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

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SUPPLEMENTAL EXCERPTS OF RECORD
VOLUME VII OF X

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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 RACHAEL PHELPS, M.D., 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, Rachael Phelps, M.D., declare:

1. I am the Medical Director of Plaintiff Medical Students for Choice ("MSFC"). MSFC is a 501(c)(3) non-profit that advocates for full integration of reproductive healthcare, including contraception and abortion, into the curricula at medical schools and residency programs. MSFC is comprised of student-led chapters at medical schools, and these grass-roots, student activists are supported by the national MSFC staff who implement programming, manage resources, and provide expertise. Medical student activists make up the majority of our Board of Directors, and the MSFC student chapters provide data and information about the state of family planning training at the local level to guide the strategic planning of the Board.

2. MSFC's central mission is to expand access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, including with respect to all aspects of sexual and reproductive health. MSFC furthers this mission by supporting future generations of family planning providers in accessing training in contraception and abortion.

3. MSFC has 163 chapters in 45 U.S. states, and another 55 chapters outside of the U.S. We have thousands of current student members.

4. Despite the considerable number of students seeking family planning training and the fact that outpatient abortion is simple, safe, and an extremely common procedure, one of the most common medical procedures undergone by women,[1] most medical students do not receive training in abortion, and some do not even receive training in contraceptive care. Less than half of our members learned about first-trimester abortion from their schools. Many members learn inaccurate and limited information about contraception.

5. I received my medical degree in 1997 from Johns Hopkins University School of Medicine. I completed residency in Pediatrics in 2000 and a fellowship in Family Planning in

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective."). 1 in 4 women will seek abortion in their lifetime. *See* Jones RK & Jerman J, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) Am. J. of Pub Health 1904 (2017).

2001. I was a resident and fellow at the University of Rochester, and only the second family planning fellow at that hospital. I am board-certified in Pediatrics.

6. After finishing my fellowship, I joined Planned Parenthood of the Rochester/Syracuse Region, which has now become Planned Parenthood of Central and Western New York ("PPCWNY"), as an abortion provider. I served in a variety of roles there, Medical Director of Surgical Services, Associate Medical Director and Medical Director, from 2001-2018. I left that position to become the Medical Director of MSFC. I continue to provide family planning and abortion care at Planned Parenthood.

7. At the University of Rochester, I am a Clinical Instructor in the OB/GYN Department and a Clinical Instructor in the Department of Pediatrics. I train medical students and residents in contraception and abortion. I am frequently invited by other institutions and organizations to lecture on contraception and abortion.

8. I authored the chapter on unintended pregnancy and options counseling in the Hillard textbook, *Practical Pediatric and Adolescent Gynecology*.

9. I have received awards in my field, including the National Council of Jewish Women Hannah G. Solomon Humanitarian Award, the Dr. Barnett A. Slepian Memorial Fund Clinical Training Award, Alpha Omega Alpha Honor Medical Society Alumni Induction by the University of Rochester, and the American Medical Student Association: Women Leaders in Medicine Award. My curriculum vitae, which sets forth my qualifications fully, is attached as Exhibit A.

10. At MSFC, I lecture student chapters about contraceptive methods and abortion care. I am also the coordinating director for MSFC's intensive training program. I monitor the state of family planning education in the United States.

11. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule").

12. I understand that teaching hospitals and residency programs are considered "direct recipients" under the Rule, and all of the institutions and programs currently training our student

members across the country would be subject to the Rule.

13. At MSFC, we run educational seminars. Each year, we run an intensive conference over several days. Our current budget allows us to accept only 400 students a year for our intensive conference. We also provide abortion training institutes, for which admission is competitive, and we can only accept less than 50% of those who apply.

14. There are many ways to deny, delay, or obstruct patient care. Once healthcare is delayed or denied, the harm is immediate and cannot be undone. To the extent the Rule enables individual employees at healthcare facilities subject to the Rule, even those not trained as healthcare providers, such as receptionists or cleaning staff, to refuse to assist in a variety of ways with a patient's access to needed healthcare, it will harm patient health and reduce access to contraception and abortion in family planning training programs throughout the nation.

15. Even without the Rule, reproductive healthcare is already being pushed out of mainstream healthcare at numerous hospitals across the country, and patients face a multitude of unnecessary barriers when trying to obtain basic family planning services. Abortion is a fundamental part of healthcare: it is a common medical procedure—1 in 3 women in the U.S. have undergone an abortion and an estimated 1 in 4 women will need an abortion in the future—and it is extremely safe[2]—14 times safer than childbirth[3] and even safer than a shot of penicillin.[4]

16. Even in progressive states, some hospitals fail to offer reproductive healthcare due to the moral or religious objections of a few, and on occasion, even due to the moral or religious objections of a lone individual. This is equally true for education about contraception and abortion in medical schools and residencies. The small minority of individuals who object to either education about or provision of reproductive healthcare often prevent the majority of medical students who want this education and training from receiving it and ultimately block the

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[2] National Academies of Science, Engineering, and Medicine, *supra* note 1.

[3] Raymond EG & Grimes DA, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2 Pt 1) Obstetrics & Gynecology 215 (2012).

[4] *Compare* Raymond EG & Grimes DA, *supra* note 3 *with* Neugut AI et al., *Anaphylaxis in the United States: an Investigation into its Epidemiology*, 161(1) Archives of Internal Med. 15 (2001).

doctors who want to provide this care from serving their patients' healthcare needs.

17. For example, I have been informed of circumstances in which university teaching hospitals do not provide certain types of abortion care, such as second trimester abortion care, because of the opinion of a few or even one staff member in a position of power, despite the presence of physicians trained in and willing to provide these desperately needed services. In one instance, the chair of a department of one hospital refused to allow the hospital's doctors to participate in abortion care, even though multiple doctors were willing to assist with abortions, thus preventing the trained and willing OB/GYN physicians in this teaching hospital from providing abortion care to the patients in their community. As a result, despite having trained and willing OB/GYNs who want to provide this care, the hospital does not provide any abortion care beyond 12 weeks.

18. First-trimester abortion providers serve patients at outpatient clinics in that region, but, due to the anesthesia department chair's policy, there is now no second-trimester abortion access for patients with Medicaid in the region and only extremely limited access for patients with private insurance. Due to the lack of access to time-sensitive health-care imposed by this one objection, patients must travel hours to obtain second-trimester abortions at a hospital in another city. Because this one hospital must now meet the need for their own community, as well as the unmet need created in another city by this one objection, all patients seeking an abortion beyond 13 weeks must wait up to 2-4 weeks to get an appointment for care. This means a woman seeking an abortion at 14 or 15 weeks will often have to wait until she is 18 or 19 weeks to access an abortion. Such delays harm patients. While the risk of morbidity and mortality remains significantly lower than childbirth throughout the second trimester, it increases approximately 20% for each additional week that the procedure is delayed.[5]

19. As an example of harmful delay, I have seen some physicians suggest admitting a woman experiencing placental abruption or a complication from an abortion procedure to the Intensive Care Unit and transfusing the patient until fetal cardiac activity ceased. This is a

[5] *See* Newmann S et al., *Clinical guidelines: Cervical preparation for surgical abortion from 20 to 24 weeks' gestation*, 77(4) Contraception 308 (2008).

dangerous and cruel practice. Continual transfusions are, themselves, dangerous. When a patient loses a lot of blood and they are repeatedly given donated blood, they can lose their ability to clot due to a serious condition called disseminated intervascular coagulopathy ("DIC"). If DIC sets in, the patient requires other types of transfusions like plasma and platelets, and the end result can be organ failure and even death. DIC is, unlike a 5-minute suction procedure, extremely dangerous and poses a significant risk.

20. In another instance, I had a patient in her late teens who already had a child and was scheduled to have an abortion in the first trimester. While awaiting her appointment, she went to see her OB/GYN who, knowing she was planning to have an abortion, falsely informed her that she was farther along in her pregnancy and that, in fact, she was too far along to have an abortion, which was also untrue.

21. Another recent patient, already a mother, thanked me for treating her with compassion and kindness. She explained that when she sought a referral for an abortion from her long-time provider, he verbally abused her. Rather than respecting her decision, the staff at that office gave her baby formula and prenatal supplies.

22. Under ethical principles and federal law, healthcare providers can refuse to perform a procedure, even in an emergency, as long as there is an alternate provider available.[6] Healthcare providers should not refuse to provide care, information, or referrals if doing so would prevent the patient from obtaining the care they need.

23. As healthcare providers, we take an oath to put the needs of our patients above our own. To the extent that the Rule tips the scale so far in favor of the provider (and non-medical staff) that it enables almost anyone in a hospital to not only refuse to provide care but to obstruct

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[6] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 6, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

the patient's ultimate access to care, it violates medical ethics and puts patients at risk.

24. There are countless individuals involved in the treatment of patients in any hospital setting. It takes a coordinated effort of multiple individuals with varying levels of training and professionalism to ensure that a patient receives care in a safe and timely manner: schedulers making appointments, receptionists checking patients in, medical assistants rooming patients, phlebotomists drawing blood for lab testing, technicians placing IVs, laboratory technicians running lab testing and entering results, radiology technicians performing ultrasounds, radiologists reviewing the resulting scans, technicians cleaning instruments, pharmacy technicians stocking medicines, pharmacists filling prescriptions, housekeeping cleaning exam rooms, billing staff getting pre-authorizations and billing for services, technicians transporting patients, and nurses to recover patients and administer medications. To the extent that the Rule would encourage or permit any of these individuals to object to what the Rule deems "assisting" in a procedure, the Rule would harm patient care in the hospital setting. It only takes one objecting individual at a hospital to bring the process to a grinding halt.

25. All of these scenarios discussed above describing harms to patients that result from delayed or denied abortion care impact patients in need of miscarriage management as well. In the context of miscarriage management, it is also often the case that patients are refused appropriate and timely treatments for miscarriages, even when carrying non-viable fetuses with no chance of survival, due to the presence of fetal cardiac activity.

26. When patients who need appropriate and timely treatments for miscarriages are denied such care, they are at risk of infections, sepsis, hemorrhage, DIC due to repeated transfusions as described above, and a greater risk of subsequent pregnancy complications or infertility. These delays in care compound the already deeply painful experience of losing a much wanted pregnancy.

27. As healthcare providers, we are in a position of power with respect to our patients. We have knowledge that they do not. We control their access to diagnostic testing and therapeutic treatments that they need to protect their health and lives. We hold the skills necessary to perform the procedures and surgeries they need. With that power comes a fundamental duty—to use our

power only to benefit the patient who has entrusted us with their life and health. We have an ethical responsibility to give them the information they need to make their own informed decisions and to either provide the treatment they need or refer them to someone who can. Withholding information or treatment, lying, or obstructing patient care is never the appropriate exercise of our duty to our patients.

28. Those hospitals across the U.S. where abortion is offered or can be offered—*i.e.*, not religiously-affiliated hospitals that provide no contraception or abortion services[7]—are already under great pressure to avoid providing contraception and abortion.

29. Hospitals across the U.S. are large businesses that demand significant administrative resources. The Rule, to the extent that it requires employers to permit an unprecedented number and type of refusals, is extremely unworkable for any hospital. Many hospitals already deem contraception and abortion too much trouble to protect because of the effort required to accommodate refusals and the additional expense they entail. To the extent that the Rule conflicts with policies requiring treatment of patients in emergencies and other requirements for patient care, it is both practically and financially untenable. When hospital

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[7] *See, e.g.*, Adam Sonfield, *In Bad Faith: How Conservatives Are Weaponizing "Religious Liberty" To Allow Institutions To Discriminate*, Guttmacher Policy Review (May 16, 2018) https://www.guttmacher.org/gpr/2018/05/bad-faith-how-conservatives-are-weaponizing-religious-liberty-allow-institutions; United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018) [hereinafter *Ethical and Religious Directives*]. The *Ethical and Religious Directives*, which govern all Catholic health institutions and must be integrated into any hospital wishing to merge with a Catholic facility, forbid doctors working in Catholic hospitals from participating in all abortion and contraception procedures and counseling, except "natural family planning." *Id.* at 19. The *Ethical and Religious Directives* also significantly restrict postpartum and direct sterilization, elimination of ectopic pregnancy, medical miscarriage management or other fetal loss, screening for fetal anomalies, assisted reproductive technologies like IVF, and HIV and STI prevention counseling. *See id.* at 18-19; *see also* Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage Of Medicine Report*, MergerWatch 1 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=XlfagUpjX2g9GXDKAyqHQHDUbig%3D ("Catholic hospitals operate under ethical directives that prohibit the provision of key reproductive health services (such as contraception, abortion, sterilization and infertility services). We documented instances in which, as a result of these directives, women suffering reproductive health emergencies — including miscarriages — have been denied prompt, appropriate treatment at Catholic hospitals." (citing *Ethical and Religious Directives*)).

administration is disrupted by refusals that threaten the organization and patient experience, reproductive healthcare pays the price. This has been true across the country.

30. In my capacity as Medical Director of MSFC, I am aware of the curricula at medical schools across the country in the 45 states where our chapters are located. Contraception and abortion have been marginalized in medical education in many areas. By pushing training in abortion and contraceptive services out of additional hospitals in the country, the Rule threatens to significantly constrict education of future physicians in contraception and abortion in the areas where it still exists.

31. A survey of our chapters at a cross-section of medical schools demonstrated that, while 85% of U.S. medical schools covered erectile dysfunction drugs, like Viagra, one out of four medical schools provide no education on IUDs, the most effective contraceptive method available.[8] And while almost 90% of medical students learn about counselling patients on prenatal care, less than half learn about counselling their patients on family planning.[9] This meager training in contraception is not commensurate with the need for such training. A sexually active woman who wants only two children will need contraception to prevent pregnancy for more than 30 years,[10] and 99% of American women aged 15-44 who have ever had sexual intercourse have used at least one contraceptive method.[11] There is no other class of medication that is more fundamental to the health and lives of the American population than contraception, yet most doctors leave medical school with inadequate and often inaccurate education and training in its provision. Despite the fact that almost half of all pregnancies in the U.S. are unintended and that all of these patients need pregnancy options counselling, only 30% of

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[8] *See* Steinauer J et al., *First impressions: what are preclinical medical students in the US and Canada learning about sexual and reproductive health?*, 80(1) Contraception 74 (2008).

[9] *Id.*

[10] *Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[11] Daniels K & Mosher WD, *Contraceptive methods women have ever used: United States, 1982-2010*, 62 *Nat'l Health Stat. Rep. 1* (2013).

medical schools cover this topic.[12] In addition, only a minority (40%) of medical schools covered first trimester surgical abortion, and of those schools that did cover abortion care, one third spent less than 30 minutes on the topic.[13] More than a third of schools spent more class time on erectile dysfunction drugs than on all methods of abortion.[14]

32. A student who participated in a lecture program I gave to 30-40 students at her medical school recently told me that she only received a short lecture on birth control pills and that much of the information conveyed during the lecture was medically inaccurate. Long Acting Reversible Contraception (LARC) methods, like IUDs and implants, were not mentioned at all, despite the fact that these methods are the most effective contraceptive methods available, 20 times more effective than birth control pills for adult women and 40 times more effective than birth control pills for teens.[15] When the student inquired of the professor about additional instruction in family planning, the professor stated that they did not want to "risk offending" any students opposed to contraception or abortion. Should the Rule go into effect, it will embolden refusals that will result in full exclusion of these topics from medical education.

