in the recruitment, selection for training (including but not limited to apprenticeship), hiring, employment, assignment, promotion, layoff, rates of pay or other forms of compensation. Nor shall Provider discriminate in the provision of services provided under this contract because of age, race, color, national origin, ancestry, religion, sex, gender identity, gender expression, sexual orientation, mental disability, physical disability, medical condition, political beliefs, organizational affiliations, or marital status.

**(c)** Compliance with Wage and Hour Laws: Provider shall comply with all applicable wage and hour Laws, which may include but are not limited to, the Federal Fair Labor Standards Act, the California Labor Code, and, if applicable, any local minimum wage, prevailing wage, or living wage Laws.

**(d)** Definitions: For purposes of this Subsection 11.22, the following definitions shall apply. A "Final Judgment" shall mean a judgment, decision, determination, or order (i) which is issued by a court of law, an investigatory government agency authorized by law to enforce an applicable Law, an arbiter, or arbitration panel and (ii) for which all appeals have been exhausted or the time period to appeal has expired. For pay equity Laws, relevant investigatory government agencies include the federal Equal Employment Opportunity Commission, the California Division of Labor Standards Enforcement, and the California Department of Fair Employment and Housing. Violation of a pay equity Law shall mean unlawful discrimination in compensation on the basis of an individual's sex, gender, gender identity, gender expression, sexual orientation, race, color, ethnicity, or national origin under Title VII of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, California Fair Employment and Housing Act, or California Labor Code section 1197.5, as applicable. For wage and hour Laws, relevant investigatory government agencies include the federal Department of Labor, the California Division of Labor Standards Enforcement, and the City of San Jose's Office of Equality Assurance.

**(e)** Prior Judgments, Decisions or Orders against Provider: By signing this Agreement, Provider affirms that it has disclosed any final judgments that (i) were issued in the five (5) years prior to executing this Agreement by a court, an investigatory government agency, arbiter, or arbitration panel and (ii) found that Provider violated an applicable wage and hour law or pay equity law. Provider further affirms that it has satisfied and complied with – or has reached Agreement with the County regarding the manner in which it will satisfy – any such final judgments.

**(f)** Violations of Wage and Hour Laws or Pay Equity Laws during Term of Contract: If at any time during the term of this Agreement, Provider receives a Final Judgment rendered against it for violation of an applicable wage and hour Law or pay equity Law, then Provider shall promptly satisfy and comply with any such Final Judgment. Provider shall inform the Office of the County Executive-Office of Countywide Contracting Management (OCCM) of any relevant Final Judgment against it within 30 days of the Final Judgment becoming final or of learning of the Final Judgment, whichever is later. Provider shall also provide any documentary evidence of compliance with the Final Judgment within 5 days of satisfying the Final Judgment. Any notice required by this paragraph shall be addressed to the Office of the County Executive-OCCM at 70 W. Hedding Street, East Wing, 11th Floor, San José, CA 95110. Notice provisions in this paragraph are separate from any other notice provisions in this Agreement and, accordingly, only notice provided to the Office of the County Executive-OCCM satisfies the notice requirements in this paragraph.

**(g)** Access to Records Concerning Compliance with Pay Equity Laws: In addition to and notwithstanding any other provision of this Agreement concerning access to Provider's records, Provider shall permit the County and/or its authorized representatives to audit and review records related to compliance with applicable pay equity Laws. Upon the County's request, Provider shall provide the County with access to any and all facilities and records, including but not limited to financial and employee records that are related to the purpose of this Subsection 11.22, except where prohibited by federal or state laws, regulations or rules. County's access to such records and facilities shall be permitted at any time during Provider's normal business hours upon no less than 10 business days' advance notice.

**(h)** Pay Equity Notification: Provider shall (i) at least once in the first year of this Agreement and annually thereafter, provide each of its employees working in California and each person applying to Provider for a job in California (collectively, "Employees and Job Applicants") with an electronic or paper copy of all applicable pay equity Laws or (ii) throughout the term of this Agreement, continuously post an electronic copy of all applicable pay equity Laws in conspicuous places accessible to all of Provider's Employees and Job Applicants.

**(i)** Material Breach: Failure to comply with any part of this Subsection 11.22 shall constitute a material breach of this Agreement. In the event of such a breach, the County may, in its discretion, exercise any or all remedies available under this Agreement and at law. County may, among other things, take any or all of the following actions:

i. Suspend or terminate any or all parts of this Agreement.

ii. Withhold payment to Provider until full satisfaction of a Final Judgment concerning violation of an applicable wage and hour Law or pay equity Law.

iii. Offer Provider an opportunity to cure the breach.

**(j)** Subcontractors: Provider shall impose all of the requirements set forth in this Subsection 11.22 on any subcontractors permitted to perform work under this Agreement. This includes ensuring that any subcontractor receiving a Final Judgment for violation of an applicable Law promptly satisfies and complies with such Final Judgment.

**11.23 Contracting Principles**. All entities that contract with the County to provide services where the contract value is $100,000 or more per budget unit per fiscal year and/or as otherwise directed by the Board of Supervisors, shall be fiscally responsible entities and shall treat their employees fairly. To ensure compliance with these contracting principles, all Providers shall: (i) comply with all applicable federal, state and local rules, regulations and laws; (ii) maintain timekeeping and expense records, and make those records available upon request; (iii) provide to the County unaudited balance sheet and financial information; (iv) upon County's request, provide County reasonable access, through representatives of Provider, to facilities, timekeeping and expense records that are related to the purpose of the Agreement, except where prohibited by federal or state laws, regulations or rules.

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**11.24 Electronic Signature**. Unless otherwise prohibited by law or County policy, the parties agree that an electronic copy of a signed contract, or an electronically signed contract, has the same force and legal effect as a contract executed with an original ink signature. The term "electronic copy of a signed contract" refers to a transmission by facsimile, electronic mail, or other electronic means of a copy of an original signed contract in a portable document format. The term "electronically signed contract" means a contract that is executed by applying an electronic signature using technology approved by the County.

