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 IX OF X

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF MAUREEN BROOM IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Maureen Broom, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my own knowledge.

2. I am the Enterprise Finance Officer and Associate Vice President

of UW Medicine. In this role, I oversee Accounting, Finance, Cost Reporting, Payroll, Financial Decision Support, Budget and Long Range Planning, Internal Controls and Population Health Analytics. I have the held this position since March, 2016. I have worked in the Healthcare Administration Field for twenty one years. Prior to the position I hold now, I served in a number of other leadership roles within Finance and Accounting at UW Medicine. I have a Bachelor's degree in Business and Accounting from the Foster School of Business at the University of Washington.

3. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule).

4. UW Medicine has a mission to improve the health of the public by providing a care experience for patients and their families that helps them achieve their personal goals for wellness and disease management; an educational environment for health professionals, students, and trainees that prepares them for leadership in their professional careers; and a research enterprise for scientists that enables them to advance medical knowledge and clinical innovations with groundbreaking discoveries. This includes collaborative support of healthcare providers and networks across the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) region. The Final Rule would place nearly all funding for these activities at risk.

5. UW Medicine receives $1.167 billion in federal funding from Department of Health and Human Services and more than $35 million in federal funding from Department of Education. UW Medicine receives $636 million in federal funding from the National Institute of Health and $690,000 from the Department of Labor. All contracted insurance carriers require CMS participation as a condition of providing patient care. UW Medicine consists of eight organizations and multiple joint ventures. We have more than 2,200 physicians, 28,000 employees, and more than 4,600 students and trainees. UW Medicine provides 1.64 million outpatients visits and 64,000 inpatient admissions annually. Services range from emergency airlift transport, the only Level 1 Trauma for the five state WWAMI region, unique regional transplant services, comprehensive Burn ICU and inter-specialty treatment team, and collaboration with community providers in rural areas across the WWAMI region. There are multiple types of medical services that can only be received at a UW Medicine facility within a five state region. Loss of this employment, training, and medical care in the PNW region would have a catastrophic impact on Seattle, Washington State, and the WWAMI region.

6. UW Medicine uses this money to fulfill the organization Mission and Vision to improve the health of the public by providing a care experience for patients and their families that helps them achieve their personal goals for wellness and disease management; an educational environment for health

professionals, students and trainees that prepares them for leadership in their professional careers; and a research enterprise for scientists that enables them to advance medical knowledge and clinical innovations with groundbreaking discoveries.

7. I anticipate the Final Rule will increase costs for UW Medicine and all related sub-recipients, and will likely have crippling impacts to the economy, health care access, and medical training opportunities in Seattle, the State of Washington, and the WWAMI region. In addition to serving populations in the Greater Seattle Area, UW Medicine is also a hub of collaboration for rural providers across Washington, Wyoming, Alaska, Montana and Idaho. This allows patients to receive top level care in their local communities. Providers can consult with top specialists at UW Medicine so they can address complex medical needs and also reduce the overall cost and disruption of care when patients are placed hundreds of miles from their support system.

8. The rule will impose immediate and long term costs on UW Medicine. This includes but is not necessarily limited to, the following activities:

a. changes to UW Medicine webpages;

b. preparation and physical posting of notices at all UW Medicine locations which include notices for both the public and for agency

employees;

c. preparation and publication of revisions to UW Medicine, applications, policy guidance, and other materials for use by agency employees, sub-recipients, and contractors;

d. providing notice to and overseeing implementation by all UW Medicine contractors, and various other sub-recipients of the implicated federal funds;

e. translation services to ensure all language groups that make up 5% or greater of the regional population are able to review this notification in their primary language;

f. creating and distributing education to more than 30,000 employees.

g. creating a short term tracking mechanism for data collection & maintenance process in time for July 22, 2019; and

h. building out technical tools and remediating downstream systems in order to maintain records of all reported employee conscientious objections within enterprise HR Systems.

9. As a preliminary estimate, UW Medicine projects these costs in the first year will cost approximately $8.2 million. These expenses include both the initial set-up and ongoing operational monitoring. Initial costs are increased due to the limited time from the Final Rule's effective date to the date of required compliance. Ongoing costs will range from $1–3 million annually to maintain

records, training, infrastructure, investigations, and expanded accommodation requirements in regard to moral obligations.