33. At my initial lecture at MSFC's yearly intensive conference, I take the students through the most up-to-date contraceptive methods. I always poll the audience. Of the percentage of students who were taught anything about contraception, approximately half had learned medically inaccurate information.

34. In short, some medical schools already deem contraception and abortion too politically sensitive to include substantively. Others find it to be simply insignificant. This exclusion of contraception and abortion from mainstream medical education disserves patients because they will often see healthcare providers who are misinformed or underinformed about contraception and abortion, even if those providers do not oppose contraception and abortion.

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[12] *See* Steinauer, *supra* note 8.

[13] *See id.*

[14] *See id.*

[15] Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 New England J. of Med. 1998 (2012).

When women are not offered the most effective birth control options because their doctors are poorly trained in contraception, they have more unintended pregnancies, more abortions, and more pregnancy complications due to lack of birth spacing. This leads directly to worse maternal and child health outcomes as well decreased educational and professional attainment, and increased poverty. The Rule will make matters worse, and the health of women and children will suffer.

35. As described above, it is already the case that religious-based objections to care by institutions and individuals are pushing abortion and contraception care and training out of healthcare facilities across the country. There are, however, institutions and individuals that remain committed to providing and championing this care. These institutions have implemented thoughtful processes to accommodate religious refusals while protecting patient health and safety. If permitted to go into effect, the Rule will undermine these thoughtful processes, because it cannot be implemented in a manner that ensures patient health, and avoids liability for harms to patients, without providers risking the loss of all HHS federal funding. The Rule therefore creates extremely powerful incentives for even the most committed providers to stop providing abortion and contraception. As a result, these hospitals will be incentivized, if not forced, to forego providing contraception and abortion.

36. The provision of training in contraception has worsened since anti-choice advocates have cast contraception as equivalent to abortion. This messaging and others that emphasize the exceptionality or political sensitivity of contraception and abortion are fueled by the anti-choice movement, which is highly organized and well-funded.[16] The Rule is the regulatory embodiment of a biased approach to family planning that prioritizes the beliefs of the provider over the well-being of the patient, and it will impose this approach on every hospital in the U.S.

[16] *See, e.g.*, White K et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105(5) Am. J. of Pub. Health 851 (2015); *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

37. Contraception and abortion are essential components of healthcare.[17]

38. Patients have autonomy and the right to make personal health decisions that we, their healthcare providers, may disagree with. Our responsibility is to educate them about risks and benefits of the available treatment options and to provide them with the care they choose. We are free to practice medicine how we choose, as long as we stay within ethical boundaries and we do no harm. Withholding information critical to a patient's care or impeding a patient from receiving care when medically appropriate in unethical and causes harm. We have an ethical and professional duty to provide our patients with complete and accurate medical information and referrals to other providers for care that we are not capable or willing to provide.

39. OB/GYNs are specialists who serve pregnant persons. At least approximately half of any OB/GYN's patients are of reproductive age. To fail to provide them with any information or assistance with family planning, even by informing them that such options are available, is the equivalent to obstructing or denying care and impedes a patient's fundamental right to bodily autonomy.

40. Even outside the context of obstetrical and gynecological care, all manner of physicians and other providers routinely order pregnancy tests for patients. For example, pregnancy tests are performed routinely by all primary care providers, emergency physicians, surgeons prior to surgery, sub-specialists prior to starting certain medications, radiologists before imaging studies, and anesthesiologists prior to anesthesia. It is the most frequently ordered laboratory test on women in medicine.

41. It is standard medical practice for any provider ordering a laboratory test to be able to interpret the test results, to understand all potential treatment options based on the test results, to counsel the patient on all of their treatment options, and then to either provide appropriate

[17] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, *Committee Opinion No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015); American College of Obstetricians and Gynecologists College Executive Board, *College Statement of Policy: Abortion Policy*, American College of Obstetricians and Gynecologists (Nov. 2014), https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20190416T1311496019.

treatment or refer for treatment based on the test results.[18] The Rule's enforcement will press the relatively few hospitals providing contraception and abortion, and education about those services, to discontinue their commitment to reproductive healthcare, resulting in an expanding number of physicians who will not know how to counsel a patient who is pregnant. Many patients will be told they are pregnant by physicians who have little to no knowledge about contraception and abortion. This is particularly worrisome given that almost half of all people with a positive pregnancy test are experiencing an unintended pregnancy.[19] Many patients in that situation will not be told of all of their treatment options by their provider—no information about abortion (although 25% of pregnant persons choose abortion in their lifetime)[20] and no information about methods of contraception for future use.

42. When patients do not receive accurate or appropriate contraceptive counseling, women are at greater risk of unintended pregnancy and thus in greater need of abortion services.[21]

43. These outcomes of the Rule will be problematic even if the provider is only misinformed or underinformed. Other healthcare providers are opposed to contraception and abortion and will be emboldened by the Rule to actively prevent their patients from obtaining that care. To the extent that the Rule permits healthcare providers to obscure needed information, for example, to decline to tell a patient that she has a fetal anomaly until it is too late for her to have an abortion, it is unethical and threatens patient health and autonomy.

44. I have also encountered a resident in a rotation at a health center where I provide care. He told me that if he encountered any patients with an unintended pregnancy, he would not provide pregnancy options counselling himself or refer them to another healthcare provider who

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[18] *See* American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 363*: *Patient Testing: Ethical Issues in Selection and Counseling*, 109 Obstetrics & Gynecology 1021 (2007).

[19] *See Contraceptive Use in the United States*, Guttmacher Institute (July 2018), https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[20] *See* Jones & Jerman, *supra* note 1.

[21] *See* Lawrence B. Finer & Mia R. Zolna, *Declines in unintended pregnancy in the United States, 2008–2011*, 374 New England J. of Med. 843 (2016).

could, but rather, he would send them to a crisis pregnancy center, which do not provide any health care, so they could be convinced not to have an abortion. The Rule will encourage physicians like this resident to obstruct patient care.

45. Patients denied care will face increased health risks and be funneled into more expensive ports of entry into the healthcare system like emergency rooms or other acute care facilities.

46. In the interest of preventing unintended pregnancies, medical schools should be instructing students in evidence-based contraception.[22] If the Rule goes into effect, many medical schools will restrict their contraceptive education because they fear that they will be accused of violating the rule and because they wish to avoid complaints from students, professors, board members, or others who may object personally to the provision of contraception and abortion.

47. Some time ago, outpatient abortion clinics attempted to meet the educational needs of students and residents in family planning with external rotations. Many clinics have now closed due to increasing restrictions and political pressure.[23] The Rule will create and expand areas of the country where patients simply cannot access abortion care at all, and providers cannot become educated in effective family planning, creating both access and educational deserts.

48. MSFC strives to fill this gap. We already struggle to do so with our existing resources. Almost all people need reproductive healthcare at some point in their lives. Should the Rule go into effect, MSFC will be even less able to instruct the growing number of medical students and residents who want and need education in contraception and abortion so that they can meet the healthcare needs of their patients, and patients across America will pay the price.

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[22] *See* Blumenthal PD et al., *Strategies to prevent unintended pregnancy: increasing use of long-acting reversible contraception*, 17(1) Hum. Reprod. Update 121 (2011); Jennifer J. Frost et al., *Contraceptive Needs and Services, 2013 Update*, Guttmacher Institute (July 2015), https://www.guttmacher.org/report/contraceptive-needs-and-services-2013-update.

[23] The number of U.S. abortion-providing facilities declined 3% between 2011 and 2014 (from 1,720 to 1,671). Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017). The number of clinics providing abortion services declined 6% over this period (from 839 to 788). *Id.*

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 8/30/19 in Rochester, New York,

R. Phelps MD

Rachael Phelps, M.D., F.A.A.P.
Medical Director, Medical Students for Choice

EXHIBIT A

Curriculum Vitae

Rachael Phelps MD, FAAP

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Rochester, NY 14605

Rachael.phelps@ppcwny.org
(585)734-5379

EDUCATION:

The University of Rochester, Department of Family Medicine:
Fellowship in Family Planning (2000-2001)

The University of Rochester, Department of Pediatrics:
Residency in Pediatrics (1997-2000)
American Board of Pediatrics Certification (10/2000- present)

The Johns Hopkins University School of Medicine:
Doctor of Medicine (1997)

The Pennsylvania State University:
Bachelor of Science in Anatomy and Physiology (1992)
Minor in Fine Arts
University Scholars Program
Graduated Cum Laude
Dean's List (7/8 semesters)
Golden Key National Honors Society
Alpha Epsilon Delta Premedical Honors Society
Phi Lambda Upsilon National Honorary Chemical Society
Phi Sigma Eta Freshman National Honor Society

PROFESSIONAL EXPERIENCE:

- Medical Students for Choice (2019)
  - Medical Director
- Planned Parenthood of Central and Western New York (2014- present):
  - Medical Director (2014- 2018)
  - Program Director for the following clinical services (2014- 2018)
    - Medication Abortion
    - Surgical abortion
    - Basic Breast
    - Colposcopy
    - Early Pregnancy Evaluation and Management of Complications
    - Sedation
    - Ultrasound
  - Family planning staff physician (2014- 2018)
  - Abortion provider (2014- present)
- Planned Parenthood of the Rochester/Syracuse Region (2001- 2013):
  - Medical Director (2011- 2013)
  - Associate Medical Director (2009- 2010)
  - Medical Director of Surgical Services (2005-2009)
  - Program Director for Surgical services (2009-2013)
  - Program Director for Early Pregnancy Loss (2007-2013)
  - Program Director for Ultrasound (2005-2013)
  - Family planning staff physician (2002- 2013)
  - Abortion provider (2001-2013)
- University of Rochester Clinical Instructor in the Department of Obstetrics and Gynecology (2012-present)

- University of Rochester Clinical Instructor in the Department of Pediatrics (2001-present)
- Liletta trainer and Speaker's Bureau (2015- present)
- Implanon/Nexplanon Training Faculty (2006-present)
- Planned Parenthood Federation of America Accreditation Consultant Surveyor (2009-2013)
- University of Rochester- Department of Family Medicine- Reproductive Health Program: Clinical Faculty (2001-2005)
    - Provided clinical training and weekly seminars on contraception, abortion and ultrasound
- Visiting Faculty for National Institute of Health/ National Institute Child Health and Human Development: Preventing Unplanned Pregnancy: Advances in Hormonal Contraception (2003)
- Pediatric Links with the Community: Co-director (2001-2005)
- Anthony Jordan Teen Center: Clinician (1998-2002) Clinical Director (2001-2002)

LEADERSHIP and COMMUNITY SERVICE:

- Healthy Baby Network Board of Directors (2017-present)
- Planned Parenthood Federation of America's Medical Director's Council (2006-present)
    - Board of Trustees (2017-present)
    - CEO/Medical Director Partnership taskforce (2016-present)
- Physicians for Reproductive Health: Adolescent Reproductive and Sexual Health Education Project Faculty ARSHEP (2005-present)
- Planned Parenthood Medical Director Mentor (2012-present)
- Columbia University: New York Promoting and Advancing Teen Health (NYPATH) Initiative: Advisory Council (2011-2016)
- VOXENT Clinical Advisory Group (2013-2016)
- Planned Parenthood Federation of America's National Medical Committee Member (2008- 2014 & 2017)
    - Executive Subcommittee (2010-2014)
    - Nominating Subcommittee Chair (2014)
    - Nominating Subcommittee (2012 &2013)
    - Subcommittee Chair (2013 &2014)
- Actavis Women's Health Advisory Board (2014)
- ANSIRH Early Abortion Training Workbook 4th addition: Advisory Committee (2012)
- Association of Reproductive Health Professionals' Expert Medical Advisory Committee: Non-Hormonal Contraception Quick Reference Guide (2012)
- Association of Reproductive Health Professionals' Expert Medical Advisory Committee: Choosing a Birth Control Method Quick Reference Guide (2009 & 2011)
- Association of Reproductive Health Professionals and the National Campaign to Prevent Teen Pregnancy Expert Advisory Committee: Providers' Perspectives: perceived barriers to contraceptive use in youth and young adults (2007)
- University of Rochester Adolescent Medicine Fellowship Scholarship Oversight Committee (2007-2009 & 2011-2014)
- National Board of Directors for Medical Students for Choice (2006-2009)
    - Chair of Fundraising Committee (2006-2009)
- Centers for Disease Control Expert Focus Group: Hepatitis B Vaccination in Teens (3/02)

Medical School:

AMSA's Women's Rights Month: Chairperson (1992)
Women's Fund Association: President (1993-1995)
Johns Hopkins Medical Students for Choice: Founder and Co-President (1994-1995)
Johns Hopkins American Medical Women's Association Chapter: Founder (1994-1995)
Educator in Dunbar Teen Sexuality Education Program (1993-1995)
Hotline Crisis Counselor at the House of Ruth Shelter for Battered Women (1993)

Undergraduate:

Collegians Helping Aid Rescue Missions: Director (1990-1992)

AWARDS:

- National Council of Jewish Women Hannah G. Solomon Humanitarian Award (2017)
- The Dr. Barnett A. Slepian Memorial Fund Clinical Training Award (2012)
- Alpha Omega Alpha Honor Medical Society Alumni Induction by the University of Rochester (2011)
- The Medical Students For Choice Alumni Award (2010)
- American Medical Student Association: Women Leaders in Medicine (2010)
- Rochester Business Journal: Forty Under 40 (2009)
- University of Rochester Pediatric Residency Program: Blue Wig Award (1998)

PUBLICATIONS/RESEARCH:

Hillard: Practical Pediatric and Adolescent Gynecology 2013. Chapter author: Unintended pregnancy: options and counseling

Coles MS, Makino KK, **Phelps RH**. Knowledge of Medication Abortion Among Adolescent Medicine Providers. J Adol Health. 2012;50:383-388.

Coles MS, Makino KK, **Phelps RH**. Medication abortion knowledge among Adolescent Medicine providers. Poster presentation. Society for Adolescent Health and Medicine Annual Meeting. March 30, 2011. Seattle, WA.

Coles MS, Makino KK, **Phelps RH**. Barriers and supports to medication abortion provision by adolescent medicine providers. Poster presentation. North American Forum on Family Planning. 2011. Washington, DC.

Phelps RH, Dream Team: The European Approach to Teens, Sex and Love, in pictures. Slate Magazine (2010)

Phelps RH., Schaff E.A., and Fielding S.L. Mifepristone abortion in minors. *Contraception* 64 (2001) 339-344.