**IN WITNESS WHEREOF**, the Parties hereto have caused this Agreement to be executed by their duly authorized representatives effective as the Effective Date.

| | |
|---|---|
| **Provider_Contract_Name** | County of Santa Clara dba **Valley Health Plan** |
| Signing_Authority's_Name Date<br>Title<br><br>«TaxId»<br>**TAX ID #**<br><br>Billing NPI #<br>**NPI #** | Bruce Butler Date<br>Chief Executive Officer, Valley Health Plan<br><br>Approved By:<br><br>Jeffrey V. Smith, MD, JD Date<br>County Executive<br><br>Approved as to form and legality:<br><br>Jennifer S. Sprinkles Date<br>Deputy County Counsel |

**Exhibits incorporated into Agreements:**

| | |
|---|---|
| Exhibit A-1 | Compensation Schedule – Employer Group-Classic |
| Exhibit A-2 | Compensation Schedule – Employer Group-Preferred |
| Exhibit A-3 | Compensation Schedule – Covered California and Individual & Family Plan |
| Exhibit A-4 | Compensation Schedule – Medi-Cal Managed Care |
| Exhibit A-5 | Compensation Schedule – Healthy Kids |
| Exhibit A-6 | Compensation Schedule – County Responsibility Patients |
| Exhibit B | *RESERVED* |
| Exhibit C | List of Individual Providers & Sites |
| Exhibit D | Contacts for Prior Authorization |
| Exhibit E | Insurance & Indemnity Requirements |
| Exhibit F | Language Assistance Program Requirements |
| Exhibit G | Timely Access Standards |
| Exhibit H | Covered CA Requirements |

**EXHIBIT A-1**
**COMPENSATION SCHEDULE**
**Line of Business: Commercial**
**Product: Employer Group-Classic**

**PROVIDER_CONTRACT_NAME**

**BILLING:**

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

**VHP Commercial**
P.O. Box 26160
San Jose, CA 95159

**PAYMENT:**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

**EXHIBIT A-2**
**COMPENSATION SCHEDULE**
**Line of Business: Commercial**
**Product: Employer Group-Preferred**

**PROVIDER_CONTRACT_NAME**

**BILLING:**

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

**VHP Commercial**
P.O. Box 26160
San Jose, CA 95159

**PAYMENT:**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

**EXHIBIT A-3**
**COMPENSATION SCHEDULE**
**Line of Business: Commercial**
**Product: Covered California and Individual & Family Plan**

**PROVIDER_CONTRACT_NAME**

**BILLING:**

Provider shall submit Clean Claims in an electronic format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Claims shall be submitted electronically to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

VHP's Trading Partner Number: HT007700-001
Customer Service Number: 877-693-3071

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately to the address below:

**VHP Covered California / IFP**
P.O. Box 26160
San Jose, CA 95159

**PAYMENT:**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Plan Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS), Medicare billing and reimbursement guidelines, including any applicable reductions and/or discounts, which may be amended by CMS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable and prevailing Medicare rate, less applicable reductions for the Region where services were provided, as of the date services were rendered.

Covered Services for which there are no CMS defined billing and reimbursement guidelines or for which Medicare has not established a rate and which are eligible for payment using industry standard coding and billing conventions shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

**EXHIBIT A-4**
**COMPENSATION SCHEDULE**
**Line of Business: Government**
**Product: Medi-Cal Managed Care**

**PROVIDER_CONTRACT_NAME**

**BILLING**

**(a)** Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

**(b)** VHP Medi-Cal Managed Care: Original (or initial) Medi-Cal claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

**(c)** Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

**VHP Medi-Cal Managed Care**
P.O. Box 28407
San Jose, CA 95159

**PAYMENT**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

**EXHIBIT A-5**
**COMPENSATION SCHEDULE**
**Line of Business: Government**
**Product: Healthy Kids**

**PROVIDER_CONTRACT_NAME**

**BILLING**

**(a)** Provider shall submit Clean Claims for all Contracted Services rendered to a Member, within six (6) months in which services were rendered, pursuant to this Agreement within the requirements set forth below:

**(b)** VHP Healthy Kids: Original (or initial) Healthy Kids claims must be received within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Claims that are not received within the six-month billing limit and do not meet any of the other delay reasons are subject to be reimbursed at a reduced rate or will be denied as follows, in compliance with *California Welfare and Institutions Code, Section 14115.*

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

**(c)** Claims Submission. Provider shall submit Clean Claims in an electronic format approved by Plan. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s).

- Electronic Clean Claims shall be submitted to Plan via Utah Health Information Network (UHIN), Plan's EDI clearinghouse as set forth below:

  VHP's Trading Partner Number: HT007700-001
  Customer Service Number: 877-693-3071

Further information can be located within the VHP Provider Manual or by contacting the Plan's Provider Relations Department at 408-885-2221.

In the event Plan permits an exception to electronic claims submission, approved written format claims shall be submitted appropriately as follows:

**VHP Healthy Kids**
P.O. Box 28410
San Jose, CA 95159

**PAYMENT**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

Plan agrees to pay Provider for Medically Necessary Covered Services provided to Members at the following rates, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Covered Services provided in accordance with Plan's Authorization procedures shall be reimbursed in accordance with the California Department of Health Care Services (DHCS) Medi-Cal billing and

reimbursement guidelines, including any applicable reductions, which may be amended by DHCS from time to time. Covered Services shall be reimbursed by Plan at the lessor of Provider's billed charges or at one hundred percent (100%) of the applicable Medi-Cal Fee Schedule, less applicable reductions in effect on the date services are rendered.

Covered Services for which there are no DHCS defined billing and reimbursement guidelines or for which Medi-Cal has not established a rate and which are eligible for payment utilizing industry standard coding and billing conventions, shall be reimbursed at twenty-five percent (25%) of Provider's usual and customary billed charges.

**EXHIBIT A-6**
**COMPENSATION SCHEDULE**
**Line of Business: Coverage Program**
**Product: County Responsibility Patients**

**PROVIDER_CONTRACT_NAME**

**BILLING:**

Provider shall submit Clean Claims in an electronic or written format approved by Plan within ninety (90) days of the date in which service was rendered. A Clean Claim must include, without limitation, the patient's name, patient identification number, the service(s) provided, the date(s) services were rendered, and the charge(s) as required by this Agreement or in the Provider Manual available on the VHP website: www.valleyhealthplan.org.