10. The Final Rule imposes significant ongoing record-keeping and compliance costs. This includes the obligation to maintain any information regarding discrimination on the basis of religious belief or moral conviction; any complaints, statements, policies, or notices; procedures for accommodating employees' or other protected individuals' religious beliefs or moral convictions; and records of request for accommodation and the response to it. Further, it is my understanding that a sub-recipient's violation of the Final Rule similarly places all federal funds at risk.

11. UW Medicine has many "sub-recipients," which I understand as defined as any person, organization, or any entity to whom there is a pass-through of Federal financial assistance or funding through UW Medicine. Those sub-recipients include providers, faculty, and research investigators.

12. In order to comply with the Final Rule's assurance/certification and compliance processes, UW Medicine will need to develop and maintain a comprehensive system for tracking and monitoring compliance at UW Medicine as well as the compliance status of all sub-recipients and contractors in the state. This system will require dedicated staff and contractor resources to fulfill the many recordkeeping and compliance activities required by the Final Rule including, but not limited to:

a. maintaining complete and accurate records of compliance with the with the Rule, including sub-recipients;

b. tracking all accommodation requests and complaints across programs;

c. facilitating an investigation of UW Medicine or any sub-recipient; implementing, or overseeing sub-recipient implementation of any corrective action required under the Rule; and

d. providing ongoing oversight of and training to the many sub-recipients and contractors across the state.

13. The Final Rule provides that the Department of Health and Human Services will consider posting of notices of non-discrimination as defined by the rule as non-dispositive evidence of compliance with the Rule. It lists placement of notice on agency websites, in prominent and conspicuous physical locations, in personnel manuals, in employment applications, and in any student handbooks as "postings" the Department will consider.

14. As a preliminary estimate, UW Medicine projects annual recordkeeping, compliance, training, and administrative costs in the range of $2 million to $3 million. This includes HR personnel to monitor the program, coordinate annual updates to employee documentation of objections, investigating complaints raised to the University Office of Civil Rights, legal review and revision of policies & procedures, updates to signage websites, and

written communication, and employee education regarding their rights. Additionally, smaller clinics may be more impacted by an employee with specific objections and would be required to over staff clinical areas in order to accommodate employee objections without moving them to a different clinic. This would result in increased salary, wage, benefits expense for the clinic and UW Medicine overall.

15. The Rule places at risk all federal funds UW Medicine receives from the U.S. Department of Health, U.S. Department of Education, the U.S. Department of Labor, and the National Institute of Health. The approximated total amount of federal funds UW Medicine received in the 2018–19 State Fiscal Year was approximately $1.2 billion.

16. It is also my understanding that the Final Rule does not just apply to health care professionals but to all personnel who "assist in the performance" of furthering a procedure. It is my understanding that the rule defines assistance broadly to include assisting with scheduling a procedure, transporting a patient to the procedure, or preparing a room for that procedure. In the context of services provided by UW Medicine this could include Environmental Services, Admissions, scheduling, securing prior authorizations for insurance coverage, transporting the patient for pre or post care, and even ensuring the patient is fully informed about their medical options and risks. Thus UW Medicine would need to accommodate, track, investigate, and manage a greater number of

potential objections than historically received.

17. UW Medicine currently accommodates religious objections to providing specific types of medical care. In the hospitals, there is a strong redundancy infrastructure to ensure both employee needs and safe patient care. However, in smaller clinics, last minute religious objections could significantly disrupt patient care. At least thirty days' notice is required to change staffing accommodations without impacting patient care.

18. UW Medicine manages Harborview Medical Center, the safety net hospital in King County, Washington, and cares for underserved populations who are unable to secure care in other settings. This includes birth control, abortions, and care for victims of sexual violence, homeless, immigrant, and the poor. If Harborview Medical Center is unable to provide these services, healthcare access in the community and many critical services would be significantly compromised.

19. The Final Rule appears to support overt discrimination against patients in need of care. An employee will be able to object to providing care to specific people or group of people, denying patients to equitable access to care based on any of criteria such as lifestyle, gender identity, infectious diseases, marital status, etc. This is directly contrary to both federal and state laws that explicitly forbid discrimination. UW Medicine has clearly communicated to employees and the community that we provide equitable care for all patient

populations in a safe and respectful matter, regardless of gender, race, religion, sexual identity, mental status, or immigration status. This is reinforced by a strong governance structure around diversity and non-discrimination in the workplace and provision of care. Any deviation from this standard of care would both contradict our Mission and organizational culture, as well as open up UW Medicine to significant risk of incurring lawsuits for discrimination.