TRAINING OF RESIDENTS AND MEDICAL STUDENTS:

- University of Rochester Department of OB/GYN residency program- abortion training (2010-present)
- University of Rochester Family Medicine Residency program- pregnancy options counseling and abortion shadowing (2014-present)
- University of Rochester Division of Adolescent Medicine- pregnancy options counseling and abortion shadowing for all pediatric and internal medicine-pediatric residents during required adolescent medicine rotation (2007-present)
- University of Rochester Department of Internal Medicine Residency Program- women's health elective (2007-present)
- University of Rochester Department of Family Medicine Chief Resident– abortion and ultrasound training to competency (2007-2009)
- University of Rochester Division of Adolescent Medicine fellowship- abortion and ultrasound training to competency for 2 fellows, month elective for all others (2007-present)
- Rochester General Hospital Department of OB/GYN Residency Program- abortion and ultrasound training to competency (2005-present)
- University of Rochester Department of Family Medicine Ryan Family Planning fellowship– abortion and ultrasound training to competency (2005-2006)

- University of Rochester School of Medicine- reproductive health summer externship-2 students per summer (2005-present)
- University of Rochester Department of Emergency Medicine Residency Program- first trimester transvaginal ultrasound (2005-2009)
- University of Rochester Pediatric Links with the Community (Pediatrics, Family medicine and Internal Medicine-Pediatrics residents)- pregnancy options counseling (2001-present)

NATIONAL INVITED LECTURES AND GRAND ROUNDS:

- Albany Planned Parenthood Day of Action: Rally Keynote Speaker (2018)
- American Academy of Pediatrics National Conference: Contraception for Teens: Tips, Tricks and Tools (2017)
- Alfred State University: One in 3: This Common Secret (2017)
- Albany Planned Parenthood Day of Action: Rally Keynote Speaker (2017)
- MSFC Annual Conference: (2016)
    - Plenary: Reflections on the Election and the Future of Women's Access to Reproductive Health Care
    - Emergency Contraception: It's Complicated! Providing Our Patients with a Last Chance to Prevent Pregnancy
    - One in 3: This Common Secret… How to have a Conversation about Abortion
    - Practitioners' Perspectives Panel
- University of Rochester Annual Anne E. Dyson Pediatrics Grand Rounds and Child Advocacy Forum (2016)
    - Panel Discussion: "Solutions Summit: Making Progress against Poverty, School Failure and Childhood Disease by Investing in Effective Teen Pregnancy Prevention"
    - Preventing Teen Pregnancy with Long-Acting Reversible Contraception (LARC)
- Duval County, FL: Teens and LARC: Fact, Fiction & First Line Contraception (2016)
- Duval County, FL: Providing Evidence Based Contraception for Adolescent Patients (2016)
- American Academy of Pediatrics National Conference: Evidence Based Contraception for Adolescents (2015)
- Indian Health Service National Webinar: Teens and LARC: Fact, Fiction & First Line Contraception (2015)
- Adolescent Reproductive and Sexual Health Education Project Annual Faculty Conference (2014)
    - EC Update
    - Evidence Based Contraception
    - LARC and Teens
- MSFC Annual Conference: (2013)
    - Beyond Abstinence and Risk: Exploring a New Paradigm for Teen Pregnancy Prevention
    - Evidence Based Contraception: Providing the Best Birth Control To Your Patients
    - Practitioners' Perspectives Panel
- National Abortion Federation Annual Conference: Beyond Abstinence and Risk: Exploring a New Paradigm for Adolescent and Young Adult Sexual Health (2013)
- Adolescent Reproductive and Sexual Health Education Project Annual Faculty Conference: Adolescent Medicine Specialists and Abortion Care: Overcoming Barriers (2013)
- American Medical Student Association Annual Conference (2013)
    - Abortion Provision: What It Means To Make It a Part of Your Career
    - Clinical Session: Manual Vacuum Aspiration Papaya Workshop
- Medical Students for Choice Annual Conference (2012)
    - Barriers to the Best Birth Control: What Stands in Women's
    - Evidence Based Contraception: Providing the Best Birth Control to your Patients
    - Practitioner's Perspectives Panel
- Champlain Valley Physician's Hospital Grand Rounds David McDowell Reproductive Health Lectureship Series: Lessons from Europe: Adolescent Pregnancy Prevention (2012)

NATIONAL INVITED LECTURES (cont.):

- Bassett Medical Center (2012)
  - Pediatric Grand Rounds: Evidence Based Contraceptive Care for Adolescents
  - Interdisciplinary Grand Rounds: Contraceptive Counseling: Dispelling Myths and Assessing Risk

- SUNY Upstate Department of Pediatrics Grand Rounds: Evidence Based Contraception for Teens (2012)
- American Medical Student Association Annual Conference: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2012)
- SUNY Upstate Pediatrics Grand Rounds: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2011)
- Medical Students for Choice Annual Conference (2011)
  - Intrauterine Contraception: The BMW of Birth Control
  - Evidence Based Contraception: Providing the Best Birth Control to your Patients
  - Practitioner's Perspectives Panel
- Northern Ontario School of Medicine: Evidence Based Contraception (2011)
- Funders Network on Population, Reproductive Health and Rights
  Washington Briefing: Keynote address: Why I am an Abortion Provider (2011)
- Planned Parenthood of Southeastern Pennsylvania Annual Fundraiser: Keynote speaker: Why I am an Abortion Provider (2011)
- George Washington University School of Medicine: Current and Future Barriers to Abortion Access (2011)
- NAF Annual Conference Closing Plenary: "Owning Our Moral Center" (2011)
- PPFA National Leadership Conference: Why I am an Abortion Provider (2010)
- Medical Students for Choice Annual Conference (2010)
  - Keynote Address: An MSFCer's Personal Reflections: Current and Future Barriers to Abortion Access for Women
  - Evidence Based Contraception
  - Practitioner's Perspectives Panel

- American Medical Student Association Annual Conference: Post Abortion Care: Improving Maternal Mortality in the Developing World (2010)
- University of Rochester Department of OB/Gyn Grand Rounds: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- RGH Department of Pediatrics Grand Rounds : We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2009)
- Indian Health Service Adolescent Health Conference on the Navajo Nation (2009)
  - Contraception for Adolescents
  - Pregnancy Options Counseling for Teens
- University of Utah School of Medicine MSFC: Unplanned Pregnancy and Abortion in the U.S. (2009)
- ARHP Webinar: Choosing a Birth Control Method (2009)
- Medical Students for Choice National Leadership Training Conference (2009)
  - Keynote Address: Why I Provide Abortions
  - Abortion 101
  - Practitioner's Perspectives Panel
- University of Buffalo: American Medical Student Association: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)

- Western Regional Medical Students for Choice Conference: Keynote: Better than a Ban: Proven Practices to Decrease Abortion through the Prevention of Unplanned Pregnancy (2009)

NATIONAL INVITED LECTURES (cont.):

- American Medical Student Association Annual Conference: Fear and Loathing: How the U.S. Approach to Adolescent Sexuality Differs from the Rest of the World and What We Can Do About It (2009)
- University of Rochester Department of Pediatrics Annual Dyson Day Grand Rounds: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- University of Rochester Annual Anne E. Dyson Pediatrics Grand Rounds: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2009)
- Vanderbilt School of Medicine Women's Health Week: We Can Do Better: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- Medical Students for Choice Annual Conference (2008):
  - The BMW of Birth Control: Implanon Workshop
  - Practitioner's Perspectives
  - How Late is "Too Late"? Considering Our Comfort with Gestational Age and Abortion
- Brown School of Medicine's Annual Reproductive Health Donor Lecture: We Can Do Better: Proven Practices to Decrease Abortion through the Prevention of Unplanned Pregnancy (2008)
- University of South Dakota: Better than a Ban: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- South Dakota State University: Better than a Ban: Proven Practices in the Prevention of Unplanned Pregnancy (2008)
- Children's National Medical Center: Options Counseling for Pregnant Adolescents (2008)
- Medical Students For Choice Annual Conference (2008):
  - EC Advanced Edition: The Controversy, the Evidence and Remaining Questions
  - Practitioner's Perspectives
  - Closing Plenary: Preventing Unplanned Pregnancy and Abortion in the U.S. and Canada: What Can We Learn from Europe?
- Medical Students For Choice Annual Conference (2007):
  - International Family Planning and Reproductive Health
  - Practitioner's Perspectives
  - How Late is "Too Late"? Considering Our Comfort with Gestational Age and Abortion
- American Medical Students Association 57th Annual Convention: The Right to Reproductive Choice: Bringing it Home to Our Curricula (2007)
- Medical Students for Choice Southeastern Regional Conference (2006):
  - Keynote Address
  - Abortion Provider Panel
  - Manual Vacuum Aspiration Workshop
- Medical Students for Choice National Leadership Training Program: Keynote address: Physicians as Leaders for Choice (2006)
- Southeastern Regional Medical Students for Choice Conference(2005):
  - Unplanned Pregnancy: Why is the U.S. Failing?
  - Preventing Maternal Mortality through Post Abortion Care
- American Academy of Physician Assistants Annual Conference: Advanced Gynecologic Procedures Workshop (2004)
- National Abortion Federation Mifepristone Early Options Series (2001):
  - Continuum of Patient Care
  - Patient Management
- National Abortion Federation Annual Conference: Advanced Medical Abortion Management (2001)

LOCAL INVITED LECTURES:

- Rochester General Hospital Department of OB/GYN Residency Program:
  - Unplanned Pregnancy and Abortion in the U.S. (annually 2005-present)
  - Medication Abortion (annually 2005-present)
  - Surgical Abortion Techniques (annually 2005-present)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: How to Advocate through Speaking to the Media (annually 2002- present)
- MCTP Youth Leaders: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- Highland Family Medicine Leadership Track: Political Advocacy and Reproductive Health (2017)
- PPCWNY Rochester Donor event: Panel Discussion with Dr. Willie Parker (2017)
- Trillium Outreach Staff: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- NCJW: One in 3: This Common Secret (2017)
- Healthy Baby Network Annual Meeting Keynote: Life, Liberty & the Pursuit of Happiness: Why health care should be a right not a privilege (2017)
- URMC Pediatric Residency: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- MCTP Youth Workers: Teens and LARC: Fact, Fiction and First Line Contraception (2017)
- Delaware Pediatrics: Evidence Based Birth Control for Adolescents (2016)
- St. John Fisher College: School of Nursing: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- The WNY Women's Bar Association & SUNY Buffalo Law School: Whole Women's Health Care V. Cole: Will Administrative Regulations be the Undoing of Roe v. Wade? (2016)
- Pediatric Emergency Medicine Fellows Conference: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- Rochester City School District: Teens and LARC: Fact, Fiction and First Line Contraception (2016)
- MSFC SUNY Upstate: Evidence Based Contraception (2016)
- URMC Annual Pediatric Nursing Conference: STIs and Adolescents: Screening, Diagnosis and Treatment (2016)
- PPCWNY Annual Cocktail Reception: One in 3: This Common Secret (2016)
- Ithaca Ending Abortion Stigma: Pro-Choice and the Medical Professional: How to Live it. How to Support it (2016)
- PPCWNY Former Board Member Luncheon: Reflections on the Election and the Future of Women's Access to Reproductive Health Care (2016)
- Nurse Family Partnership: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Roe v Wade Anniversary Panel (2015)
- A Path Appears: Panel discussion at The Little on teen pregnancy and poverty (2015)
- Perinatal Network: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- SOAR youth leaders: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Pediatric Nursing Conference: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- University of Rochester Pediatrics Residency: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- Teens' Health and Success Partnership: Teens and LARC: Fact, Fiction and First Line Contraception (2015)
- NYPATH statewide webinar: Teens and LARC: Fact, Fiction & First Line Contraception (2014)
- AAP Contraceptive Updates for the Pediatrics Practice: Evidence Based Contraception (2014)
- The Susan B. Anthony Institute of Women and Gender Studies: Women's History Month Panel: The Last Clinic (2014)
- Chatterbox Luncheon Lecture: 1 in 3: Dispelling Myths About the "A" Word (2014)
- SUNY Upstate School of Medicine: Evidence Based Contraception (2014)

- Rochester Village Educators Network: LARC and Teens (2014)
- Perinatal Network: LARC and Teens (2014)
- Youth Services Quality Council: LARC and Teens (2014)

LOCAL INVITED LECTURES (cont.):

- March of Dimes Mothers To Be: Choosing the Best Birth Control Postpartum (2013)
- University of Rochester MSFC: Pregnancy Prevention: Lessons from Europe (2013)
- SUNY Upstate School of Medicine: Evidence Based Birth Control (2013)
- Onondaga County Pediatric Society: Barriers to Birth Control Access: What Stands in Teens' Way (2012)
- Finger Lakes Perinatal Network Forum: Evidence Based Contraception: How to Advocate for the Best Contraception for Women (2012)
- SUNY Upstate School of Medicine MSFC: Abortion Provider panel (2012)
- University of Rochester School Of Medicine MSFC: Advocating for Abortion Care (2012)
- SUNY Upstate School of Medicine MSFC: Evidence Based Contraception (2012)
- Finger Lakes Regional Perinatal Network Forum: Evidence Based Contraception (2011)
- Monroe County Case Workers: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2011)
- Rochester City School Summit on Condoms in Schools: Panelist (2011)
- University of Rochester Family Medicine: Evidence Based Contraception (2011)
- RIT Osher Pfaudler Lecture Series: We Can Do Better : Proven Practices to Prevent Teen Pregnancy (2011)
- University of Rochester Department of Pediatrics Leadership Education in Adolescent Health Fellowship Seminar: Unplanned Pregnancy, Abortion, and Adolescents (annually 2002-2011)
- University of Rochester Adolescent Medicine Education Series:
    - Evaluation and Management of Abnormal Pregnancy (2007-2010)
    - Follow-up and Management of Medical and Surgical Abortion Complications (2007-2010)
- Orgasm Inc. "Talk Back at The Little" Panelist (2010)
- University of Rochester Medical Students for Choice Chapter: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- Rochester Area Tipsters Club: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2010)
- University for Rochester Internal Medicine- Pediatrics Noon Conference : Evidence Based Contraception (2010)
- Albion Correctional Facility : Evidence Based Contraception (2010)
- University of Rochester Medical Students for Choice Chapter: Introduction to surgical abortion techniques and Papaya workshop (2010)
- University of Rochester Med/Peds Noon Conference: Evidence Based Contraception (2010)
- Roe v. Wade Anniversary Celebration: Keynote: Protecting Our Future: A Report form the Front Lines (2010)
- Metro Council for Teen Potential: Contraception Update (2009)
- Nurse Family Partnership: Birth Control Update (2009)
- Batavia Community Lecture: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- University of Rochester Medical Students for Choice Chapter: Why I Became an Abortion Provider (2009)
- Building Healthy Children: We Can Do Better: Proven Practices to Prevent Teen Pregnancy (2009)
- Strong Memorial Hospital Inpatient Adolescent Psychiatric Department: Birth Control Workshop (2009)
- Threshold Adolescent Clinic : Options Counseling (2009)

- University of Rochester School of Medicine: 2nd year medical student OB/GYN core lecture: Medical Aspects of Abortion (2008-2012)
- University of Rochester Department of Pediatrics Noon Conference: Pregnancy Options Counseling (2009)

LOCAL INVITED LECTURES (cont.):