Approved written format claims shall be submitted appropriately to the address below:

**Valley Health Plan**
**VMC / APD Claims**
2480 N. First St., Suite 160
San Jose, CA 95131

**PAYMENT:**

All of the rates are as defined and are subject to payment rules including **Coordination of Benefits** and base calculations as delineated in the Member's Evidence of Coverage (EOC).

Covered Services that are within Provider's scope of practice and provided to a Member pursuant to the EOC in effect at the time services are rendered shall be compensated in accordance with this Agreement.

County agrees to pay Provider for Medically Necessary Covered Services provided to Members at the rates set forth below, less any applicable Co-payments collected from Member, pursuant to this Agreement:

Authorized Covered Services shall be reimbursed at one hundred percent (100%) of the applicable and prevailing Medi-Cal Fee Schedule as of the date services were rendered.

Authorized Covered Services billed with a valid code for which Medi-Cal does not report a prevailing rate, will be reimbursed at twenty-five percent (25%) of billed charges.

**EXHIBIT C**
**LIST OF INDIVIDUAL PROVIDERS & SITES**

**PROVIDER_CONTRACT_NAME**

The following list includes the most current roster submitted by Provider as of the Agreement's Effective Date. Updates thereto shall be provided in accordance with Section 2.9 of this Agreement.

| Name | Address | Phone No. | NPI # / Type | License Type | License No. & Expiration date |
|---|---|---|---|---|---|
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**EXHIBIT D**
**CONTACTS FOR PRIOR AUTHORIZATION OF COVERED SERVICE**

**PROVIDER_CONTRACT_NAME**

**Valley Health Plan Customer Service Department**

**1-888-421-8444**, select **option 4** for *VHP Customer Service Department*
Select **option 2** to check *Benefits*, Coverage*, Eligibility, & Authorization Status'.*

- Specify to representative the MEMBER's Plan ID#

**Questions for Medi-Cal and Healthy Kids Members, relating to benefits, coverage limitation/exclusions, and/or description of covered services will be redirected to SCFHP.*

**Emergency Department to notify Plan immediately post stabilization by calling 855-254-8264**

For further information regarding VHP's Authorization and Referrals Process, please reference the Provider Manual which can be located on the VHP Website at https://www.valleyhealthplan.org/sites/p/manual/Pages/home.aspx.

**EXHIBIT E**
**INSURANCE & INDEMNITY REQUIREMENTS FOR**
**VHP MEDICAL PROVIDER**

**PROVIDER_CONTRACT_NAME**

## Indemnity

The Provider shall indemnify, defend, and hold harmless the County of Santa Clara (hereinafter "County"), its officers, agents and employees from any claim, liability, loss, injury or damage arising out of or in connection with, performance of this Agreement by Provider and/or its agents, employees or sub-Providers, excepting only loss, injury or damage caused by the sole negligence or willful misconduct of personnel employed by the County. It is the intent of the Parties to this Agreement to provide the broadest possible coverage For the County. The Provider shall reimburse the County for all costs, attorneys' fees, expenses and liabilities incurred with respect to any litigation in which the Provider is obligated to indemnify, defend and hold harmless the County under this Agreement.

## Insurance

Without limiting the Provider's indemnification of the County, the Provider shall provide and maintain at its own expense, during the term of this Agreement, or as may be further required herein, the following insurance coverages and provisions:

### A. Evidence of Coverage

Prior to commencement of this Agreement, the Provider shall provide a Certificate of Insurance certifying that coverage as required herein has been obtained. Individual endorsements executed by the insurance carrier shall accompany the certificate. In addition, a certified copy of the policy or policies shall be provided by the Provider upon request. The Certificate of Insurance shall list the certificate holder as follows:

County of Santa Clara
c/o EBIX RCS, Inc.
P.O. Box 257
Portland, MI USA 48875

This verification of coverage shall be sent to the requesting County department, unless otherwise directed. The Provider shall not receive a Notice to Proceed with the work under the Agreement until it has obtained all insurance required and such insurance has been approved by the County. This approval of insurance shall neither relieve nor decrease the liability of the Provider.

### B. Qualifying Insurers

All coverages, except surety, shall be issued by companies which hold a current policy holder's alphabetic and financial size category rating of not less than A-V, according to the current Best's Key Rating Guide or a company of equal financial stability that is approved by the County's Insurance Manager.

**C. Notice of Cancellation**

All coverage as required herein shall not be canceled or changed so as to no longer meet the specified County insurance requirements without 30 days' prior written notice of such cancellation or change being delivered to the County of Santa Clara or their designated agent.

**D. Insurance Required**

1. ***Commercial General Liability Insurance*** - for bodily injury (including death) and property damage which provides limits as follows:

   a. Each occurrence - $1,000,000
   b. General aggregate - $2,000,000
   c. Personal Injury - $1,000,000

2. ***General liability coverage shall include:***

   a. Premises and Operations
   b. Personal Injury liability
   c. Severability of interest

3. **Workers' Compensation and Employer's Liability Insurance**

   a. Statutory California Workers' Compensation coverage including broad form all-states coverage.
   b. Employer's Liability coverage for not less than one million dollars ($1,000,000) per occurrence.

4. **Professional Errors and Omissions Liability Insurance**

   a. Coverage shall be in an amount of not less than one million dollars ($1,000,000) per occurrence/aggregate.
   b. If coverage contains a deductible or sell-retention, it shall not be greater than fifty thousand dollars ($50,000) per occurrence/event.
   c. Coverage as required herein shall be maintained for a minimum of two years following termination or completion of this Agreement.

5. **Claims Made Coverage**

If coverage is written on a claim made basis, the Certificate of Insurance shall dearly state so. In addition to coverage requirements above, such policy shall provide that:

a. Policy retroactive date coincides with or precedes the Provider's start of work (including subsequent policies purchased as renewals or replacements).

b. Policy allows fix reporting of circumstances or incidents that might give rise to future claims.

## E. Special Provisions

The following provisions shall apply to this Agreement:

1. The foregoing requirements as to the types and limits of insurance coverage to be maintained by the Provider and any approval of said insurance by the County or its insurance consultant(s) are not intended to and shall not in any manner limit or qualify the liabilities and obligations otherwise assumed by the Provider pursuant to this Agreement, including but not limited to, the provisions concerning indemnification.