20. Harborview Medical Center is a Level 1 Trauma Center that services patients with life threatening injuries on a daily basis. This requires careful navigation of end of life issues, including when to cease extreme measures. The strong staffing redundancy in a hospital setting currently ensures that staff members are not required to participate in care that does not meet the paradigms of their religious beliefs. This includes administration of blood products, abortions, end of life measures, etc. This rule would allow staff to go against the specific wishes of a patient and their family written in an Advanced Directive without full and complete communication regarding all available care options. This is in direct conflict with laws regarding patient consent and would open up UW Medicine to untenable legal risks from patient lawsuits when their care is not what they consented to. UW Medicine's mission, vision, and written policies do not support providing uninformed care to patients.

21. This Final Rule erodes the trust and teamwork in a clinical setting that is critical to providing effective, safe, and compassionate care to patients

during the most vulnerable times in life. This will create discord between care givers and patients, and erode the populations trust in the healthcare community when it is openly known that providers may be holding back vital information regarding a patient's care.

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

DATED this 24th day of June, 2019, at Seattle, Washington.

MAUREEN BROOM

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

/s/ Paul Crisalli
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Assistant Attorney General

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF MARY JO CURREY IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Mary Jo Currey, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my own knowledge.

2. I am the Assistant Secretary for Health Services for the Washington State Department of Corrections (DOC). I have worked in Health Services for

DOC for ten years. I have held this position since January 4, 2019. As the Assistant Secretary for Health Services, I am responsible for approximately 920 health care FTEs and a $170–185 million annual operating budget. I also: plan, direct, lead, and organize the work performed by the health services division of DOC; establish, monitor, and evaluate standards of clinical care and practice within the health services division; work collaboratively with other DOC executives to develop strategic plans and initiatives to carry out the agency mission; engage in labor relation issues; and evaluate risk. Prior to the position I hold now, I served as the Health Services Administrator for DOC from 2013 to 2019. As the Health Services Administrator, I had the following responsibilities: served as the Appointing Authority over Health Services units in the facilities within Command A; worked collaboratively with labor relations team to ensure staffing processes complied with collective bargaining agreement; initiated recruitment and retention efforts to strengthen clinical and auxiliary staff; had authority over hiring, personnel issues, and discipline; and reviewed and revised DOC's health services policies as needed or appropriate and engaged with health services leadership at each facility to ensure clinics are well equipped, staff are appropriately trained, and quality patient care is delivered safely and in a timely manner. Prior to that I served as the Health Services Manager from 2009 to 2013. In that position, I: managed clinic operations and served as the health authority for facility health services unit; had administrative oversight of dental, mental

health, nursing, and practitioner teams; led quality improvement initiatives to strengthen care delivery processes and patient outcomes; and handled staff management, including evaluations, corrective action, recognition and retention. I hold a Bachelor of Sciences Degree from the University of Wyoming and a Masters of Public Health from Texas A&M University.

3. Based on my review of Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule), the Final Rule will have significant impacts on DOC.

4. The Final Rule creates a categorical right by providers to refuse to provide information or services to which they have a religious or moral objection. This would include a provider's objection to an individual's socioeconomic status, race, color, gender/gender identity, sexual orientation, religion, national origin, language spoken, political preference, etc. Specific to DOC, providers could refuse to provide information or services to a population that many find morally reprehensible such as rapists, child molesters, and murderers. The Final Rule does not specifically identify which religious or moral values are protected and puts the patients that DOC is constitutionally required to protect at risk in a situation where patients already have a decreased access to providers.

5. The Final Rule places at risk all federal assistance DOC receives from the U.S. Department of Health and Human Services (HHS). The approximated total amount of federal financial assistance DOC received in the

2018–19 State Fiscal Year was in excess of $13.8 million.