- University of Rochester Medical Students for Choice Chapter: Why I Became an Abortion Provider (2009)
- Lifetime Care Visiting Nurses: Evidence Based Postpartum Contraception (2009)
- University of Rochester Department of Family Medicine Residency lecture: Evidence Based Contraception: Providing the Best Birth Control to Your Patients (2008)
- Barnett Slepian's 10th Anniversary Memorial Service: Guest Speaker (2008)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: Preventing Teen Pregnancy (2007 & 2008)
- University of Rochester Medical Students for Choice Chapter: Provider Panel (2008)
- Rochester General Hospital Department of OB/GYN Grand Rounds: Emergency Contraception and Adolescents (2007)
- Nazareth College Undergraduate Human Sexuality Course Guest Lecturer: Reproductive Health Care Access in the US (2007)
- The Western New York Council Of Child and Adolescent Psychiatry: Adolescent Reproductive Health Care Update (2007)
- University of Rochester Medical Students for Choice: Manual Vacuum Aspiration Papaya Workshop (2006)
- Nazareth College Graduate Global Feminism Seminar (2006):
  - Improving Maternal Mortality through Post Abortion Care
  - Unplanned Pregnancy and Abortion: Why is the U.S. Failing?
- SUNY Upstate Medical Students for Choice: Unplanned Pregnancy and Abortion: Why is the U.S. Failing (2006 & 2007)
- University of Rochester Medical Students for Choice: Physicians as Leaders for Choice (2006)
- University of Rochester Department of Pediatrics Community Advocacy in Residency Education Program: International Work that Makes a Difference: Keys to Success (2006)
- University of Rochester Department of Pediatrics Resident Conference: HPV and Pap Management (2006)
- University of Rochester Women's Caucus: Panel on female sexuality and the double standard (2006)
- University of Rochester Pediatric Resident Conference: Hormonal Contraception in Adolescents (2006)
- University of Rochester Department of Pediatrics Resident Conference: Unplanned Pregnancy and Abortion in Adolescents (2006)
- SUNY Upstate Medical University Department of OB/GYN Grand Rounds: Unplanned Pregnancy and Abortion in the U.S. (2005)
- University of Rochester Department of Family Medicine Reproductive Health Program Seminar Series (weekly 2001-2005):
  - Week 1: Contraception: Evidence Based Use of Oral Contraceptives, Emergency Contraception, and New Contraceptive Technologies
  - Week 2: Vaginal Ultrasound: Normal Anatomy, Normal and Abnormal Pregnancy
  - Week 3: Medical Abortion: Regimens, Counseling, and Patient Management
  - Week 4: Surgical Abortion: Surgical Technique, Complications, Tissue Examination and International Post Abortion Care
- University of Rochester Department of OB/GYN 3rd year medical student lecture: Introduction to Abortion (monthly 2003-2005)
- Planned Parenthood of the Southern Finger Lakes: First Trimester Ultrasound: Lecture and Clinical Practicum (2004)

- Planned Parenthood community lecture: Politicians Prescribing Women's Health Care without a License (2004)
- University of Rochester Medical Students for Choice: Improving Maternal Mortality in the Developing World through Post Abortion Care (2004)

LOCAL INVITED LECTURES (cont.):

- Planned Parenthood Chatterbox Society Luncheon: Understanding Teen Sexuality (2003)
- University of Rochester Medical Students for Choice: Preventing Teen Pregnancy (2003)
- 30th Anniversary of Roe v. Wade (Rochester, NY): Keynote Address (2003)
- University of Rochester Department of Pediatrics Resident Conference: Unplanned Pregnancy and Abortion in Adolescents (2003)
- University of Rochester Department of Family Medicine: Unplanned Pregnancy in Adolescence (2001)

- University of Rochester Amnesty International Panel: The Impact of the "Global Gag Rule" (2001)
- University of Rochester School of Medicine: Interviewing the Adolescent Patient (2001)
- University of Buffalo Medical Students For Choice: Introduction to Mifepristone Medical Abortion (2001)
- University of Rochester Pediatric Resident Conference: Hormonal Contraception in Adolescents (2001)
- University of Rochester Health Services: Introduction to Medical Abortion (2001)
- Roe v Wade Anniversary Panel: Medical Abortion and Emergency Contraception (2001)
- Annual Nurse Practitioner Conference: Adolescent Contraception (2000)

MEDIOGRAPHY:

- NPR WXXI Evan Dawson Connections: Pro-choice advocates discuss a possible post-Roe v. Wade world (2018)
- NPR WXXI Evan Dawson Connections: Dr. Willie Parker and Reproductive Rights (2017)
- NPR WXXI: "When to Get Your Next Mammogram or Cervical Cancer Screening? Most Women Don't Know" (2016)
- NPR WXXI: Radio Guest on Connections w/ Evan Dawson: "The Future of Women's Health if Roe v. Wade is Overturned" (2016)
- Syracuse Post Standard Letter to the Editor "Family planning is key to solving the world's problems" (2016)
- Rochester Democrat and Chronicle: Guest Essay "Info to know about Zika" (2016)
- Vox: "The biggest myth about abortion that you probably believe is true" (2016)
- Syracuse Post Standard Commentary: "Congress must reject move to gut family planning aid" (2015)
- NPR WXXI: Radio Guest on Connections w/ Evan Dawson: Access to Abortion (2014)
- Time Warner Cable: LARC and Teens (2014)
- Slate Magazine: Quoted in "The Cleverest New Anti-Abortion Law" (2013)
- NPR WXXI radio interview: EC over the counter for teens (2013)
- Syracuse Post Standard Letter to the Editor "Stay Healthy by getting STD tests and treatment" (2012)
- ABC News online: Quoted in "Teens Should be Offered IUDs, Top Doctors Group Says" (2012)
- Rochester Democrat and Chronicle Letter to the Editor "Access to Contraception Good for Women's Health" (2011)
- Syracuse Post Standard Letter to the Editor "Stop Playing Politics with Women's Lives" (2011)
- Syracuse Post Standard Letter to the Editor "Medication Abortion Can Save Lives of Women" (2010)
- NPR Pat Morrison Show "The New Abortion Providers" (2010)
- New York Times Magazine: Profiled in "The New Abortion Providers" (2010)

- Syracuse Post Standard: In defense of Roe v. Wade: Dr. Rachael Phelps, associate medical director of Planned Parenthood of the Rochester/Syracuse Region, comments on 37th anniversary of Supreme Court ruling (2010)
- Youth Pages: Shifting the Paradigm of Adolescent Sexual Health (2009)

MEDIOGRAPHY (cont.):

- Rochester Democrat and Chronicle: Guest editorial on the New York State Reproductive Health and Privacy Protection Act (2008)
- WHEC Channel 10: New York State Reproductive Health and Privacy Protection Act (2008)
- The Citizen, Auburn, NY: Editorial on federal abortion ban (2007)
- In Good Health: "IUDs and Implanon: Birth Control's Best Kept Secrets" (2007)
- Rochester Democrat and Chronicle Friday Face-off: Guest editorial and on-line debate on federal abortion ban (2007)
- Syracuse University Newspaper interview: Implanon (2007)
- Syracuse University Newspaper interview: HPV (2006)
- In Good Health interview: Abortion Access in Western New York (2006)
- In Good Health interview: Medication Abortion (2006)
- Syracuse Post Standard: Editorial on pharmacist provision of emergency contraception (2005)
- WHEC Channel 10: Teens and sex (2005)
- R News: HPV and HSV in adolescents (2004)
- Rochester Democrat and Chronicle interview: Herpes (2004)
- R News: Teen pregnancy (2003)
- Syracuse NPR: Partial birth abortion (2003)
- WROC Channel 8: Teen sexuality (2003)
- WHEC Channel 10: Condoms and HIV(2003)
- WARM radio Hillside Family Forum: Planning a healthy pregnancy (2003)
- WROC Channel 8: Jordan Teen Center's future (2002)

MEDIA TRAINING:

- Fellowship in Family Planning Communications Workshop (2012)
- PPFA Media Training Workshop at NMC (2010)
- Medical Students for Choice Media Training Workshop (2006)
- National Abortion Federation Media Training Workshop (2001)

INTERNATIONAL EXPERIENCE:

- **Kenya**: Policy work to legalize abortion with IPAS (2001)
- **Bangladesh**: Post-abortion care clinical trainer with Engender Health /AVSC International (2001)
- **Philippines**: Post-abortion care clinical trainer with Engender Health / AVSC International (2001)
- **Pakistan**: Post-abortion care clinical trainer with Engender Health / AVSC International and International Rescue Committee in Afghan refugee camps in Tribal Belt of Northwest Frontier Province (2000)
- **Kenya**: Introduction to post-abortion care and the management of complications of illegally induced abortion with IPAS (2000)

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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
No. C 19-02769 WHA
No. C 19-02916 WHA

DECLARATION OF STIRLING PRICE 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, Stirling Price, declare:

1. The matters stated in this declaration are true based upon my own personal knowledge, except as to those matters stated on information and belief, and as to those matters, I believe them to be true, and if called as a witness, I would competently so testify.

2. I am employed by the California Department of State Hospitals (DSH). I was appointed in August 2019 as the DSH Chief Deputy Director. I report to the Director of the Department of State Hospitals. In my position as the Chief Deputy Director of DSH, my duties include briefing the Director on any significant matters pertaining to DSH. As the Chief Deputy Director, five executive directors of the five state hospitals report to me. In addition, the deputy directors of the following DSH's divisions report to me: Legal, Forensic Services, Statewide Quality Improvement, Hospital Strategic Planning and Implementation, Administrative Services, Clinical Operations, Office of Protective Services, and Technology Services. My current duties as the Chief Deputy Director include the following: I attend all the DSH executive team meetings regarding DSH policy and procedures. I am involved in DSH matters concerning the Health and Human Services Agency, other DSH control agencies, and public and private stakeholders. I also attend budget hearings before the state legislature.

3. Prior to being appointed as DSH's Chief Deputy Director, I was the Acting Chief Deputy Director from September, 2018 to August, 2019. Prior to being appointed as Chief Deputy Director, I was the Executive Director of DSH-Atascadero. I was in this position from January 1, 2015 to August 31, 2018. Prior to working at DSH-Atascadero, I was the interim Deputy Director, Forensic Services. Prior to that, I was the Executive Director for DSH-Stockton. I was in this position when the hospital opened on July 22, 2013. This facility is now under the jurisdiction of the California Department of Corrections and Rehabilitation (CDCR). Prior to working at DSH-Stockton, in 2011 I was the Executive Director at the DSH-Vacaville Psychiatric Program and the acting Executive Director at DSH-Salinas Valley Psychiatric Program, both of which are currently under the jurisdiction of CDCR. In May 1981, I earned an Associate of Arts degree from Los Angeles Valley College. In May 1989, I earned a Bachelor of Arts Degree in Social Work from California State University, Sacramento. In May 1991, I earned

a Master's Degree in Social Work from California State University, Sacramento. In 1994, I became a California Licensed Clinical Social Worker (LCSW).

4. DSH is one of 16 departments and offices in the California Health and Human Services Agency. DSH manages the California state hospital system, which provides mental health services to patients admitted into DSH facilities. The department strives to provide effective treatment in a safe environment and in a fiscally responsible manner. DSH oversees five state hospitals: Atascadero, Coalinga, Metropolitan (in Los Angeles County), Napa and Patton. As of 2018, the department employs more than 11,000 staff and serves more than 12,000 patients annually in a 24/7 hospital system.

5. In the last ten years, the population demographics of DSH has shifted from fewer civil court commitments to primarily a forensic population committed through the criminal court system. Approximately 91 percent of the patient population is forensic. The remaining 9% are patients admitted in accordance with the Lanterman-Petris-Short (LPS) Act (mental health confinements).

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 (Rule), and published in the Federal Register on May 21, 2019.

7. The Rule will impose an immediate cost on DSH due to its notice, assurance and certification, recordkeeping, and reporting requirements. The Rule has already imposed costs on DSH as DSH has been required to spend approximately fifteen hours reading and analyzing the Rule, and attempting to determine its impact on DSH programs and whether programmatic changes are necessitated.

8. The Rule creates a broad exemption for medical professionals and personnel to opt out of healthcare services based on a moral or religious ground. Specifically, personnel may opt out of healthcare services involving abortion, sterilization, and euthanasia. Further, the rule appears to enable objections to providing a broad range of healthcare services, including certain vaccinations if there is an "aborted fetal tissue" connection (rubella, polio, Hep A, chickenpox, small pox), contraception, gender transition/gender dysphoria (counseling, administering

hormone prescriptions, etc.), tubal ligations, hysterectomies, and assisted suicide. There does not appear to be any exception provided for emergency situations under the Rule.

9. DSH does not deny medically necessary care for its patients. Thus, as a result of the Rule, DSH would be required to adopt a Policy Directive that would enforce the patient's legal right to necessary medical treatment (even though it may be against an employee's religious beliefs). Specifically, the policy would state that any legally and medically required service with patient consent or a court order, shall be provided by DSH staff or DSH contractors.

10. Currently, if staff refuse to perform work due to a religious belief, substitute staff is brought in to perform the objected-to service. But the Rule expands the scope of objections that can be made to include objections on the basis of "conscience, religious beliefs, or moral convictions" to not just services such as abortion, sterilization, and euthanasia (none of which DSH performs), but also "other health services." 84 Fed. Reg. 23170, 23228. And the Rule will be unworkable if it permits a medical provider to refuse "other health services" without notifying a supervisor of the denial of service, or without providing notice or alternative options and/or referrals to patients.

11. The notification provision of the Rule will impose costs on DSH. Although the Rule indicates that the notice provisions are now voluntary (unlike in the proposed rule), the Rule also states that adherence to the notice provisions will be taken into consideration when assessing whether an agency is in compliance. To provide notice, DHS will need to: (1) post the notice in Appendix A (or similar text) at each DSH establishment where notices to the public and workforce are customarily posted, and thereafter continuously take steps to ensure that the notice is not altered, defaced, or covered by other materials, (2) include the notice on each of its websites, and (3) include the notice in its personnel manuals, applications, and benefits and training materials, as inclusion in these materials will be a factor in determining whether DSH is in compliance. The estimated costs of compliance with these notification provisions is approximately $600 per hospital, due to the necessary changes to websites, physical postings at all five hospitals and administrative facilities, as well as costs associated with updates to training manuals, new employee documentation, internship materials, and updates to benefits handbooks.

12. The Rule will require DSH to create and draft a new policy in response to its requirements. DSH estimates the cost of creating this new policy at $2,000, taking into account preparation costs and legal review. In addition, the Rule will require DSH legal staff to interpret and give advice, especially in the first year. DSH estimates costs of $4,000 for these services in the first year.

13. However, the aforementioned figures do not include costs that may be associated with the assurance, certification, and record-keeping requirements, to the extent that they apply, that should be included with all applications, reapplications, and amendments and modifications. Notably, under the compliance provision, if a sub-recipient (as defined by the Rule) is found in violation, DSH will be subject to remedial action. This Rule thus places some oversight obligation on DSH which could result in additional staffing costs to engage in this sub-recipient monitoring component. This is significant because DSH contracts out for several health services for its patients to off-site entities.

14. The Rule places at risk federal funds DSH receives from the U.S. Department of Health and Human Services. In fiscal year 2017-2018, DSH received $4.6 million in Medicare revenue; only about $429,000 of this was Medicare Part B funding and not considered Federal Financial Assistance under the Rule. Loss of approximately $4.2 million of federal funding would have a grave impact on DSH operations and its ability to continue to provide services to its population. DSH would be unable to absorb such a large loss of funding without a reduction in staffing and services.

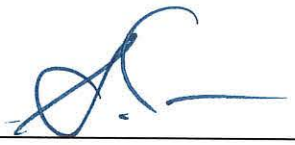
15. On the contrary, DSH already operates under a constrained budget and continues to seek solutions to address the significant growth in its patient population. As of December 31, 2018, DSH had a total of 1,101 patients pending placement, of which 815 were Incompetent to Stand Trial (IST). DSH continues to explore alternatives both in the state hospitals and through contracted facilities to address the waitlist. Thus, a loss of funding in the magnitude of $4.2 million (either because it, a sub-recipient, or another California agency is found in violation) would only further diminish DSH's ability to serve its population.