2. The County acknowledges that some insurance requirements contained in this Agreement may be fulfilled by self-insurance on the part of the Provider. However, this shall not in any way limit liabilities assumed by the Provider under this Agreement. Any self-insurance shall be approved in writing by the County upon satisfactory evidence of financial capacity. Provider's obligation hereunder may be satisfied in whole or in part by adequately funded self-insurance programs or self-insurance retentions.

3. Should any of the work under this Agreement be sublet, the Provider shall require each of its subcontractors of any tier to carry the aforementioned coverages, or Provider may insure subcontractors under its own policies.

4. The County reserves the right to withhold payments to the Provider in the event of material noncompliance with the insurance requirements outlined above.

## Acknowledgement of Insurance Requirements

I, ***Signing Authority's Name***, on behalf of ***Provider Contract Name*** have read and understand the terms and conditions of the Insurance Requirements under this Agreement. I understand that all Insurance certificates MUST be in effect, prior to the services rendered. I understand that if ***Provider Contract Name*** is not compliant with these insurance requirements, ***Provider Contract Name*** will not be compensated for services rendered until insurance certification is obtained that meets the requirements set forth in this agreement. In addition, if ***Provider Contract Name*** fails to obtain the required insurance certification in a timely manner, this agreement may be terminated.

_____

Signature Date

## EXHIBIT F
## LANGUAGE ASSISTANCE PROGRAM REQUIREMENTS

## PROVIDER_CONTRACT_NAME

Without limiting any of other obligations of the Parties under this Agreement, the Parties shall comply with such regulatory requirements of the Health Care Language Assistance Act, pursuant to Health and Safety Code Section 1367.04 et seq. and California Code of Regulations ("CCR") 28 CCR 1300.67.04 et seq., key provisions of which are summarized in this exhibit. To the extent that the provisions in this exhibit are inconsistent with provisions in the Agreement, the terms in this exhibit shall prevail as to the obligations of the Parties under the Health Care Language Assistance Act ("Act").

**Plan Responsibilities:**

- Plan shall provide a copy of the Plan's Language Assistance Program requirements and all written policies and procedures regarding the Language Assistance Program and the Act.
- Plan shall ensure that the threshold language needs of Plan Members are identified and made available to Provider. Provide list of covered languages and update list as necessary.
- Plan shall generate and periodically update a list of vital documents that Provider shall translate in threshold languages. Vital documents are those documents that contain information that is critical for accessing medical services and/or benefits and are identified in the Plan's operating guidelines and provided to Provider.
- Plan will monitor and audit Provider regarding compliance with language assistance requirements.

**Provider Responsibilities:**

- Provider agrees to provide or arrange for the provision of qualified interpretation services to Limited English Proficiency (LEP) Members, in threshold languages, at no cost to the Member. Provider shall comply with Plan's Language Assistance Program requirements, policies and procedures so long as they conform to Provider's own Language Assistance Policies and applicable law.
- Provider agrees to provide or arrange for the translation of vital documents in threshold languages.
- Provider will document in the medical record if patient authorizes use of family member as an interpreter.

**EXHIBIT G**
**TIMELY ACCESS STANDARDS**

**PROVIDER_CONTRACT_NAME**

## I. Appointments

a. To ensure members have timely access to care, Provider shall follow the following standards set by DMHC and Accrediting Agency.

| SERVICE | ACCESS TIME FRAME |
|---|---|
| **Urgent Care Appointment**<br>PCP and Specialists<br>• Services not requiring a prior Authorization<br>• Services requiring a prior Authorization | • Within 48 hours of request for appointment<br>• Within 96 hours of request for appointment |
| **Non-urgent Appointment**<br>For the diagnosis or treatment of injury, illness, or other health condition.<br>PCP and All Mental Health Providers<br><br>Specialist and Ancillary Services | Within 10 business days of request for appointment<br>Within 15 business days of request for appointment |
| **Preventative Care Appointment**<br>All Practitioners<br>• Periodic follow-up<br>• Standing referrals for chronic conditions<br>• Pregnancy<br>• Cardiac condition<br>• Mental health conditions<br>• Laboratory and radiology monitoring | May be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed healthcare Provider acting within the scope of his/her practice. |
| **Telephone Triage or Screening**<br>All Practitioners | • Triage or screening waiting time does not exceed 30 minutes.<br>• Triage or screening must be available to Enrollees 24 hours per day, 7 days a week. |

b. When it is necessary for a Practitioner or Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with professionally recognized standards of practice.

c. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care Provider, or the health care professional

providing triage or screening-services, as applicable, acting within the scope of his or her practice and, consistent with professionally recognized standards of practice; has determined and noted in the relevant records that a longer waiting time will not have a detrimental impact on the health of Member. (1300.67.2.2 (c)(5)(G))

## II. During and After Business Hours Services

Provider shall employ an answering service or a telephone answering machine during and after business hours, which provide instructions regarding how Members may obtain urgent or emergent care including, when applicable, how to contact another Practitioner who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care, and length of wait time for a return call from the Practitioner. (1300.67.2.2 (c)(8)(B)(1))

## III. Timely Access Reporting

Provider shall work with Plan's Quality Management to develop a process for tracking and reporting timely access compliance. Provider shall provide a report of their findings to Plan on a quarterly basis if required.

**EXHIBIT H**
**COVERED CALIFORNIA REQUIREMENTS**

**PROVIDER_CONTRACT_NAME**

Provider shall comply with the following terms required by the QHP Contract. These provisions apply only to services provided to Covered California and Individual & Family Plan Members, collectively "Covered California Members".

1. **Compliance.**

   a. **Compliance Coordination**. Provider shall coordinate and cooperate with Plan to the extent necessary to promote compliance by Plan and Provider with the applicable terms of the QHP Contract.

   b. **Compliance with All Laws.** Provider shall comply with all applicable federal, state, and local laws, regulations, executive orders, ordinances and guidance, including without limitation, the Affordable Care Act and the California Affordable Care Act; the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, and the Knox-Keene Health Care Service Plan Act of 1975; as applicable.