6. DOC receives a variety of federal grants from HHS which are used for several vital services:

a. Programs to assist with the release, care, identification, screening, and referral of incarcerated individuals with Opiate Use Disorder who are reentering the community, for which DOC receives approximately $3.2 million annually; temporary housing services for HIV-positive individuals released from DOC into certain counties, for which DOC receives approximately $160,000 annually; Medicaid reimbursements to inform incarcerated individuals about the Medicaid program and assist them with the Medicaid enrollment process, for which DOC estimates receiving approximately $82,717 annually; and pre and post-release support services for fathers reentering the community to strengthen positive father engagements, support healthy partner relationships, and enhance education and employment opportunities for these individuals to improve their economic mobility, for which DOC receives approximately $1.5 million annually.

7. DOC also receives financial assistance for hospital treatment from HHS. When a patient is admitted in an inpatient status to a hospital for treatment and meets the eligibility criteria for Medicaid benefits, DOC forwards the bill to

Medicaid for payment. DOC is responsible for bill payment if a patient is ineligible for Medicaid benefits. The total amount of inpatient hospital bills and related ancillary services paid for by Medicaid were $8.9 million for fiscal year 2018.

8. DOC operates twelve prisons and twelve work release facilities across Washington for over 19,361 inmates. DOC also provides supervision to 20,455 individuals who have been released into the community. DOC is responsible for providing housing, food, and health care to incarcerated individuals, as well as various educational and vocational programming to promote their successful reentry to the general public.

9. DOC is required by state law, Chapter 72.10 RCW, to provide all medically necessary physical and mental health care to all individuals incarcerated in DOC prisons. DOC also provides health care for DOC violators (individuals who are temporarily detained due to a violation of their terms of supervision) who are housed at local jurisdictions, but, as a general rule, DOC does not provide health care for those on Work Release or on Community Supervision. Over 940 healthcare professionals and support personnel provide health services, including medical, mental health, dental and pharmacy services, through clinics and infirmaries in the prisons. The DOC Offender Health Plan (OHP) describes the criteria and process for determining what health services the Department provides to its patients. A true and correct copy of the OHP is

attached as Exhibit 1. The OHP defines three Levels of Care: Level 1—care that is medically necessary; Level 2—care that can be medically necessary in some instances, but not others, and Level 3—care that is not medically necessary and not authorized (e.g., procedures with primarily cosmetic benefits, treatment of minor ailments that do not have a serious impact on health, and certain specific interventions such as bariatric surgery and chiropractic care). Under the OHP, reproductive health services and health services for transgender patients, such as hormone replacement therapy, is considered medically necessary care.

10. Under the Eighth and Fourteenth Amendments of the United States Constitution, DOC has an obligation to provide medically necessary medical and mental health care. DOC can incur significant tort liability for damages and reasonable attorney fees if it fails to provide adequate medical care to its incarcerated patients. This is in addition to any injunctive relief that a court may impose on DOC.

11. The provision of Health Services at DOC for incarcerated patients poses unique challenges, especially if coverage is required due to a conscience objection. Health Services are provided at DOC prisons through outpatient clinics, infirmaries, and pharmacies. There are four small prisons that generally only have one provider on staff at a time. There are eight large prisons that have one or more clinics, but each clinic has a limited number of nurses and other practitioners at any one time. Coverage can be even more limited at night often

with only one or two registered nurses on duty. Advanced Care Practitioners, nursing staff and most ancillary providers are union represented and cannot be required to work at multiple locations. Further, most of the prisons are a considerable distance from one another making it virtually impossible to share practitioners between locations. In addition, transporting incarcerated patients to a willing provider is complicated by the fact that patients can't always be moved due custody levels and the types of treatments available at different locations. Even taking a patient to a hospital or non DOC clinic is a challenge because most of our prisons are located in geographically remote areas of the state sometimes with limited access to hospitals and clinics. All of this makes it difficult, if not impossible, to provide medical care in the event coverage is needed for a conscience objector.

12. The Final Rule defines "assist in the performance" to include taking an action that has a specific, reasonable, and articulable connection to furthering a procedure. This may include counseling, referral, training, or otherwise making arrangements for the procedure. In addition to personnel who provide healthcare services directly, such as physicians, advanced care practitioners, and nurses, all personnel who "assist in the performance" of furthering a procedure could similarly object. For DOC, personnel involved in scheduling or accessing care could include schedulers, correctional officers who serve as transport staff, bill payers, or staff who order supplies. As an example, if a correctional officer

objects to a clinical procedure or a specific patient, the officer could refuse to assist with the transportation of a patient to an appointment, or to perform the duties of hospital watch. The correctional officers are represented by a bargaining unit and under their contract are able to bid on positions based upon seniority. This bid process could make it very challenging for roster managers to accommodate conscience objections, manage the various posts, and ensure timely and responsive service delivery to our population, all while avoiding claims of "discrimination" as defined by the Final Rule.