16. DSH receives federal Medicare funds and this impacts the development of its annual budget. These federal funds are put at risk under the Rule and can upset current and future budget years. The annual budget process is a complex process. The Governor must submit a budget to the Legislature by January 10. If proposed expenditures for the budget year exceed estimated revenues, the Governor is required to recommend sources for additional funding. (State of California Department of Finance website, "California's Budget Process.") State agencies prepare their budgets pursuant to instructions of the Director of Finance. DSH must use the current department's level of funding as a base amount to be adjusted by budget change proposals (BCPs). The BCPs are submitted to the Department of Finance (DOF) for review and analysis. The resulting Governor's Budget includes details for each department's past, current and future budget years. By statute, DOF is required to give the Legislature all proposed adjustments, other than the Capital Outlay and May Revision, to the Governor's Budget by April 1. Capital Outlay adjustments are due by May 1. Traditional May Revision adjustments are due by May 14. By constitutional requirement, the Governor's Budget must be accompanied by a Budget Bill itemizing the recommended expenditures to be introduced in the Legislature. The Constitution requires the Legislature to pass the bill by June 15. Some proposed budget changes will require changes to existing law. Subsequently, budget implementation bills, called "trailer bills" are heard concurrently with the Budget Bill. By law, all proposed statute changes necessary to implement the Governor's Budget are due to the Legislature by February 1. DSH's current budget under the Budget Act of July 2019 was determined without any input regarding loss of federal funding due to the Rule. Likewise, future budget years could be impacted by the loss of Medicare funds.

17. DSH does not have budgeted funds that can supplant the federal funds placed at risk by the Rule. DSH's mission critical services are never overfunded. For example, the capacity of DSH's five state hospitals is outpaced by California's ever-increasing forensic population. DSH is unable to admit these patients as readily as the courts order which subjects DSH to further action by the courts. Consequently, DSH cannot afford the loss of available federal funding due to the Rule. A sudden disruption in anticipated federal funds would cause serious budgetary and operational deficiencies.

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 September 9, 2019 in Sacramento, California.



Stirling Price
Chief Deputy Director
California Department of State Hospitals

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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 RANDY PUMPHREY, D.MIN., LPC, BCC, SENIOR DIRECTOR OF BEHAVIORAL HEALTH, WHITMAN-WALKER HEALTH, 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, Randy Pumphrey, declare:

1. I am the Senior Director of Behavioral Health at Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker). After earning a B.S. in American Studies, I received Masters of Divinity and Doctor of Ministry degrees from Wesley Theological Seminary. I initially worked as a Board Certified Chaplain at St. Elizabeth's Hospital (which became the Commission on Mental Health Services for the District of Columbia and the Psychiatric Institute of Washington), and subsequently received my Professional Counselor Licensure in 1997. I have worked in mental-health and substance-use-disorder treatment since 1984, initially as an intern at Washington Hospital Center, then with St. Elizabeth's Hospital. In 1998 I became the Clinical Director of the Lambda Center, a joint partnership between the Psychiatric Institute of Washington and Whitman-Walker Clinic. I joined Whitman-Walker's staff in 2007 as the Manager of Mental Health Services, and became Senior Director of Behavioral Health in 2015. In addition to managing Whitman-Walker's behavioral-health services, I maintain a panel of patients for whom I provide direct care. 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

2. As the Senior Director of Behavioral Health, I oversee Whitman-Walker's robust portfolio of mental-health services, and substance-use-disorder-treatment services. Our mental-health services include individual and group psychotherapy, psychiatry, and peer counseling. For individuals struggling with substance misuse, we offer individual and group counseling and support, and Medically-Assisted Treatment (MAT). In 2018, we provided mental-health or substance-use-disorder-treatment services to 2,342 patients. Our psychiatrists, psychologists, licensed psychotherapists, and trained peer counselors have a special mission to the lesbian, gay, bisexual and transgender (LGBT) community, and also to individuals living with HIV and their families and caregivers.

3. Many if not most of the individuals in our very diverse behavioral-health-patient population face considerable stigma and discrimination—as people living with HIV, as sexual or gender minority people, as people of color—and many of them struggle with internalized stigma

and with acute or lower-level but persistent trauma. Many of them have experienced difficulty in finding therapists or other mental-health or substance-use-disorder professionals who are understanding and welcoming of their sexual orientation, gender identity, or struggles with HIV. We frequently receive phone calls and other inquiries from people seeking non-discriminatory, welcoming assistance with their substance use, depression, anxiety, or other challenges. Many of these individuals have suffered from traumatizing encounters with hostile or disapproving healthcare professionals.

4. All Whitman-Walker employees, and all volunteers who serve as peer counselors or otherwise are involved in any way with our behavioral-health services, are asked to commit to our mission, which is to be welcoming to and understanding of every patient, regardless of sexual orientation, gender identity, race or ethnicity, income or educational background, or life experience. We welcome staff and volunteers from a wide range of religious, spiritual, cultural, and philosophical perspectives, but patient needs must always be paramount. The message of the Denial-of-Care Rule, that the personal beliefs or feelings of a provider or other healthcare staff member can justify refusal to participate in any aspect of their job or of the care of any patient, threatens to substantially harm patients who already are vulnerable to stigma and discrimination. The message that healthcare staff members' personal preferences or beliefs take priority over patient needs also violates fundamental professional ethical standards that apply to all licensed therapists, psychologists, psychiatrists, and substance-use-disorder-treatment professionals, including myself.

5. Behavioral-health treatment assumes, and requires, trust between the patient and provider, and full and frank disclosure by the patient of all potentially relevant information about their life, including their sexual orientation, sexual and affectional experiences, and gender identity. I, and the providers that I supervise at Whitman-Walker, frequently work with patients who have concealed some or all aspects of their sexual and affectional orientation or history, or gender identity, from non-Whitman-Walker therapists or other behavioral health providers, often to the patients' harm. The Denial-of-Care Rule will very likely discourage LGBT people and others needing treatment from fully disclosing relevant information to their therapists or counselors, or to

those helping them with substance-use issues, which will likely increase their distress and undercut the effectiveness of their treatment.

6. For persons with a minority, traditionally stigmatized sexual orientation—such as gay, lesbian, or bisexual—or whose gender identity is transgender or gender-nonconforming, competent mental-health services, or services for treatment of substance-use disorders, require an accepting—indeed, an affirming—attitude towards their sexual orientation or gender identity by their provider. Discriminatory behavior, statements, or attitudes expressed by a provider are a tremendous barrier to effective care. It is critical that a patient feel empowered and supported in fully disclosing their sexuality and gender identity to their counselor, therapist, psychologist, or psychiatrist. Without a trusting patient-provider relationship and full disclosure of all possibly relevant feelings and facts by the patient, effective treatment is unlikely to be possible. This is critical for good medical care as well. In my work with patients as a behavioral-healthcare provider, I have counseled patients about the importance of full disclosure of their sexuality and gender identity to their doctor and other medical personnel.

7. Even before the Denial-of-Care Rule was proposed or issued, I and the providers and other behavioral-health staff that I supervise at Whitman-Walker have learned from patients about many incidents of discrimination or mistreatment in other behavioral-health settings that were motivated by the personal beliefs of providers or other staff. For instance:

a. A transgender teenager was hospitalized after a suicide attempt. Hospital staff refused to address the teenager by the young person's preferred pronouns and gender throughout the teenager's hospital stay. This was experienced by the teenager as disapproval and contempt for the young person's gender identity. This discrimination exacerbated the teenager's acutely fragile state when the teenager was so desperately in need of healthcare providers' support and healthcare services that were free of judgment.

b. A facility that specializes in inpatient mental health and substance-use-disorder treatment, and which has explicit non-discrimination policies,

nonetheless has significant trouble from nurses on weekend shifts (when the facility uses pool nurses rather than regular employees), who express strong disapproval of LGBT patients based on their religious beliefs or cultural upbringing. Despite the facility's non-discrimination policies, LGBT patients encounter hostility, expressions of disapproval, and lack of responsiveness to their needs or requests from these nurses. For patients hospitalized for mental or substance-use disorders, these experiences can activate their disorders.

c. A Muslim woman patient who also identifies as Lesbian was hospitalized for suicidal ideation based on depression and anxiety from PTSD at an inpatient facility. While processing her discharge, a nurse at the facility, who identified herself as Christian, stated that she believed that 911 was a blessing since it woke up Christians about how bad Muslims are. The client reported feeling very exposed and vulnerable and told the nurse that not only was she Muslim, but she herself had been the victim of terrorism. The encounter with the nurse exacerbated the patient's depression and anxiety.

d. As I previously noted, behavioral health staff that I supervise often receive calls or other communications from LGBT persons expressing desperation about finding a therapist or substance use professional who will not discriminate against them because of their sexual orientation or gender identity.

e. Our behavioral-health providers who regularly interview our transgender patients to assess their stage of gender transition and readiness for gender-affirming surgical procedures, or who provide psychotherapy for these patients, report that the large majority of the patients they meet with—as many as four out of every five—report incidents of mistreatment or discrimination by healthcare providers and staff at hospitals, other clinics, doctor's offices, and other facilities.

8. These incidents reveal that many healthcare providers and other staff harbor explicit or implicit biases against LGBT people. Because of legal requirements, healthcare facility non-discrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By empowering healthcare staff to think that they have the legal right to act on their personal beliefs, even at the expense of patient needs, the Denial-of-Care Rule is very likely to result in many more incidents of discrimination and greater harm to LGBT individuals struggling with mental health or substance use issues, including the patients whom I treat and whose treatment I supervise.

9. I and Whitman-Walker provide referral services for patients who need specialist care that we do not provide—including inpatient behavioral healthcare as well as specialist medical care. We also receive many outside requests for recommendations for LGBT-welcoming, non-discriminatory therapists and substance-use professionals in the community. The Denial-of-Care Rule will make it significantly more difficult for us locate and monitor appropriate referrals, and patients will suffer as a result. Even more concerning, our behavioral-health patients who may need hospitalization for a mental-health or substance-use crisis, or may need specialist medical care, will be in greater danger of encountering discrimination at inpatient behavioral health facilities or when they seek medical care outside Whitman-Walker—which may make their care at Whitman-Walker more difficult and perhaps less successful.

10. Whitman-Walker is a certified healthcare provider under the Medicare program and also under the District of Columbia's Medicaid program. Healthcare providers with Whitman-Walker, are credentialed under the Medicare program and also under the District of Columbia's Medicaid program. Both programs are overseen by HHS's Center for Medicare and Medicaid Services (CMS). These funds and related benefits account for a significant portion of my work and the healthcare services that I, and those that I supervise, provide to patients. Without such funding, we could not provide proper treatment to our patients, especially because a large portion of the population that we serve relies heavily on Medicaid and Medicare for its healthcare needs. A loss of Medicare or Medicaid funding as a possible sanction under the Denial-of-Care Rule resulting from enforcement of Whitman-Walker's nondiscrimination mandate, which applies to all of our

healthcare providers and staff, would result in service reductions if not closure of our programs in their entirety. As a clinician who provides care under these programs, I have a reasonable fear not only that Whitman-Walker's continued certification under these vital programs might be endangered, but also that I could individually be sanctioned for enforcing Whitman-Walker's mission with respect to the providers and other staff that I supervise.

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 Washington, D.C.

Randy Pumphrey, D.MIN., LPC, BCC

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Attorneys for Plaintiff
CITY AND COUNTY OF SAN FRANCISCO

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 BEN ROSENFIELD 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, Ben Rosenfield, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am employed by the City and County of San Francisco ("San Francisco" or "City") as Controller. I have held this position since March 2008. Prior to my appointment to this position, I was the Deputy City Administrator from 2005 to 2008. Prior to that position, I served as the Mayor's Budget Director for Mayors Willie L. Brown, Jr. and Gavin Newsom, for the period from 2001 to 2005. Prior to that position, I served as a Project Manager in the Controller's Office (2000-2001) and as a Financial and Policy Analyst and as a Deputy Director in the Mayor's Budget Office (1997-2000). I have worked in a variety of budget, financial planning, public finance, and general administrative positions during my 22 years of work for the City.

3. San Francisco budgets for a fiscal year that runs from July 1 to June 30. The last fiscal year began July 1, 2017, and ended June 30, 2018 ("FY17-18").

4. In FY17-18, San Francisco expended an estimated $1 billion in U.S. Department of Health and Human Services ("HHS") funds.

5. Most of this was from entitlement programs such as Medicaid (budgeted at $642,304,232) and Medicare (budgeted at $128,336,293), Temporary Assistance for Needy Families ($58,360,424), Foster Care ($34,718,746), and various child welfare programs. The majority of entitlement program funds are provided to San Francisco as reimbursements.

6. In addition to entitlement programs, San Francisco expended significant HHS grant funds. The San Francisco Department of Public Health alone expended over $61 million in HHS grant funds in FY17-18.

7. Other than Medicare and Medicaid, the complete list of HHS funds expended by San Francisco is in FY17-18 is reflected in the FY17-18 Federal Single Audit. The relevant pages of the Single Audit Report are attached as Exhibit A to this declaration. The full Federal Single Audit is available at

https://sfcontroller.org/sites/default/files/Documents/Accounting/CCSF%20Single%20Audit%20Report%20FY2018.pdf.

8. In all, HHS funds accounted for approximately 10.2% of San Francisco's total FY 17-18 budget of $10.1 billion and approximately 20.1% of its total FY 17-18 General Fund budget of $5.1 billion.

9. It would be catastrophic for San Francisco to lose all HHS funds. It would not be possible for San Francisco to backfill the loss of more than $1 billion with local revenue sources.

10. San Francisco's existing reserves are insufficient to cover the loss of all federal funds. San Francisco currently has contingency reserves of approximately $450 million in a Rainy Day Fund and a Stabilization Fund, which were created and funded over the last decade for the purpose of managing local tax revenue volatility created by economic conditions. These reserve levels, totaling approximately 9% of general fund revenues, are below levels recommended by the Government Finance Officers Association for local governments. There are restrictions on the use of these reserves, and even if entirely depleted, their levels would be inadequate to cover a shortfall in federal funds for even a single year. To fully absorb the loss of all HHS funds for even a single year, San Francisco would have to deplete these reserves, suspend capital projects needed to maintain the City's aging infrastructure, and make drastic service cuts in order to maintain a balanced budget, as it is legally required to do. All of these actions would result in significant job losses and the abandonment of key safety net services.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 10, at San Francisco, California.