2. **Independent Contractors**. The Parties acknowledge and agree that, as required by 45 C.F.R. § 155.200(e), in carrying out its responsibilities, Covered California is not operating on behalf of Plan or Provider. In the performance of this Agreement, Plan and Provider shall always be acting and performing as an independent contractor, and nothing in the Provider Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venture or principal and agent between or among Plan and Provider. Neither Plan, Provider, or any agents, officers or employees of any of them are agents, officers, employees, partners or associates of Covered California.

3. **Disclosure of Financial Information**. Provider agrees that Plan may disclose information relating to contracted rates between the Plan and Provider that is treated as confidential information by the DMHC pursuant to Health and Safety Code § 1385.07(b). Provider shall cooperate with Plan in providing Covered California with financial information relating to Provider that is (i) provided by Provider or Plan to the DMHC or other regulatory bodies, and (ii) reasonable and customary financial information that is prepared by Provider, including, supporting information relating to Covered California Members as required by Covered California. Possible requests may include (but not be limited to), annual audited financial statements, and annual profit and loss statements.

4. **Network Disruption.**

   a. Plan and Provider shall implement policies and practices designed (i) to reduce the potential for disruptions in Plan's Provider network, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Covered California Members in the execution of the transition of care as required under state laws, rules and regulations in connection with any such disruption. Plan and Provider will maintain adequate

records, reasonably satisfactory to Covered California, documenting its policies and its compliance with these requirements by Plan and Provider.

b. In the event termination of the Agreement requires a block transfer of Covered California Members from Provider to a new Provider, Provider shall cooperate with Plan and Covered California in planning for the orderly transfer of Covered California Members as necessary and as required under applicable laws, rules, and regulations including but not limited to those relating to continuation of care set forth at Health and Safety Code § 1373.95.

c. Provider shall notify Plan with respect to any material changes in its Provider network as of and throughout the term of this Agreement. For purposes of this Agreement, a material change in the disclosures shall relate to an event or other information that may reasonably impact Provider's ability to perform under this Agreement.

**5. Member Out-of-Network and Other Costs; Hold Harmless.**

a. Plan shall and shall require Providers to, comply with applicable laws, rules and regulations governing liability of Members for Covered Services provided to Members, including, those relating to holding a Member harmless from liability in the event Plan fails to pay an amount owing by Plan to a Provider as required by federal and state laws, rules and regulations.

b. To the extent that Plan (i) provide coverage for out-of-network services and/or (ii) impose additional fees for such services, Plan shall disclose to the Member the amount it will pay for covered proposed non-emergent out-of-network services when requested by the Member.

c. Plan shall require its Providers to inform every Member in a manner that allows the Member the opportunity to act upon that Provider's proposal or recommendation regarding (i) the use of a non-network Provider or facility or (ii) the referral of a Member to a non-network Provider or facility for proposed non-emergent Covered Services. Plan shall require Providers to disclose to the Member who is proposing or considering using out-of-network non-emergent services if a non-network Provider or facility will be used as part of the network Provider's plan of care. Plan's obligation for this provision can be met through an update to their Provider's contract manual that is effective as of January 1, 2014. Providers may rely on Plan's Provider directory as updated from time to time in fulfilling their obligation under this provision.

**6. Nondiscrimination.**

a. In accordance with the Affordable Care Act § 1557 (42 U.S.C. 18116), Provider shall require as well as its agents and employees to refrain from causing an individual to be excluded from participation in, or to be denied the benefits of, or to be subjected to discrimination under, any health program or activity offered through Covered California on grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), § 504 of

the Rehabilitation Act of 1973 (29 U.S.C. 794), or any other applicable state and federal laws.

b. Provider shall, as well as its agents, employees and sub-contractors to refrain from unlawful discrimination or harassment or from allowing harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity or use of family and medical care leave. Participating Provider Group (PPG) shall and shall require its Sub-Subcontractors as well as their agents and employees to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. PPG shall and shall require its Sub-Subcontractors as well as their agents and employees to comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2, CCR Section 8103, et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

7. **Conflict of Interest; Integrity.**

a. Provider shall be free from any conflicts of interest with respect to Covered Services provided under this Agreement. Provider represents that Provider and its personnel do not currently have and will not have throughout the term of the Agreement, any direct or interest which may present a conflict in any manner with the performance of Covered Services required under this Agreement. Provider also represents that it is not aware of any conflicts of interest of any Sub-Subcontractors or any basis for potential violations of Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services to Covered California Members, including, federal and state anti-kickback and anti-self-referral laws, rules and regulations. Provider shall immediately (i) identify any conflict of interest that is identified during the term of the Agreement and (ii) take any necessary action to assure that any activities are not properly influenced by a conflict of interest.

b. Provider shall comply with all applicable policies adopted by Covered California regarding conflicts of interest and ethical standards.

8. **Customer Service.** Provider shall meet all state requirements for language assistance services that are applicable to Plan's Commercial HMO line of business.

9. **Credentialing.** Plan shall perform, or may delegate activities related to, credentialing and re-credentialing in accordance with this Agreement. Plan agrees to maintain quality accreditation as outlined in this Agreement.

10. **Other Laws.** Provider shall comply with applicable laws, rules and regulations, including the following:

    a. Americans with Disabilities Act. Provider shall comply with the Americans With Disabilities Act (ADA) of 1990, (42 U.S.C. 12101, et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

    b. Drug-Free Workplace. Provider shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350, et seq.).

    c. Child Support Compliance Act. Provider shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.

    d. Domestic Partners. Provider shall fully comply with Public Contract Code Section 10295.3 with regard to benefits for domestic partners.

    e. Environmental. Provider shall comply with environmental laws, rules and Regulations applicable to its operations, including, those relating to certifies compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.

    f. Other Laws. Provider shall comply with all other state and federal laws, rules and regulations applicable to this Agreement and Provider's provision of Covered Services under this Agreement.