13. Further, if a healthcare provider refuses to provide a medical service, or even refer the patient to another provider who *is* willing to provide that service, the patient's necessary medical needs could go unmet potentially resulting in harm to the patient, increased medical costs if a delay or complete failure to provide care exacerbates a medical condition, and liability. For example, if an incarcerated patient sends a notice indicating that he needs a certain procedure, the nurse who receives the notice could chose to disregard the patient's request and refuse to refer the patient or make arrangements for the patient's medical needs to be served. Further, DOC would be prevented from taking any action against the employee who caused these harms.

14. Additionally, although DOC is able to provide basic health care to patients on site, the agency still relies on a limited number of community providers for consultation and treatment of complicated cases. Since there are

very few community providers, particularly specialists, willing to contract with DOC to treat incarcerated patients, should any of the community providers cite the Final Rule and refuse to see our patients, DOC's ability to provide care would be limited even further. The cost of care would also be increased due to the need to find an alternate provider, transport the individual to the alternate provider, and, if treatment is delayed, a minor incident could turn into a more costly and significant medical incident.

15. There are many types of health care services that DOC provides or plans to provide in the near future that could give rise to religious or moral objection. For example, DOC provides a full range of reproductive health services to incarcerated patients (including services for patients who are pregnant upon incarceration or discover they are pregnant when they become incarcerated), vaccinations, and Hepatitis B and C treatment, or other potentially controversial care.

16. Notably DOC provides health care to a number of incarcerated patients who are gay, lesbian, bisexual, transgender, or queer. Some of these patients have very specific healthcare needs, such as hormone therapy. And if, for example, the prescription for hormone therapy is discontinued because a provider refuses to provide that necessary medical care, the patient could experience significant physical and mental health repercussions. It is also my understanding that under the Final Rule, care can be refused based solely on the

fact that the patient is gay, lesbian, bisexual, transgender, or queer. This violates current DOC policy and only serves to further exacerbate the unique challenges DOC faces when scheduling and providing care for its patients.

17. Specifically, DOC has already encountered one physician assistant who refused to provide medical care based on his religious beliefs. In that case the physician assistant refused to provide hormone therapy to the transgender patient under his care. In handling this situation DOC concluded that it would be an undue burden to allow the physician assistant to refuse to treat those conditions for two reasons. First, it would be permitting the employee to discriminate against patients based on their gender in violation of DOC policy. Second, because this patient was in a special unit, it posed logistical challenges to require other providers to drop their current work and attention to their patients in order to serve this physician assistant's patient in another part of the prison. It is my understanding that this case is potentially not an isolated incident and that other DOC medical providers wish to refuse care in other contexts. This could potentially have a major impact on DOC due to the unique challenges DOC faces in serving an incarcerated population described above. Further, I believe that if this rule is in effect, the healthcare needs of a very vulnerable population in the prisons system would be negatively impacted.

18. It is important to underscore that, unlike patients in other settings, patients in prisons have no alternative method for accessing health care.

Incarcerated patients cannot just go to another clinic, hospital, or provider who *is* willing to serve them. The provider on staff is often the only provider available. So if that provider refuses to provide the necessary care and refuses to refer the patient as allowed by the Final Rule, the patient could be left with no options or alternatives, which can result in physical and mental damage to the patient in addition to exposing DOC to tort liability.

19. Even when the provider refers a patient to another provider, I anticipate the Final Rule will increase costs for DOC. For example, in locations where only one provider is located, DOC would likely have to choose between transporting the patient to another facility for care (which has its own difficulties discussed above), or potentially having to hire and schedule a second provider in a manner that does not meet the Final Rule's definition of "discrimination." Additionally, the Final Rule would forbid DOC from asking the applicant before they are hired whether they have religious or moral objections to certain procedures or patients. Thus DOC could find itself in the untenable situation of having hired a second provider to accommodate a conscience objector only to have hired a second conscience objector.