Ben Rosenfield

EXHIBIT A

CITY AND COUNTY OF SAN FRANCISCO

BASIC FINANCIAL STATEMENTS
AND SINGLE AUDIT REPORTS

FOR THE YEAR ENDED JUNE 30, 2018

mGO Certified Public Accountants

CITY AND COUNTY OF SAN FRANCISCO
BASIC FINANCIAL STATEMENTS AND SINGLE AUDIT REPORTS
FOR THE YEAR ENDED JUNE 30, 2018

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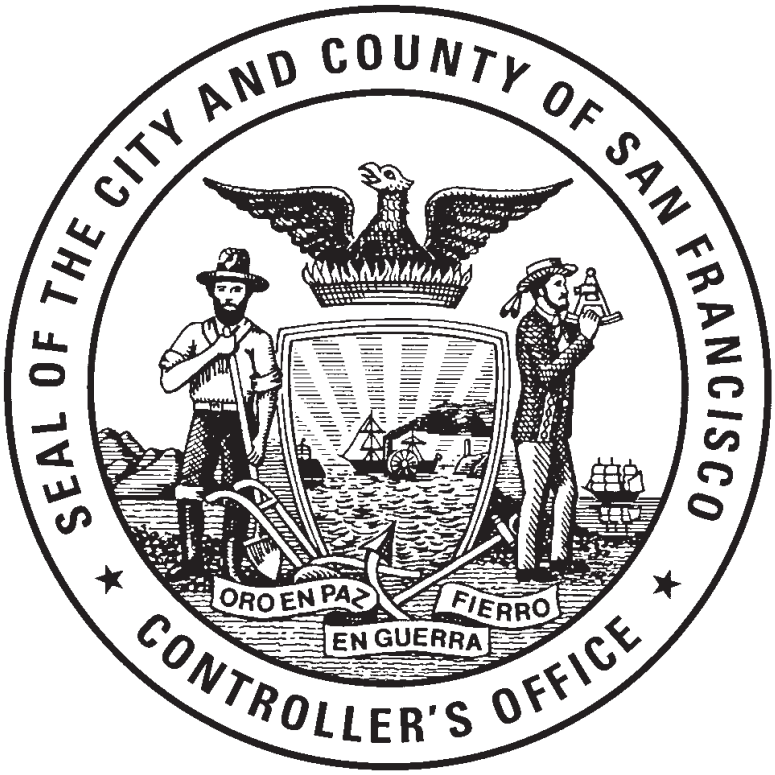

FINANCIAL SECTION

- Independent Auditor's Report
- Management's Discussion and Analysis
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CITY AND COUNTY OF SAN FRANCISCO
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (Continued)
FOR THE YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Catalog of Federal Domestic Assistance Number (CFDA)	Pass-Through Identifying Number	Federal Expenditures	Amount Provided to Subrecipients
U.S. DEPARTMENT OF EDUCATION				
Passed through State of California Department of Rehabilitation				
Rehabilitation Services Vocational Rehabilitation Grants to States	84.126	29888	$ 66,399	$ -
TOTAL U.S. DEPARTMENT OF EDUCATION			66,399	-
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES				
Direct Program				
Environmental Public Health and Emergency Response	93.070	--	199,626	-
Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SED)	93.104	--	1,236,086	806,060
Project Grants and Cooperative Agreements for Tuberculosis Control Programs	93.116	--	587,885	10,966
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	--	358,971	-
Viral Hepatitis Prevention and Control	93.270	--	31,713	-
Drug Abuse and Addiction Research Programs	93.279	--	119,834	-
Child Abuse and Neglect Discretionary Activities	93.670	--	182,224	182,224
PPHF: Racial and Ethnic Approaches to Community Health Program Financed Solely by Public Prevention and Health Funds	93.738	--	681,757	-
Alzheimer's Disease Initiative: Specialized Supportive Services Project (ADI-SSS) thru Prevention and Public Health Funds (PPHF)	93.763	--	291,149	282,823
HIV Emergency Relief Project Grants	93.914	--	16,133,829	12,016,652
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	--	333,932	118,673
Special Projects of National Significance	93.928	--	151,685	97,933
HIV Prevention Activities Non-Governmental Organization Based	93.939	--	969,727	-
HIV Prevention Activities Health Department Based	93.940	--	8,938,923	638,547
Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	93.944	--	1,945,591	-
Sexually Transmitted Diseases (STD) Prevention and Control Grants	93.977	--	1,362,685	145,872
Passed through State of California Department of Aging				
Aging Cluster				
Special Programs for the Aging, Title VII, Chapter 3, Programs for Prevention of Elder Abuse, Neglect, and Exploitation	93.041	AP-1718-06	13,443	13,443
Special Programs for the Aging, Title VII, Chapter 2, Long Term Care Ombudsman Services for Older Individuals	93.042	AP-1718-06	31,400	31,400
Special Programs for the Aging, Title III, Part D, Disease Prevention and Health Promotion Services	93.043	AP-1718-06	58,231	58,231
Special Programs for the Aging, Title III, Part B, Grants for Supportive Services and Senior Centers	93.044	AP-1718-06	1,003,898	426,615
Special Programs for the Aging, Title III, Part C, Nutrition Services	93.045	AP-1718-06	1,579,198	1,579,198
National Family Caregiver Support, Title III, Part E	93.052	AP-1718-06	415,465	415,465
Nutrition Services Incentive Program	93.053	AP-1718-06	1,677,265	1,677,265
Subtotal Aging Cluster			4,778,900	4,201,617
Medicare Enrollment Assistance Program	93.071	MI-1517-06	46,304	46,304
State Health Insurance Assistance Program	93.324	HI-1718-06	106,353	97,353
Passed through Regents of the University of California				
Global AIDS	93.067	10076sc	80,605	-
Global AIDS	93.067	10120sc	23,364	-
Global AIDS	93.067	10129sc	6,344	-
Global AIDS	93.067	10129sc 01	8,153	-
Global AIDS	93.067	10408sc	2,208	-
Global AIDS	93.067	8775sc 02	31,406	-
Global AIDS	93.067	8853sc 03	32,886	-
Global AIDS	93.067	8940sc a02	20,798	-
Global AIDS	93.067	9289sc a01	13,639	-
Global AIDS	93.067	9733sc a01	986	-
Global AIDS	93.067	9970sc	16,375	-
Global AIDS	93.067	9974sc	20,291	-
Subtotal Global AIDS			257,055	-
Prevention of Disease, Disability, and Death by Infectious Diseases	93.084	8829sc a03	9,493	-
Coordinated Services and Access to Research for Women, Infants, Children, and Youth	93.153	10259sc	97,531	-

See accompanying notes to the Schedule of Expenditures of Federal Awards.

CITY AND COUNTY OF SAN FRANCISCO
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (Continued)
FOR THE YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Catalog of Federal Domestic Assistance Number (CFDA)	Pass-Through Identifying Number	Federal Expenditures	Amount Provided to Subrecipients
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (continued)				
Passed through Regents of the University of California (continued)				
Mental Health Research Grants	93.242	9563sc	$ 12,512	$ -
Mental Health Research Grants	93.242	9739sc	27,796	-
Mental Health Research Grants	93.242	9833sc	16,002	-
Mental Health Research Grants	93.242	9833sc a01	6,854	-
Drug Abuse and Addiction Research Programs	93.279	8278sc a2	5,149	-
Drug Abuse and Addiction Research Programs	93.279	8952sc a4	37,882	-
Child Welfare Research Training or Demonstration	93.648	00009093	8,467	-
Allergy and Infectious Diseases Research	93.855	10612sc	8,400	-
Allergy and Infectious Diseases Research	93.855	7258sc a04	5,068	-
Passed through State of California Department of Public Health				
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	14-10536	105,845	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	14-10536-05	180,443	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	17-10188	658,996	-
Subtotal Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements			945,284	-
Injury Prevention and Control Research and State and Community Based Programs	93.136	16-10233	66,781	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	15-10979	93,533	-
PPHF Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance financed in part by Prevention and Public Health Funds	93.539	17-10345	292,627	-
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	16-38-90899-00	72,044	27,190
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	17-38-90899-00	227,158	27,532
Medical Assistance Program	93.778	201638	5,689	-
Medical Assistance Program	93.778	201738	4,901,150	-
Medical Assistance Program	93.778	17-10259	256,787	-
Maternal, Infant and Early Childhood Home Visiting Grant Program	93.870	15-10169	1,042,912	-
HIV Care Formula Grants	93.917	15-11073	2,855,161	2,387,582
HIV Care Formula Grants	93.917	16-10856	1,204,231	1,062,274
Subtotal HIV Care Formula Grants			4,059,392	3,449,856
Maternal and Child Health Services Block Grant to the States	93.994	201738	391,537	-
Passed through State of California Department of Social Services				
Guardianship Assistance	93.090	None	2,494,923	-
Promoting Safe and Stable Families	93.556	None	431,386	296,929
Temporary Assistance for Needy Families	93.558	None	58,360,424	7,849,235
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	None	212,103	-
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	ORSA1607	2,206	2,206
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	RESS1506	28,445	-
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	RESS1607	27,679	-
Refugee and Entrant Assistance State/Replacement Designee Administered Programs	93.566	RESS1706	3,397	-
Refugee and Entrant Assistance Targeted Assistance Grants	93.584	TAFO1706	10,275	-
Refugee and Entrant Assistance Targeted Assistance Grants	93.584	TAFO1506	29,990	23,341
Refugee and Entrant Assistance Targeted Assistance Grants	93.584	TAFO1606	55,661	37,140
Subtotal Refugee and Entrant Assistance Targeted Assistance Grants			95,926	60,481
Community-Based Child Abuse Prevention Grants	93.590	None	24,738	20,006
Adoption and Legal Guardianship Incentive Payments	93.603	None	3,686	-
Stephanie Tubbs Jones Child Welfare Services Program	93.645	None	1,651,730	79,320
Foster Care Title IV-E	93.658	None	34,718,746	7,485,645
Adoption Assistance	93.659	None	9,906,392	170,981
Social Services Block Grant	93.667	None	1,216,848	-
Chafee Foster Care Independence Program	93.674	None	450,059	360,990
Medical Assistance Program	93.778	None	75,410,618	2,533,047

See accompanying notes to the Schedule of Expenditures of Federal Awards.

CITY AND COUNTY OF SAN FRANCISCO
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (Continued)
FOR THE YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Catalog of Federal Domestic Assistance Number (CFDA)	Pass-Through Identifying Number	Federal Expenditures	Amount Provided to Subrecipients
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (continued)				
Passed through Public Health Foundation Enterprise				
Injury Prevention and Control Research and State and Community Based Programs	93.136	0392.0101	$ 48,161	$ -
Injury Prevention and Control Research and State and Community Based Programs	93.136	0392.0102	22,340	-
Mental Health Research Grants	93.242	0349.0102	3,670	-
Mental Health Research Grants	93.242	0349.0103	156,628	-
Drug Abuse and Addiction Research Programs	93.279	0176.0105	2,712	-
Drug Abuse and Addiction Research Programs	93.279	0208.0105	58,009	-
Drug Abuse and Addiction Research Programs	93.279	0333.0103	30,370	-
Minority Health and Health Disparities Research	93.307	0350.0103	33,781	-
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	0187.4004	7,258	-
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	0187.1390	153,199	-
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	0187.4005	265,553	-
Subtotal Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)			426,010	-
Allergy and Infectious Diseases Research	93.855	0014.0105	76,471	-
Allergy and Infectious Diseases Research	93.855	0014.0106	35,969	-
Child Health and Human Development Extramural Research	93.865	0419.0102	31,827	-
Passed through State of California Department of Mental Health				
Projects for Assistance in Transition from Homelessness (PATH)	93.150	68-0317191	444,846	444,845
Passed through Essential Access Health				
Family Planning Services	93.217	380-5320-71209-17-18	32,229	-
Family Planning Services	93.217	380-5320-71219-16-17	162,950	-
Subtotal Family Planning Services			195,179	-
Passed through San Francisco Community Clinic Consortium				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224	6 H80CS00049-16-03	726,037	-
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224	6 H80CS00049-17-02	747,296	-
Subtotal Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing			1,473,333	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	5 H76HA00163-25-00	64,374	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	6 H76HA00163-26-01	88,163	-
Passed through State of California Department of Child Support Services				
Child Support Enforcement	93.563	None	7,970,454	-
Passed through Contra Costa County Office of Education				
CCDF Cluster				
Child Care and Development Block Grant	93.575	1700230	2,140	-
Passed through State of California Department of Education				
Child Care and Development Block Grant	93.575	16-17 14092 2563 00	218,106	191,117
Child Care and Development Block Grant	93.575	16-17 14869 2563 00	218,106	191,117
Child Care and Development Block Grant	93.575	17 14092 2563 00	153,486	-
Child Care and Development Block Grant	93.575	17 14092 2563 03	41,887	41,887
Child Care and Development Block Grant	93.575	17 14130 2563 03	85,044	85,044
Child Care and Development Block Grant	93.575	C2AP-7046	2,073,962	2,073,962
Child Care and Development Block Grant	93.575	CLPC7036	56,647	-
Child Care and Development Block Grant	93.575	CRET7034	404,753	404,753
Subtotal Child Care and Development Block Grant			3,254,131	2,987,880
Child Care Mandatory and Matching Funds of the Child Care and Development Fund	93.596	CAPP-7051	257,560	257,560
Subtotal CCDF Cluster			3,511,691	3,245,440
Passed through State of California Department of Health Care Services				
Medical Assistance Program	93.778	17-04	1,041,411	-
Medical Assistance Program	93.778	17-05	401,444	-
Medical Assistance Program	93.778	None	36,104	36,104
Block Grants for Community Mental Health Services	93.958	None	2,684,636	825,092

See accompanying notes to the Schedule of Expenditures of Federal Awards.

CITY AND COUNTY OF SAN FRANCISCO
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (Continued)
FOR THE YEAR ENDED JUNE 30, 2018

Federal Grantor/Pass-Through Grantor/Program Title	Catalog of Federal Domestic Assistance Number (CFDA)	Pass-Through Identifying Number	Federal Expenditures	Amount Provided to Subrecipients
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (continued)				
Passed through Family Health International (FHI360)				
Allergy and Infectious Diseases Research	93.855	970/0080.0172 a10	$ 9,067	$ -
Allergy and Infectious Diseases Research	93.855	970/0080.0172 a8	6,218	-
Passed through Fred Hutchinson Cancer Research Center				
Allergy and Infectious Diseases Research	93.855	0000887682	47,038	-
Allergy and Infectious Diseases Research	93.855	0000924967	80,090	-
Passed through Magee-Womens Research Institute and Foundation				
Allergy and Infectious Diseases Research	93.855	9451	30,356	-
Allergy and Infectious Diseases Research	93.855	9516 a1	31,711	-
Passed through State of California Department of Alcohol and Drug Programs				
Block Grants for Prevention and Treatment of Substance Abuse	93.959	None	8,183,576	8,183,576
Passed through University of California San Francisco				
PPHF Geriatric Education Centers	93.969	5 U1QHP28727-02-00	24,591	-
TOTAL U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			263,593,813	53,743,499
U.S. DEPARTMENT OF HOMELAND SECURITY				
Direct Program				
Assistance to Firefighters Grant	97.044	--	232,586	-
Port Security Grant Program	97.056	--	1,017,210	-
Staffing for Adequate Fire and Emergency Response (SAFER)	97.083	--	6,708,186	-
Passed through State of California Emergency Management Agency				
Emergency Management Performance Grants	97.042	2017-0007	302,680	-
Homeland Security Grant Program	97.067	2015-00078	2,361,247	595,590
Homeland Security Grant Program	97.067	2016-00102	326,297	-
Homeland Security Grant Program	97.067	2016-0102	13,085,973	10,791,139
Homeland Security Grant Program	97.067	2017-0083	3,951,783	1,823,546
Subtotal Homeland Security Grant Program			19,725,300	13,210,275
TOTAL U.S. DEPARTMENT OF HOMELAND SECURITY			27,985,962	13,210,275
TOTAL EXPENDITURES OF FEDERAL AWARDS			$ 432,851,518	$ 106,920,283

See accompanying notes to the Schedule of Expenditures of Federal Awards.

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Counsel for Plaintiffs Other Than Santa Clara County

* Admitted pro hac vice

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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 NASEEMA SHAFI, CHIEF EXECUTIVE OFFICER, WHITMAN-WALKER HEALTH, 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, Naseema Shafi, declare:

1. I am Chief Executive Officer of Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker). I received a J.D. degree from the University of Maryland School of Law in 2005. I have served at Whitman-Walker for more than twelve years, first as a Compliance Analyst and Director of Compliance; then Chief Operating Officer, and subsequently Deputy Executive Director. I assumed the CEO position in January 2019. 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.