11. **Continuity of Care, coordination and cooperation upon termination of Agreement and transition of Members.**

    a. Upon the termination of the Agreement, Provider shall fully cooperate with Plan or Covered California (the "Exchange") in order to affect an orderly transition of Members to another Provider or Certified QHP as directed by the Exchange. This cooperation shall include, without limitation, (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Providers to assure the appropriate continuity of care, and/or (iii) communicating with affected Members in cooperation with the Exchange and/or the succeeding Provider, each as shall be reasonably requested by Covered California.

    b. In the event of the termination or expiration of the Agreement that requires the transfer of some or all Members into any other health plan, the terms of coverage under Plan's QHP Contract shall not be carried over to the replacement Qualified Health Plan (QHP) but rather the transferred Members shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

c. Notwithstanding the foregoing, the coverage of Member under Plan's QHP Contract may be extended to the extent that a Member qualifies for an extension of benefits including, those to affect the continuity of care required due to hospitalization or disability pursuant to Health and Safety Code section 1373.96 et. seq. as amended.

d. For purposes of this Agreement, "disability" means that the Member has been certified as being totally disabled by the Member's treating physician, and the certification is approved by Plan. Such certification must be submitted for approval within thirty (30) calendar days from the date coverage is terminated. Recertification of Member's disability status must be furnished by the treating Provider not less frequently than at sixty (60) calendar day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

(i) Until total disability ceases;
(ii) For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;
(iii) Until the Member's enrollment in a replacement plan; or
(iv) Recertification.

JAMES R. WILLIAMS, County Counsel (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
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*Counsel for Plaintiffs*

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF MARY E. HANNA-WEIR IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

| | |
|---|---|
| Date: | October 30, 2019 |
| Time: | 8:00 AM |
| Courtroom: | 12 |
| Judge: | Hon. William H. Alsup |
| Action Filed: | 5/2/2019 |

I, MARY E. HANNA-WEIR declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am Deputy County Counsel for the County of Santa Clara and am counsel of record for Plaintiff County of Santa Clara in this matter.

3. Attached hereto as **Exhibit A** is a true and correct copy of the Declaration of Phuong Nguyen, M.D., Interim Chief Medical Officer, Santa Clara Valley Medical Center, executed on June 4, 2019, and filed on June 11, 2019, in support of Plaintiff's Motion for Preliminary Injunction (Dkt. 36-16).

4. Due to unforeseen personal circumstances requiring her to be out of the office and out of contact, Dr. Nguyen is unavailable to execute a renewed declaration in support of Plaintiffs' Motion for Summary Judgment and in Support of Their Opposition to Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment. Plaintiffs accordingly submit her prior declaration, which addresses factual information relevant to the current motion practice.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on September 6, 2019 in San José, California.

MARY E. HANNA-WEIR
Deputy County Counsel

# EXHIBIT A

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*Counsel for Plaintiffs*

**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF CALIFORNIA**

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

No. 19-cv-2916 NC

**DECLARATION OF PHUONG H. NGUYEN, M.D., INTERIM CHIEF MEDICAL OFFICER, SANTA CLARA VALLEY MEDICAL CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Phuong H. Nguyen, M.D., declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Preliminary Injunction. I have personal knowledge of the facts set forth in this declaration. If called as a witness, I could and would testify competently to the matters set forth herein.

2. I currently serve as Interim Chief Medical Officer for the Santa Clara Valley Medical Center ("Valley Medical Center"). I have been employed by Valley Medical Center in various capacities for a total of nineteen (19) years, and I have practiced as an obstetrician/ gynecologist in a clinical capacity throughout my employment with Valley Medical Center. As of March 1, 2019, when the County of Santa Clara assumed operations of O'Connor Hospital and St. Louise Hospital, I became Interim Chief Medical Officer of the single consolidated medical staff for the three hospitals.

3. The County of Santa Clara Health System operates three hospitals—Valley Medical Center, O'Connor Hospital, and St. Louise Hospital under a single consolidated hospital license and with a single consolidated medical staff. The consolidated medical staff includes 1202 physicians and advance practice providers at Valley Medical Center, 681 physicians and advance practice providers at O'Connor Hospital, and 262 physicians and advance practice providers at St. Louise Hospital. As Interim Chief Medical Officer, I supervise the consolidated medical staff, including overseeing the recruitment, hiring, training, scheduling, and supervision of physicians.

4. Valley Medical Center has policies that allow medical staff, including physicians, who have a religious or moral objection to providing certain patient care to request not to participate in that care. Those policies are being made applicable to physicians who provide care at O'Connor and St. Louise hospitals as part of the integration of those hospitals into the County's Health System. The County has procedures in place to determine whether such objections can reasonably be accommodated, in light of circumstances such as staffing levels, and to take into account religious objections in scheduling and staffing decisions. Our policies make clear that patient care must not be compromised. For example, in an emergency an objecting

physician would need to provide care until the physician can be relieved. Similarly, for end-of-life care decisions involving medically ineffective care or other healthcare instructions for which a physician has an objection, the objecting physician must assist in the transfer of the patient to another provider.

5. It would create staffing challenges if the hospitals could no longer reassign objecting staff members or shift their hours to accommodate or account for their religious objections. It is necessary to assign certain personnel to specific shifts to ensure that there are sufficient non-objecting staff to provide patient care. And if a person's religious objection is incompatible with their current role, reassignment to a different role may be necessary. While we strive to achieve mutually agreeable, voluntary reassignments, schedule changes, and other accommodations whenever possible, in some instances we require the flexibility to make assignment or scheduling decisions without the objecting staff member's consent.

6. Further, there are some circumstances in which no accommodation would be possible. For example, if a receptionist objected to informing people that our hospitals provide contraceptive and abortion care and refused to transfer inquiries about such care to another receptionist, I cannot think of any accommodation that would avoid compromising patient access to care. And even if a receptionist were willing to transfer all calls about contraceptive or abortion care to another receptionist, this could require double staffing, at the cost of a second salary. It would be operationally unworkable for the County of Santa Clara Health System if an employee retains a unilateral right to veto a reassignment.

7. Delaying necessary health care can trigger immediate and long-term costs to the County and communities nationwide. Under current County policies, patients seeking care for routine procedures that a provider may have a religious or moral objection to providing are promptly transferred to another provider or are initially scheduled to be served by a provider who does not object. If a regulatory change impedes the County's ability to ensure the timely provision of care for such patients, the resulting delays may exacerbate their medical needs, resulting in increased costs for treatment. Since the County is a safety-net provider, many of those increased costs would be borne by the County—either directly, where the County absorbs

the cost of care for uninsured or underinsured patients, or indirectly because federal health insurance programs like Medicaid and Medicare rarely cover the full cost of treatment.