20. The rule will also impose immediate costs on DOC. This includes but is not necessarily limited to, the following activities:

a. changes to DOC webpages;

b. preparation and physical posting of notices at all DOC locations

which include notices for both incarcerated individuals and for agency employees;

c. preparation and updates to 100 current job publications;

d. revisions to two existing policies ("Diversity and Inclusion" and "Non-Discrimination Disability Accommodation and Separation") as well as revisions to other materials for use by DOC employees; and

e. hiring an additional clinician at the four smaller camps (each clinician salary and benefits total approximately $173,000 per year)

21. As a preliminary estimate, DOC projects these immediate costs will be in excess of $650,000 over the next fiscal year.

22. The Final Rule imposes significant ongoing record-keeping and compliance costs. This includes the obligation to maintain any information regarding discrimination on the basis of religious belief or moral conviction; any complaints, statements, policies, or notices; procedures for accommodating employees' or other protected individuals' religious beliefs or moral convictions; and records of request for accommodation and the response to it.

23. Further, in order to comply with the Final Rule's assurance/certification and compliance processes, DOC will need to develop and maintain a comprehensive system for tracking and monitoring compliance at DOC. This system will require dedicated staff time and contractor resources to

fulfill the many recordkeeping and compliance activities required by the Final Rule including, but not limited to:

a. maintaining complete and accurate records of compliance with the with the Rule; and

b. tracking all accommodation requests and complaints across multiple prisons.

24. The Rule provides that the Department of Health and Human Services will consider posting of notices of non-discrimination as defined by the rule as non-dispositive evidence of compliance with the Rule. It lists placement of notice on agency websites, in prominent and conspicuous physical locations, in personnel manuals, and in employment applications as "postings" the Department will consider. In addition to our twelve prisons, DOC has over seventy individual field offices and locations, all of which would require the posting of notices.

25. As a preliminary estimate, DOC projects annual recordkeeping and compliance costs in excess of $ 350,000 annually. This number was calculated by estimating that eight locations would each require a half time human resource consultant to develop and implement a new system for accommodation tracking, recordkeeping, and compliance. After the system is created these costs would likely be smaller, but still significant.

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

DATED this 19th day of June, 2019, at Kennewick, Washington.

MARY JO CURREY

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
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Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF CYNTHIA HARRIS IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Cynthia Harris, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of eighteen, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

A. Introduction

2. I am the program manager for the Family Planning Program at the Washington State Department of Health (DOH or Department). DOH is Washington's statewide public health agency. It is located in the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. The Family Planning Program is a statewide family planning services program jointly funded through federal grants under Title X of the Public Health Services Act, 42 U.S.C. § 300(a), and state funds.

3. Family planning services are a critical part of basic healthcare that allow men and women to plan the number and spacing of their children, prepare for the birth of healthy children, prevent unintended pregnancies, and increase the economic well-being of their family. DOH is committed to ensuring Washington State residents have access to family planning services. We also work to integrate family planning services with primary care and link with other health care and social services, whenever possible. We prioritize services for people with low incomes, teens, hard to reach populations, people in need of confidential billing, and people who are uninsured or underinsured.

4. DOH's Family Planning Program provides leadership and oversight to our Family Planning Network of sixteen subrecipients offering Title X services at eighty-five service sites. We collaborate with other programs in the department; other state agencies; our subrecipient network organizations; and

other family planning, primary health care, and social service organizations to ensure that Title X services are available statewide. We ensure that all federal and state requirements are met. Our Title X project adheres to quality financial, operational, and clinical standards. The Family Planning Program's collaboration with other programs throughout the Department ensures coordination on issues related to women's health, adolescent health, family planning, sexually transmitted infection (STI) and Human Immunodeficiency Virus (HIV) prevention and treatment, intimate partner violence, and unintended pregnancy.

5. Family Planning Program staff work with operational staff at all levels of the department to ensure our Title X project is managed to meet all state and federal requirements, including all requirements of the Title X statute and all applicable regulations and legislative mandates. The Department uses multiple levels of review and technical assistance to ensure program integrity. Department-wide offices support communications, technology, contracting, grant management, and accounting, all of which help ensure that our Title X project meets state and federal requirements, and delivers a broad range of family planning services effectively and efficiently.