2. Whitman-Walker was founded in 1973, and legally incorporated in 1978 to respond to the healthcare needs of the lesbian, gay, bisexual and transgender (LGBT) community. Our team provides a range of services, including medical and community care, transgender care and services, behavioral-health services, dental services, legal services, insurance-navigation services, and youth and family support in Washington, DC. The mission of Whitman-Walker is to offer affirming community-based health and wellness services to all with a special expertise in LGBT and HIV care. We empower all persons to live healthy, love openly, and achieve equality and inclusion. In 2018, Whitman-Walker provided healthcare services to more than 20,700 individuals.

3. Whitman-Walker's patient population is quite diverse and reflects Whitman-Walker's commitment to being a healthcare home for individuals and families that have experienced stigma and discrimination, or have otherwise encountered challenges in obtaining affordable, high-quality healthcare. In calendar year 2018, 58% percent of our healthcare patients and clients who provided their sexual orientation identified as lesbian, gay, bisexual, or otherwise non-heterosexual, and 9% of our patients and clients—more than 1,800 individuals—identified as transgender or gender nonconforming.

4. We at Whitman-Walker also employ dynamic and diverse employees who reflect the diversity of the populations we serve. At the present, we employ 284 medical and behavioral-health providers and support staff, medical-adherence and insurance-navigation professionals, community health-workers, lawyers and paralegals, researchers, administrators, and professionals working in finance, development, human resources, and external affairs. We have employees of

many races, ethnicities, genders, sexual orientations, religious and spiritual traditions, and life experiences. What unites us all is our shared commitment to creating and sustaining a welcoming, inclusive healthcare home for everyone who seeks our care.

5. The Denial-of-Care Rule empowers religiously motivated discriminatory behavior by healthcare providers that would be corrosive of fundamental professional standards, threaten Whitman-Walker's patients' welfare, and place significant strain on our ability to fulfill our critical mission. The Denial-of-Care Rule's message that healthcare providers could be legally entitled to refuse or restrict care, based on their personal religious or moral beliefs, flies in the face of the standards and ethics of every healthcare profession, and would sow confusion and undermine the entire healthcare system. Healthcare is a fundamentally patient-oriented endeavor and the Denial-of-Care Rule's sweeping right to avoid "complicity," with complete disregard for the harm that might result to others, is legally, morally, and medically unsupportable, and is fundamentally corrosive to healthcare providers like Whitman-Walker.

6. As written, provisions in the Rule that empower healthcare personnel to refuse to provide care based on their personal beliefs apply to entities that receive any grant, contract, loan, or loan guarantee under the Public Health Service Act (PHSA); any Health and Human Services-administered grant or contract for biomedical or behavioral research; or funds for any health service program or research activity under any HHS-administered program. Section 88.3(a)(1). "Health service program" is defined so broadly that it seems to cover any health or wellness services or other activities. Section 88.2. As a Federally Qualified Health Center, Whitman-Walker receives grants and other financial support under the PHSA. We receive substantial funding under the Ryan White Care Act, which is administered by HHS. The majority of our third-party revenues for medical and behavioral-health services are reimbursed through Medicaid and Medicare, which are HHS-administered programs. As Dr. Henn, our Chief Health Officer, discusses in her Declaration, Whitman-Walker receives major funding for biomedical and behavioral research from HHS entities.

7. We are particularly concerned that the Denial-of-Care Rule is written so broadly that it would empower healthcare personnel to deny care based on personal objections to LGBT people.

HHS expressly leaves open the possibility that LGBT care might be denied, and that it might interpret the legal right to refuse to assist in "sterilization" procedures to include care for transgender patients.

8. The impact on Whitman-Walker and its patients of a broad, legally unsupported expansion of healthcare providers' refusal rights would be particularly drastic. Providing welcoming, high-quality care to the LGBT community and people living with HIV is at the core of Whitman-Walker's mission. These are communities that are in particular need of affirming, culturally competent care because of the widespread stigma and discrimination they have experienced and continue to experience. By encouraging employees of hospitals, health systems, clinics, nursing homes, and physician offices to express and act on their individual beliefs, rather than focusing on patients' specific healthcare needs, the Rule invites chaos to the overall healthcare system and undercuts Whitman-Walker's operations. Specifically, the Rule would create real harm to the sustainability of Whitman-Walker by consuming precious resources with unnecessary work-arounds and potential litigation; and increasing uncompensated patient care volume. This rule may also raise the specter of misalignment within our work-force if we have staff whose religious beliefs may cause them to wish to deny care themselves. Whitman-Walker's very mission would be at risk of being frustrated in such an environment.

9. Whitman-Walker strives to ensure that all staff understand that one's personal, religious, and moral views are irrelevant to Whitman-Walker's patients' needs and mission. It would be very difficult, if not impossible, for Whitman-Walker to accommodate individual healthcare staff who might object to providing basic aspects of Whitman-Walker's services—for example, providing treatment for gender dysphoria, counseling pregnant clients on their pregnancy termination options, HIV-prevention-related counseling, harm-reduction care for substance users, or healthcare services to lesbian, gay, or bisexual patients—without fundamentally compromising its mission and the quality of patient care.

10. The Denial-of-Care Rule announces a very broad definition of a healthcare worker's alleged right to refuse to "assist in the performance" of care to which they object for personal reasons. HHS' definition is so broad that it seems to encompass providing referrals and information

to patients and any assistance receiving care to which the employee objects, at Whitman-Walker or any place else. This could affect not only our physicians, physician assistants, nurses and nurse practitioners, and therapists, but medical assistants, persons conducting HIV and Sexually Transmitted Infection testing and counseling, front-desk staff, and persons who provide scheduling services and information over the phone. Many of Whitman-Walker's LGBT patients and patients living with HIV have experienced substantial stigma and discrimination and are appropriately concerned with being welcomed or not welcomed in a healthcare setting. If they encounter discrimination at Whitman-Walker from any staff person at any point, Whitman-Walker's reputation as a safe and welcoming place would be undermined. There are multiple "patient touches" in Whitman-Walker's system as in any healthcare system: from the staff person answering the phone or sitting at the front desk to the physician to the pharmacy worker. Because each of these interactions with Whitman-Walker staff can convey respect and affirmation or disrespect and rejection, they have a direct impact on patients' engagement in their own healthcare and can thus, depending on their nature, either promote or undermine patient health.

11. Consistent with its commitment to welcoming and nondiscriminatory healthcare, Whitman-Walker's growing work force is very diverse. Encouraging individual employees to think that their discriminatory beliefs can prevail over their duties to patients—and to their fellow employees—would introduce confusion and discord into Whitman-Walker's staff as well as pose barriers to patient care. We have had situations in which an employee has expressed personal religious or moral discomfort or disagreement with homosexuality or bisexuality; or with healthcare intended to help a transgender person transition from the sex they were assigned at birth to their own gender identity; or with a patient's drug use or sexual behavior. In such situations, we emphasize to the employee that patient needs, and maintaining a respectful and welcoming environment for every patient, are paramount and must prevail over personal beliefs of staff. If individual employees felt legally empowered to refuse to provide care, and Whitman-Walker were limited in how it could respond to such situations, the harm to our mission could be devastating.

12. The harm to Whitman-Walker's operations, finances, and employee morale would be particularly complicated because Whitman-Walker, like many healthcare entities, has a quasi-

unionized workforce. Attempts to accommodate, for instance, one employee's unwillingness to work with LGBT patients or women seeking reproductive healthcare would impose burdens on and increase workloads for other staff, and likely would result in grievances filed by other employees affected by the conscience accommodations. This is especially true where the Denial-of-Care Rule limits Whitman-Walker's options for maintaining policies and procedures for requesting religious or moral-based accommodations in advance to ensure that Whitman-Walker has sufficient staff available to meet patients' needs. Whitman-Walker would incur substantial financial costs and drains on staff time that would substantially challenge its ability to care for a growing patient load. Whitman-Walker, for example, would have to hire additional human resources staff to address the increase in accommodation requests as well as grievances related to hostile work environments resulting from religious-based objections to performing core job responsibilities and increased workloads for other staff.

13. There would also be increased difficulty in determining whether job applicants will be unwilling to perform essential job functions, which seems likely to undermine Whitman-Walker's philosophy of fostering a diverse workforce. Whitman-Walker's current recruiting process is developed to ascertain whether a job applicant would provide healthcare consistent with Whitman-Walker's mission to establish a welcoming, nondiscriminatory environment for all patients and staff, without violating the law. Whitman-Walker emphasizes these principles of inclusion with language that reflects diversity principles in our job descriptions. If an applicant appears to draw lines based on religious or moral principles that are inconsistent with Whitman-Walker's mission, hiring managers will be in a complex position of trying to ascertain whether such applicants could end up causing harm to patients given the Denial-of-Care Rule's prohibition on inquiring about these issues directly. Moreover, adherence to our mission is emphasized in our new employee orientation process, and all employees are currently required to sign a statement committing to our values of inclusiveness, non-judgment, and fully caring for every patient and for fellow staff. Providing care in a non-discriminatory manner, putting aside people's individual religious beliefs, is a core part of Whitman-Walker's job criteria for new applicants. Changing those criteria thwarts Whitman-Walker's mission.

14. The Rule's provisions regarding the accommodation of staff with personal "conscience" objections to any portion of our mission, our services, or our patients, would cause major damage to our operations and patients. My understanding is that the Rule would frustrate the important process that many mission-based organizations like Whitman-Walker have: an assessment of employees' alignment with their mission. The Rule provides that, after hiring, we could ask staff to inform us of their objections, but the objecting staff must consent to our accommodation offers and may unilaterally reject any proffered accommodations. These provisions appear to impose one-sided obligations on the employer that are unworkable for a healthcare center: there does not appear to be any requirement that the objecting employee be reasonable or willing to compromise, and the Rule expressly declares that the employer cannot object to an accommodation that would impose an undue hardship on the employer or that would compromise patient care. Furthermore, the Rule does not provide for any emergency exception to ensure that all patients receive immediate, life-saving care, regardless of staff members' religious beliefs.

15. More specifically, the accommodation provisions are not feasible for Whitman-Walker for a number of reasons. First, requiring us to devote our limited financial resources to hiring additional staff, in order to ensure that patient care does not suffer from accommodating some staff's personal objections, would almost inevitably force us to reduce our existing services. Second, the Rule states that an accommodation cannot "exclude [a] protected [person] from fields of practice on the basis of their protected objections." Section 88.2 (definition of "Discriminate or Discrimination"). Given Whitman-Walker's commitment to providing affirming healthcare to all, a healthcare provider or any other employee with objections to, for instance, LGBT patients, could not be maintained in any patient-facing role, which likely would "exclude" them from a "field of practice." Subjecting any of our patients to the risk of interactions with any Whitman-Walker staff member who expresses opposition or hostility to them or their course of treatment would result in irreversible damage to our reputation and would likely be harmful to the patient's well-being. Third, the rule provides that staff can be asked to specify their objections only once per year "unless supported by a persuasive justification." As a result, Whitman-Walker could be faced with unexpected objections in the intervening twelve months, based on newly emergent patient needs,

otherwise unanticipated situations, or an employee's evolving religious beliefs. The inability to know of objections in advance will interfere with Whitman-Walker's provision of services to its patients, either by forcing Whitman-Walker to divert resources to redundant staffing or by leaving it without an employee willing to deliver appropriate care. Fourth, any healthcare professional or other staff person may be needed to respond to an emergency situation beyond the scope of their regular duties—for instance, responding to a patient who is overdosing, or who is in acute distress or in a crisis situation that may challenge the staff person's personal comfort level. In addition, as I have already noted, efforts to accommodate an individual provider's or other staff person's personal objections to particular patients, procedures or job-related activities will inevitably decrease staff morale, increase conflict between staff members, and likely lead to grievance procedures in our quasi-unionized workplaces.

16. HHS has also defined the "workforce" covered by the Rule to include not only employees, but also contractors, trainers, and even volunteers. This interpretation is even more disruptive of our operations and patient services. For many years, Whitman-Walker has offered walk-in sexually-transmitted-infection testing, treatment and counseling, in a program that is largely staffed by volunteer healthcare professionals. In 2018, that program served more than 1,700 individuals. We also rely extensively on trained volunteers for our HIV testing and counseling services, our peer support counseling services, and our Legal Services Department. Many of the thousands of patients and clients receiving these services every year are in very vulnerable situations, and the possibility that our staff would have limited control over how these volunteers chose to deliver services, and how they might interact with patients and clients, threatens critical components of our mission.

17. Whatever its effect on Whitman-Walker ability to provide affirming, non-discriminatory care to all of our own patients, it is quite likely that the Denial-of-Care Rule will result in a substantial increase in discrimination against LGBT individuals by healthcare providers and institutions outside of Whitman-Walker. Dr. Henn's and Dr. Pumphrey's declarations describe a number of incidents of discrimination that our patients have encountered in other healthcare facilities and offices that our patients have reported to our medical and behavioral health providers.

In addition, the lawyers in our Legal Services Department learn of similar incidents from their clients.

18. Since the mid-1980s, Whitman-Walker has had an in-house Legal Services Department. Our attorneys and legal assistants provide information, counseling, and representation to Whitman-Walker patients, and to others in the community who are LGBT or living with HIV, on a wide range of civil legal matters that relate directly or indirectly to health and wellness – including access to healthcare and discrimination based on HIV, sexual orientation, or gender identity. They also oversee legal clinics, staffed largely by volunteer attorneys, which assist transgender and gender-nonconforming individuals to change their legal names and to correct their birth certificates, driver's licenses, passports, Social Security records, and other identity documents to reflect their new names and actual gender identities. Over the years, Whitman-Walker Legal Services staff and volunteer attorneys have encountered many instances of discrimination by healthcare providers and their staff based on the sexual orientation or gender identity of patients. Recent examples include:

a. As recounted in Dr. Henn's Declaration, Whitman-Walker transgender patients seeking gender transition-related surgery have been rejected at local hospitals, even for procedures that are often performed on non-transgender patients (such as breast surgery), and even though the patients had health insurance or were otherwise able to pay for the procedures.

b. A transgender woman who was about to have surgery at a Washington, DC hospital for an inner ear condition (unrelated in any way to her transgender-related healthcare) was confronted and harassed by hospital staff objecting to her gender identity. She was repeatedly and intentionally referred to as "he" and as "a man" by staff in the radiology department when she went for a pre-surgical scan; by desk staff at the surgery center; and by the nurse preparing her for surgery. Several nurses talked about her with each other and laughed. One staff person refused to talk with the patient when she addressed them. Even the anesthesiologist who she was expected

to entrust with her life in one of her most vulnerable moments before surgery, mocked her and intentionally referred to her as a man. Healthcare providers are supposed to provide comfort to patients when they seek healthcare. Instead, the staff increased her fear just before her surgery because they showed complete disrespect and lack of care for the patient's health and well-being.

c. Another transgender woman went to the office of an ophthalmologist at the same medical center for an eye exam. She arrived on time, filled out the initial paperwork, and then waited for about 45 minutes without being called for her appointment. The patient went to the desk to inquire, and was treated rudely by the staff. The staff then arbitrarily called a security guard to eject her from the office. As the patient spoke to the security guard, one of the clinic staff came to her and said, loudly and offensively, "Sir, your kind needs to go away. We're not serving your kind." She complained to the Office of the Chief Medical Officer and was eventually seen by the ophthalmologist on another day, after considerable effort by her and Whitman-Walker staff.

d. A transgender woman was seen by a medical provider at Whitman-Walker, who examined her and determined she might have broken her ankle. She was sent to the Emergency Room at a Washington, DC hospital. She identified herself to the ER check-in staff as a woman and presented a driver's license that contained a female gender marker. She then waited for a number of hours (she remembers five or six) without being examined. When she inquired about the delay, she was treated rudely and mis-gendered by ER staff. She was finally called from the waiting area, but was taken to the men's dressing room, rather than the area for women patients, to undress and put on a gown for a scan. During the four or more

hours before she received the scan, examination and treatment, she suffered very significant physical pain.

e. Another LGBT patient with end-stage renal disease, was confronted by a staff person at the dialysis clinic the patient attends regularly for care. The employee expressed a strong dislike for LGBT people and objected to being involved in the patient's care at the clinic.