8. Delays in care may also lead to malpractice claims, which are costly to defend and may lead to expensive settlements or court-ordered damages, at potentially great cost to the County. County physicians and other providers are bound by medical ethics to act in the best interest of our patients. Delaying care because a provider did not register a religious or moral objection in advance is in conflict with those ethical obligations. Patients whose medical conditions are worsened by delays or denials of care may experience preventable adverse outcomes such as long-term injury or even death as a result.

9. For example, a patient could present at Valley Medical Center with vaginal spotting, pain, missed period, and positive home pregnancy test in the context of having an intra-uterine device as a contraceptive method—a condition many Valley Medical Center physicians are qualified and willing to manage and treat. If an employee or physician were to turn that patient away from the hospital, based on moral or religious convictions, without referring her to a willing physician or otherwise providing any information about appropriate treatment, the patient could be denied prompt care, the County could be exposed to liability, and its providers could be in violation of their ethical and legal duties. Health care professionals are legally and ethically obligated to provide their patients with complete and accurate information about their treatment options.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: June 4, 2019

Respectfully submitted,

PHUONG H. NGUYEN, M.D.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

| | |
|---|---|
| Date: | October 30, 2019 |
| Time: | 8:00 AM |
| Dept: | 12 |
| Judge: | Hon. William H. Alsup |
| Trial Date: | None Set |
| Action Filed: | 5/2/2019 |

I, Roy Harker, declare:

1. AGLP: The Association of LGBTQ+ Psychiatrists is a 501(c)(3) non-profit organization based in Philadelphia, Pennsylvania, and incorporated in Pennsylvania. AGLP is a community of psychiatrists that educates and advocates on Lesbian Gay Bisexual and Transgender mental-health issues. AGLP's goals are to foster a fuller understanding of LGBTQ mental-health issues; research and advocate for the best mental healthcare for the LGBTQ community; develop resources to promote LGBTQ mental health; create a welcoming, safe, nurturing, and accepting environment for members; and provide valuable and accessible services to our members. AGLP strives to be a community for the personal and professional growth of all LGBTQ psychiatrists, and to be the recognized expert on LGBTQ mental health issues.

2. AGLP (formerly known as the Association of Gay and Lesbian Psychiatrists) represents the interests of 450 LGBTQ+ psychiatrists who are members of the Association and who reside and work across the United States. AGLP was founded in the 1970s when gay and lesbian members of the American Psychiatric Association (APA) met secretly at the annual meetings. At that time, in most states, homosexuality could be used as cause to rescind someone's license to practice psychiatry. In 1973, the APA removed homosexuality from their diagnostic manual (DSM). This allowed a more open association of lesbian and gay psychiatrists who could be a little less fearful for their jobs if they were found out to be gay. Even today, the mission of providing support and a safe space for LGBTQ psychiatrists to meet continues to be important to many of AGLP's members. AGLP is the oldest organized association of LGBTQ professionals in the country.

3. AGLP is an independent organization from APA, but works closely with APA through many projects, including but not limited to, LGBTQ representation on the APA Assembly (the Minority Caucus of the APA and AGLP's own representative), APA position statements, LGBTQ Committees of the DSM, the creation and staffing of an AIDS Committee, and research and advocacy of particular interest to the LGBTQ+ Community through their quarterly *Journal of Gay and Lesbian Mental Health, and seminars and discussion groups that are conducted concurrently with the APA's annual meeting*. AGLP works within the APA to influence policies relevant to the LGBTQ community, including issuing position statements that bring awareness to and advocate

against the misuse of religion to discriminate against the LGBTQ community as well as educating about how discrimination and stigmatization of LGBTQ people adversely affects their mental health and right to happiness.

4. AGLP continues to work with the APA and independently to support our members and advocate for LGBTQ patients. AGLP also assists medical students and residents throughout the country in their professional development, encourages and facilitates the presentation of programs and publications relevant to gay and lesbian concerns at professional meetings; and serves as liaison with other minority and advocacy groups within the psychiatric community nationwide.

5. I have been the sole staff person for AGLP for over twenty-five years, first as National Office Director for five years, then as Executive Director since 1999. I am an alumnus of Drexel and Temple Universities in Philadelphia, and completed the American Society of Association Executives ("ASAE") Association Executive Certification in February of 2018, the highest professional credential in the association industry. I submit this declaration in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

6. The Denial-of-Care Rule fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining healthcare and hence suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. AGLP's members report that their LGBTQ patients and patients living with HIV report having experienced frequent discrimination by other healthcare providers and suffer from more acute medical conditions resulting from such discrimination and fear of seeking medically-necessary healthcare services. A large percentage of AGLP members' transgender patients anecdotally report having negative experiences related to their gender identity when seeking medical care, including being exposed to verbal harassment or refusals of care. In comparison to other populations, LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by healthcare providers.

7. AGLP firmly believes that gender identity is part of the natural spectrum of human experience and expression, as is the position of the APA. The transgender and gender non-conforming community has been marginalized and continues to fight for basic civil rights. Discrimination and harassment are especially significant sources of stress for transgender youth who are navigating an especially challenging period of their lives and are vulnerable to depression and suicide when not supported by family and schools. This is especially true when even their healthcare providers, the people whom they turn to in their most vulnerable times of need, discriminate against them or deny them care. Religious objections by healthcare providers have been detrimental to the health of LGBTQ patients, and these harms would be exacerbated by the Denial-of-Care Rule. As an organization of psychiatrists who often serve and care for patients from the LGBTQ community, AGLP knows that discrimination against LGBTQ individuals in healthcare access and coverage remains a pervasive problem and that too often this discrimination is based in religious objections.

8. AGLP has long strongly held and publicly asserted that all people, whether LGBTQ or not, deserve the equal protections provided by the Fifth and Fourteenth Amendments to the Constitution; that religious liberty justifications for denying healthcare are thinly disguised efforts to return to marginalization and stigmatization of same-sex and transgender orientations and identities; that the principle cited behind such religious-liberty arguments would threaten the equal protection of vast numbers of other minority citizens; that virtually every major mental-health organization has concluded that there is no credible scientific evidence that LGBTQ citizens are psychologically impaired *per se* or need to change their orientations or identities; that LGBTQ citizens represent no more burden on American society than any other minority group, and, in fact, have made substantive contributions to the arts, sciences, and businesses in America; and that discrimination and stigmatization of LGBTQ citizens adversely affects their mental health and right to happiness. Therefore: AGLP steadfastly condemns all legislative and administrative efforts, including the Denial-of-Care Rule, to stigmatize and discriminate against LGBTQ citizens.