6. Given my leadership role, I have personal knowledge of the Family Planning Program's funding structure, all aspects of the application for and receipt of Title X funds, the Program's disbursement of grant funds to subrecipients through contract, the eligibility criteria for and identity of

subrecipients, and the eligibility criteria for patients to receive subsidized services. I also have expertise through my experience, training, education, and knowledge in the fields of family planning, health care delivery, Title X compliance, and other family planning regulatory requirements. I base this declaration on my personal knowledge, expertise, and review of program materials and data obtained through my position as head of Washington's Title X Family Planning Program, as well as available national data from peer-reviewed literature on programmatic family planning in the United States.

B. My Qualifications

7. The Family Planning Program is housed in the Office of Family and Community Health Improvement, one of four offices in DOH's Division for Prevention and Community Health. I have been the program manager for the Family Planning Program since 2013. I supervise a staff of five employees. My primary duties include overseeing the Family Planning Program, directing the Title X Project, assuring the program serves as many people in need of family planning services as possible within funding constraints, assuring the quality of services provided, overseeing the application process for Title X funding, overseeing the contracting process for the Family Planning Program, including Title X and state funds, managing program staff, and overseeing the monitoring of our subrecipients for compliance with state and federal (Title X) laws and regulations.

8. Before becoming the program manager, from 2000 to 2013, I was a Health Services Consultant at the Family Planning Program. In that role, my responsibilities included thirteen years of monitoring Washington's subrecipients for Title X compliance. As a special assignment during twelve of those thirteen years (from 2001 to 2013), I served as the point person in our program for reviewing bills proposed by the State Legislature to analyze their possible impact on the program. From 2015 to 2017, I served as chair of the State Family Planning Association, which is the national association of state health department Title X grantees. The DOH Family Planning Program is a member of the National Family Planning and Reproductive Health Association, and my staff and I currently serve as representatives of DOH in this organization. I serve on the Upstream Washington Advisory Committee, which oversees the work of a non-profit company, Upstream USA, offering contraceptive training to a variety of providers across the state in a five-year project to reduce barriers to contraception.

9. Before working for the Family Planning Program, I worked for the Hanford Health Information Network as a Health Program Specialist and Office Manager from 1993 to 2000. Before that, I worked for the Feminist Women's Health Center between 1985 and 1993, ultimately becoming its Director of Counseling and Training. I earned a Graduate Certificate in Public Health, Epidemiology Track from the University of Washington in 2000. I also have a

Bachelor of Science degree in Social Work from Heritage College and an Associate Degree in Psychology from Yakima Valley Community College.

10. I co-authored a paper on "Expanding Access to Emergency Contraception Through State Systems: The Washington State Experience," which was published in the journal *Perspectives on Sexual and Reproductive Health*, Volume 38, Number 4, December 2006.

C. Background on Washington's Title X Program

1. Washington is the sole grantee of Title X funds statewide

11. Washington State has received and administered Title X family planning funds continuously since 1971. They have been administered within DOH, through the Family Planning Program, since its formation in 1989. In addition to federal Title X funding, the Family Planning Program is funded by approximately $8.9 million in state funds each year.

12. Washington's Title X Project is a part of the Family Planning Program. The Family Planning Program pools federal and state funds and uses them collectively to achieve its mission. To qualify for federal Title X funding, including sliding scale discounts, clients must have an income of 250% of the Federal Poverty Level or lower. All current subrecipients receive a combination of federal and state family planning funds, which they use to serve their clients. It is not possible for us to track whether patients receive services with federal or

state family planning dollars. Further, subrecipients also may be paid for family planning services through private insurance, Medicaid, or client fees.

13. Nevertheless, the U.S. Department of Health and Human Services (HHS) requires that all services it deems "Title X core services" be provided in compliance with Title X regulations regardless of payor source, and we strictly enforce this requirement. All clients that receive services according to Title X regulations are counted as Title X clients in DOH's data system, regardless of the precise funding source for the services provided to that client. (These services are referred to in this declaration as "Title X services.") DOH has integrated its Title X funds with other funding sources and programs, including state funding and funding from third-party payors, to maximize efficiency and enhance its ability to provide comprehensive family planning services to those most in need of them.

14. DOH is the sole grantee of Title X funds in Washington State and runs the only Title X Project here. The Family Planning Program within DOH serves as an umbrella agency for sixteen current subrecipients operating eighty-five clinics throughout the state, which we call the Family Planning Network. The Family Planning Program expects to serve approximately 98,000 individual clients from April 1, 2019 through March 31, 2020.