19. The Denial-of-Care Rule will invite an increase in discriminatory experiences for LGBT patients seeking healthcare services, resulting in harm to the patients and community that Whitman-Walker serves.

20. Escalating healthcare discrimination and fear of such discrimination, resulting from the Denial-of-Care Rule, is also likely to result in increased demand for Whitman-Walker's healthcare services, which will present considerable operational and financial challenges. Many of Whitman-Walker's healthcare services lose money due to low third-party reimbursement rates and indirect cost reimbursement rates in contracts and grants which are substantially less than Whitman-Walker's cost of service. Increased demand for Whitman-Walker's healthcare services, driven by increased discrimination and fear of discrimination outside of Whitman-Walker, would exacerbate that pressure. We likely will be called upon to see more patients, and that patient care does not financially cover itself. As a result, Whitman-Walker may not be able to meet the increased demand and sustain the additional financial burdens resulting from an increased load of patients who either fear discrimination elsewhere or who were discriminated against or denied services at other institutions.

21. At the same time, given Whitman-Walker's mission to provide healthcare to marginalized communities, including the LGBT community and people living with HIV, Whitman-Walker needs to increase its education programs and community outreach to help those affected by the Denial-of-Care Rule find the healthcare services that they need and assist them with their trauma resulting from the Rule. Whitman-Walker needs to continue informing the community about its commitment to serving all patients in a non-discriminatory and welcoming manner and notify its patients that the Denial-of-Care Rule will not change Whitman-Walker's commitment to providing

exceptional healthcare services to all members of the community. Whitman-Walker will continue fighting for its patients' rights, including, for example, advocating on behalf of transgender patients who seek treatment for gender dysphoria, but who are rejected due to providers' religious or moral objections to treating such patients. As a result of the Denial-of-Care Rule, Whitman-Walker will also need to devote more resources to working with outside providers and organizations to remind them of the importance of providing healthcare to all patients on non-discriminatory terms.

22. The Denial-of-Care Rule also adversely impacts Whitman-Walker by necessitating a diversion and reallocation of resources in order to provide referrals to patients that it does not have the resources to treat either because Whitman-Walker has reached its capacity for new patients (especially in the behavioral-health departments) or because the patient requires treatment in a specialty that Whitman-Walker does not have. These types of referrals are routine at Whitman-Walker where its focus is on primary care and HIV-specialty care. The Denial-of-Care Rule will make it significantly more difficult and resource-intensive for us to locate, monitor, and provide appropriate referrals. With an increase in referral requests as a result of the Denial-of-Care Rule, Whitman-Walker will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to Whitman-Walker patients.

23. As I previously noted, Whitman-Walker receives various forms of federal funding for health and wellness-related services and for biomedical and behavioral research from HHS and from institutions affiliated with or themselves funded by HHS, including but not limited to funds under the PHSA, direct grants, Medicaid and Medicare programs administered by the Centers for Medicare and Medicaid Services, the FQHC and Ryan White funding administered by the Health Resources and Services Administration; funds under the 340b drug subsidy program, research grants from the Centers for Disease Control and Prevention and the National Institutes of Health, and Medicaid and Medicare reimbursements. The financial risk associated with these funds and related benefits accounts for tens of millions of dollars in revenue for the health center. Whitman-Walker, therefore, has a reasonable fear that it could be sanctioned and lose many millions of dollars of federal funding as a result of our nondiscrimination policies and other practices designed to

ensure the highest quality patient care and compliance with applicable medical guidelines, standards of care, and ethical requirements. If Whitman-Walker were to be sanctioned and lose federal funding as a result of the Rule's enforcement, the impact would include massive service reduction if not closure.

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 ___, 2019, in Washington, D.C.

Naseema Shafi
Chief Executive Officer

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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 Washington, D.C.

Naseema Shafi
Chief Executive Officer

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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 ADRIAN SHANKER, FOUNDER AND EXECUTIVE DIRECTOR OF BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, 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, Adrian Shanker, declare as follows:

1. Bradbury-Sullivan LGBT Community Center ("Bradbury-Sullivan Center") is a 501(c)(3) non-profit organization that is based in Allentown, Lehigh County, Pennsylvania, and incorporated in Pennsylvania. Bradbury-Sullivan Center is a comprehensive community center dedicated to advancing community and securing the health and well-being of the Lesbian, Gay, Bisexual, Transgender (LGBT) people of the Greater Lehigh Valley, a historically under-served region of Pennsylvania for the LGBT community. Bradbury-Sullivan Center provides programs and services to thousands of community members throughout the year.

2. I am the Founder & Executive Director of Bradbury-Sullivan Center. I assumed that role in 2014 when Pennsylvania Diversity Network restructured into Bradbury-Sullivan Center. I received a Bachelor's degree from Muhlenberg College in Religion Studies and Political Science in 2009 and earned a Graduate Certificate in LGBT Health Policy & Practice from The George Washington University in 2017. I previously volunteered as Board President of Equality Pennsylvania, served on the Office of Health Equity Advisory Board for the Pennsylvania Department of Health, and co-chaired LGBT Healthlink, which was a CDC-funded national disparity network for LGBT tobacco and cancer disparity work. At Bradbury-Sullivan Center, in addition to staff management, board development, fundraising, and strategic planning, I administer data collection for the Pennsylvania LGBT Health Needs Assessment. With Health Programs employees at Bradbury-Sullivan, I also develop health promotion campaigns to make behavioral, clinical, and policy changes to improve LGBT health. Since 2017, I have led the successful community efforts to ban "conversion therapy" in the cities of Allentown, Bethlehem, and Reading, Pennsylvania. In 2012 and 2018, Philadelphia Gay News named me Person of the Year and in 2019 Lehigh Valley Business named me a Healthcare Hero. 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.

3. Bradbury-Sullivan Center's programs and services for the LGBT community include arts and culture, health promotion, youth programs, pride programs, and supportive services. Youth services include healthy eating, active living, and HIV prevention in an every-day

after-school program. Supportive services include providing non-judgmental HIV/STI testing, Affordable Care Act open enrollment events, medical-marijuana enrollment assistance, and support groups, as well as hosting a free legal clinic. Bradbury-Sullivan Center also provides referrals to LGBT-welcoming healthcare providers, including providers engaged in services for transgender community members and family-planning services.

4. In addition to obtaining services from Bradbury-Sullivan Center, patrons of Bradbury-Sullivan Center often access healthcare services from other organizations, including religiously affiliated organizations. Bradbury-Sullivan Center works with patrons who have experienced discriminatory treatment when accessing healthcare services from such organizations and it advocates on behalf of those patrons by providing referrals to LGBT-welcoming agencies, training agencies to provide LGBT-welcoming services, and, when necessary, communicating with the agencies to inform them of their legal obligations to serve LGBT people. The Denial-of-Care Rule has major effects on Bradbury-Sullivan Center's advocacy and ability to continue such services given that the Denial-of-Care Rule invites healthcare providers to refuse to provide care to LGBT patients on the basis of religious or moral objections to LGBT patients' sex, relationship status, familial status, gender and sexual identities, healthcare needs, and medical decisions.

5. Bradbury-Sullivan Center services a region of Pennsylvania with limited options for LGBT-inclusive healthcare services. Finding LGBT-affirming healthcare options is already a struggle for the LGBT community in the region. LGBT patients experience both geographic barriers to healthcare and barriers to accessing LGBT-affirming healthcare. For some medical specialties, there often is only one or very few healthcare providers in the region who have the specialty necessary to treat a patient, so a denial of care from a provider could make it practically impossible for a patient to receive any specialty care at all. This is especially concerning given that some of the region's healthcare providers are religiously-affiliated organizations that could claim religious-based objections to providing any and all care to LGBT patients, invoking the Denial-of-Care Rule to claim an exemption from existing nondiscrimination laws, relevant medical ethical rules, and standards of care. As a result, the Denial-of-Care Rule will worsen health disparities

affecting the LGBT community and exacerbate the difficulties that members of the LGBT community have in finding and accessing necessary and respectful healthcare.

6. Bradbury-Sullivan Center patrons are already experiencing negative effects from religious discrimination in the provision of healthcare, compromising their health and well-being. For example:

a. We heard from a community member whose family member was a patient in an inpatient-care setting and was forced to participate in a so-called "conversion therapy" support group. When the patient complained about such requirements, he faced harassment and retaliation.

b. Another community member visited Bradbury-Sullivan Center for HIV testing after experiencing judgmental treatment from his primary healthcare provider. He told our staff that he did not feel comfortable receiving the service from his original healthcare professional as a result of the judgmental treatment.

c. Additionally, a program participant in one of our transgender support groups shared with a staff member that her doctor made negative, religious-based comments to her three years ago and as a result she avoided medical care for those three years. She went back for a physical examination this year and the doctor refused to touch her during her physical.

7. Bradbury-Sullivan Center also assists patrons who contact the Center because they are having difficulty finding LGBT-affirming healthcare services. Bradbury-Sullivan Center recently received an increase in referral requests. As a result of issuance of the Denial-of-Care Rule, and the inevitable increase in denials of care and discrimination that it will elicit, Bradbury-Sullivan Center may need to hire a case-manager to address the community's need for referrals to welcoming providers. Facing the Rule's imminent implementation, Bradbury-Sullivan Center has already needed to invest additional staff time to strengthen its referral process through the creation of a supportive services referral guide. It is increasingly difficult for Bradbury-Sullivan Center to find LGBT-affirming healthcare providers for certain specialties in particular, and the Denial-of-Care

Rule will further diminish the number of specialists available by emboldening additional providers to refuse healthcare treatment to LGBTQ patients, without even requiring the providers to inform prospective patients of the reason they are being turned away, let alone requiring them to give referrals or otherwise take steps to ensure that patients get the medically necessary healthcare that they need. This harms the community members that Bradbury-Sullivan Center serves and results in a major drain on its resources that need to be diverted from other programming.

8. Bradbury-Sullivan Center spends a significant amount of resources documenting health disparities in the LGBT community. Data gathered from that work confirmed that only about 17% of LGBT Pennsylvanians in 2018 had a provider whom they considered to be their personal physician. That means that in times of need, LGBT people are more likely to randomly select a healthcare provider with whom they do not have a relationship, putting them at increased risk of finding a provider who is not LGBT-welcoming. With an increase in refusals of care as a result of the Denial-of-Care Rule, LGBT people will be far less likely to receive the healthcare treatment that they need because, after being turned away, they are unlikely to seek other care out of fear of repeated rejections. Data from 2018 also indicated that over 50% of LGB and 75% of the transgender community fear going to a healthcare provider due to negative past experiences directly related to the patients' sexual orientation or gender identities.

9. The Denial-of-Care Rule will worsen those numbers as a result of increased refusals of healthcare providers to provide care to the LGBT community. This directly affects the Bradbury-Sullivan Center because it will have an increase in community members seeking referrals to LGBT-affirming healthcare providers, an increase in community members experiencing the trauma of discriminatory or unwelcoming healthcare experiences, and worsened community health outcomes among the population served by Bradbury-Sullivan Center.

10. Bradbury-Sullivan Center's research into health disparities facing the LGBT community reveals that approximately one in four members of the community in our region experience a negative reaction from a healthcare provider when they come out as LGBT. More than half of respondents report fear of a negative reaction by a healthcare provider if they come out. Indeed, approximately three quarters of all transgender respondents fear such a negative reaction.

Our research also identifies pervasive health disparities between LGBT people and the majority population with respect to tobacco use, cancer, HIV, obesity, mental health, access to care, and more, with LGBT people consistently experiencing worsened health outcomes. In other words, LGBT people, who are disproportionately likely to need a wide range of medical care, already have reason to fear, and often do fear, negative consequences of disclosing to healthcare providers their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-confirming medical treatment, and related medical histories.

11. By inviting discrimination against LGBT people based on their LGBT status and related medical histories, the Denial-of-Care Rule encourages LGBT people to remain closeted to the extent possible when seeking medical care. Bradbury-Sullivan Center's research demonstrates that more than a quarter of LGBT respondents are not out to *any* of their healthcare providers. Fewer than half are out to all of them. The Denial-of-Care Rule undoubtedly will exacerbate those numbers.

12. However, remaining closeted to a healthcare provider can result in significant adverse health consequences. 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.

13. Bradbury-Sullivan Center will have to expend more resources on its health promotion campaigns to ensure that LGBT people have access to preventative screenings for cancer, testing services for HIV and other STIs, and tobacco-cessation services given that the Denial-of-Care Rule will drastically change the healthcare landscape for the LGBT patient population. This is especially true for the transgender community because existing data predict that the transgender community will be especially afraid to seek out such care out of fear of mistreatment or rejection as a result of the Denial-of-Care Rule. There are many other new services, including, but not limited to, education and community outreach programs, that Bradbury-Sullivan Center anticipates having to initiate as a result of the Denial-of-Care Rule. For example, Bradbury-Sullivan Center intends to increase community-education efforts about the importance of having a

primary healthcare provider to ensure that LGBTQ patients have a healthcare provider whom they can trust so that they do not avoid seeking necessary care.

14. Bradbury-Sullivan Center also works with independent clinics to help them implement non-discriminatory policies and practices. Bradbury-Sullivan Center anticipates having to make clinical and structural policy changes at the organizations with which it collaborates, as a result of the Denial-of-Care Rule. In turn, the Bradbury-Sullivan Center will have to work harder to ensure that these clinics maintain and establish clear policies that prevent discrimination against the LGBTQ community, including having the correct signage that will signal to LGBTQ people that they are still welcome and will not be mistreated in such facilities in spite of the Denial-of-Care Rule.

15. Bradbury-Sullivan Center has a dedicated team of employees who focus on fostering a welcoming, nondiscriminatory atmosphere for patrons to access supportive services. Many employees of Bradbury-Sullivan Center could be negatively impacted by the Denial-of-Care Rule in the form of increased demand on their time and resources by patrons, a diminished number of affirming resources to provide, and the need to develop new resources and training materials from scratch.

16. Bradbury-Sullivan Center receives pass-through funding from HHS through a grant agreement with Pennsylvania Department of Health for Bradbury-Sullivan Center's youth program. Bradbury-Sullivan Center's state funding for this program comes from the federal Maternal & Child Health Block Grant. Bradbury-Sullivan Center, therefore, has a reasonable fear that it could be sanctioned and lose federal funding if subject to a complaint under the Denial-of-Care Rule in the course of Bradbury-Sullivan Center's efforts to ensure the best possible services for youth program participants.

As a result of the Denial-of-Care Rule, Bradbury-Sullivan Center will be required to redirect additional staff and resources from providing our own services to assisting patrons in finding healthcare providers in the region who will serve LGBT patients in a nondiscriminatory manner. Bradbury-Sullivan Center's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and creation of resources to address the

ill-effects of the Denial-of-Care Rule.

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

Executed on September 5, 2019, in Allentown, Pennsylvania.

Adrian Shanker
Founder and Executive Director