9. The Denial-of-Care Rule will result in greater discrimination against LGBTQ patients and in increased denials of services based not just on the medical services that patients seek, but on

the basis of the patients' LGBTQ identities in violation of the law, medical ethics, and standards of care. The Denial-of-Care Rule presents a direct conflict with nondiscrimination standards adopted by all the major health-professional associations, who have already recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other healthcare settings. All the leading health-professional associations—including the American Medical Association, American Osteopathic Association, American Academy of Physician Assistants, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that healthcare providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity. By allowing discrimination against patients on the grounds of moral and religious freedom, the Denial-of-Care Rule obviates the ethical standards that healthcare professionals are charged to uphold.

10. If not enjoined, the Denial-of-Care Rule will harm AGLP members, LGBTQ patients whose interests AGLP also represents, and the patients who AGLP members treat nationwide. The Rule invites healthcare facilities to discriminate against LGBTQ employees and patients without concern about the impact that a complaint for non-compliance with purported conscience protections would have on ensuring the provision of medically-necessary care for patients, adherence with medical standards of care, ethical requirements, accreditation requirements, and nondiscrimination requirements in employment and in the provision of patient care. The Rule, therefore, frustrates AGLP's mission of achieving and enforcing safe workspaces for LGBTQ psychiatrists and nondiscriminatory healthcare services to AGLP members' LGBTQ patients. The Denial-of-Care Rule frustrates AGLP's mission of advocating for nondiscrimination standards of care for patients and nondiscriminatory work environments for its members that protect against discrimination on the basis of sexual orientation and gender identity and advocating for cultural competency standards of care for treatment of LGBTQ patients.

11. Some members of AGLP are employed by religiously-affiliated healthcare organizations. AGLP has members who are Medical Directors and administrators in Hospitals and Clinics all over the Country and, in the course of their employment, these healthcare providers treat LGBTQ patients. Members of AGLP employed by religiously-affiliated hospitals will experience employment discrimination for adhering to their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically-necessary care that is in the patient's best interest. The Rule impinges on and conflicts with AGLP members' legal obligations as healthcare providers and harms the patients that they serve.

12. Additionally, some members of AGLP are employed by the federal government. In the course of their employment, these health professionals have benefited from, and have depended upon, protections against discrimination in federal sector employment based on sexual orientation and gender identity. These nondiscrimination policies have deterred anti-LGBTQ harassment and other forms of discrimination, regardless of the motive for that discrimination. The Denial-of-Care Rule is in direct conflict with those nondiscrimination policies.

13. The Denial-of-Care Rule invites harassment and discriminatory treatment of AGLP members in the workforce by fellow employees who claim a right to accommodation for discriminatory behavior empowered by the Rule. AGLP members and their LGBTQ patients are stigmatized and demeaned by the message communicated by the Denial-of-Care Rule that their government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the healthcare context. The Denial-of-Care Rule invites religious-based discrimination against AGLP members as well as their LGBTQ patients.

14. Based on their years of working with LGBTQ patients who have reported concealing their identities out of fear of discrimination, AGLP members know that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. AGLP will need to be a resource for patients who are in need of medical services but do not know where to go for LGBTQ-affirming healthcare. The Rule will predictably result in more denials of care, and, consequently, more requests for referrals. AGLP offers an online referral service to patients seeking LGBTQ-affirming counselling, support, and psychiatric treatment. The Denial-of-Care Rule adversely impacts AGLP by necessitating the diversion and reallocation of resources in order to provide referrals to increasing numbers of members and their patients seeking assistance with healthcare referrals as a result of the Rule. The Denial-of-Care Rule will make it more difficult and resource-intensive for AGLP to locate and monitor appropriate referrals that will not cause further harm to AGLP patients who have already been discriminated against or who fear discrimination on the basis of religious objections to the patients' gender identities or sexual orientation. AGLP will have to continuously update its online referral search engine, especially because many healthcare providers currently listed on the website are affiliated with religious hospitals and organization. As a result of the Denial-of-Care Rule, AGLP expects to see increased use of its referral resources and assistance, which will require AGLP to allocate additional staff time to support such requests.

16. As a result of the Denial-of-Care Rule, AGLP is required to expend its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Rule causes. AGLP has been working with other medical and health associations, including the APA, to express disapproval of the Denial-of-Care. Such work has diverted resources away from other proactive projects and outreach efforts that are core to AGLP's mission. AGLP also spends resources answering AGLP members' inquiries about the Denial-of-Care Rule given the pervasive concern that the Denial-of-Care Rule contradicts medical ethical requirements and standards of care. AGLP must spend resources educating its members and the general healthcare community about AGLP's position on the Denial-of-Care Rule and its negative effects on healthcare practices and providers as well as their patients.

17. The Denial-of-Care Rule empowers and incites religious-based discrimination against AGLP members and will create discriminatory work environments for AGLP members. AGLP, in turn, sees and will continue seeing an increase in psychiatrists seeking its assistance with addressing

such discrimination. AGLP will need to help its members navigate through these hostile work environments and may need to intervene on its members' behalves when necessary. The increased demand for such services will further hamper AGLP's other work because AGLP already has a very limited bandwidth for such services.

18. AGLP members receive various forms of federal funding directly and indirectly via federal programs. AGLP's members may, therefore, be subject to the restrictions of the Denial-of-Care Rule. Without such funding, AGLP members would not have the resources to provide proper treatment to their patients or proceed with their medical research programs. AGLP's members, therefore, have a reasonable fear that they could be sanctioned and lose federal funding for the work that they do as a result of nondiscrimination policies, ethical requirements, and standards of care that they enforce in their psychiatric practices, which are vital to providing proper care to their patients.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Executed on September 9, 2019, in Philadelphia, Pennsylvania.

Roy Harker

Roy Harker
Executive Director of AGLP