15. My Family Planning Program staff work together on every aspect of our Title X-related activities. They are responsible for planning and evaluation;

the application process; contract administration; monitoring subrecipient compliance with state and federal guidelines and regulations; promoting collaboration among stakeholder groups; serving as a clearinghouse for family planning information and training opportunities; and providing consultation and technical assistance to subrecipient organizations and stakeholders.

2. Washington's demographic characteristics related to reproductive health care

16. Washington is divided into thirty-nine counties encompassing 71,298 square miles. Three-quarters (29/39) of these counties have a population density of less than 100 people per square mile, and one county is smaller than 250 square miles. These twenty-nine counties are considered "rural" under Washington State law.

17. The Cascade Mountains, running from north to south, form a geographic barrier between western and eastern Washington. While the east side of the state is geographically larger, it has a markedly lower population density. Eastern Washington's size and low population density present significant barriers to healthcare access. In general, people must travel farther to access services in the eastern part of the state. It is also more difficult to recruit and retain health care providers in rural areas.

18. Nearly half of Washington's counties are designated as Primary Care Health Professional Shortage Areas—having a population to provider ratio greater than 3,500 people per primary care provider. Rural areas of the state tend

to have lower percentages of people with health insurance and higher percentages who tend to postpone doctor visits due to cost. Rural area residents also tend to get fewer preventive screening services. In general, the farther away people live from an urban core area, the greater the magnitude of health disparities.

19. Of Washington State's estimated 7.4 million residents in 2017, 20% (1.46 million) were women of childbearing age (15–44 years). In 2014, the Guttmacher Institute reported 884,410 women in need of family planning services and supplies in Washington State. Of these, 429,300 (48.5%) were in need of publicly supported services—this figure includes all women between the ages thirteen and forty-four who are: sexually active, not sterile, and are either teens or have incomes at or below 250% of the federal poverty level. In that same year, the Washington Title X Project provided services to 74,842 women—fewer than one in five compared to the number of women in need.

20. The number of Washington State women in need of publicly funded family planning services grew by 35% from 2000–2014, the last year for which we have data. The number of Title X clients served was relatively stable from 2012–2015 but increased to 90,168 clients in 2016 and 91,329 in 2017, 14.9% more than the 2012–2015 average.

21. While the priority of the Title X program is reaching low-income populations, adolescents face major barriers to contraceptive and reproductive health services and often do not access needed services, either due to barriers or

lack of knowledge about where such services are available. Barriers for this population include cost, lack of transportation, and confidentiality concerns, and the real or perceived inability to use insurance while maintaining confidentiality of services. In addition, sex education is not mandated in Washington's public schools (though it must be comprehensive and medically accurate, if provided). This leaves some adolescents with little knowledge of sexual health and safe sex practices. Adolescents face higher risks of unintended pregnancy and sexually transmitted infections (STIs), with some of the highest rates of STIs in women between the ages of fifteen to twenty-four. While the age distributions of Title X clients are shifting, most clients are under the age of twenty-five, which highlights the importance of these clinics for young adults and adolescents. Adolescents experience a disproportionate rate of unintended pregnancies and face significant barriers to affordable and confidential family planning and reproductive health services. Disparities exist in teen pregnancy rates across Washington counties and are especially high in rural counties and those with higher poverty rates.

3. Amount of funding and services provided

22. Washington's Family Planning Program delivers family planning services to low-income individuals in Washington, including a broad range of contraceptives, counseling on reproductive health and other medical issues, testing for STIs and HIV, and screening for human papillomavirus (HPV) and

cancer. DOH distributes Washington's Title X funds via an allocation process, approved by DOH and the Office of Population Affairs (OPA) within HHS, to subrecipients that provide these services.

23. For the current Title X funding period, DOH initially received a grant for a three-year period, which began on April 1, 2017. Partway through that period, DOH received a letter from HHS shortening the project period to one year, ending March 31, 2018. HHS did not announce a new funding opportunity in time to make awards for the next project period before March 31, 2018, so DOH was granted an extension of the grant period to August 31, 2018. DOH applied for and received a grant in the amount of $2,783,000 for the period of September 1, 2018 to March 31, 2019. Attached hereto as Exhibit 1 is a true and correct copy of the notice of award for that grant.

24. For 2017, Washington's Family Planning Program expenditure (using both state and federal funds) was approximately $13 million. The state-funded amount was approximately $9 million, and the federally funded amount was approximately $4 million.

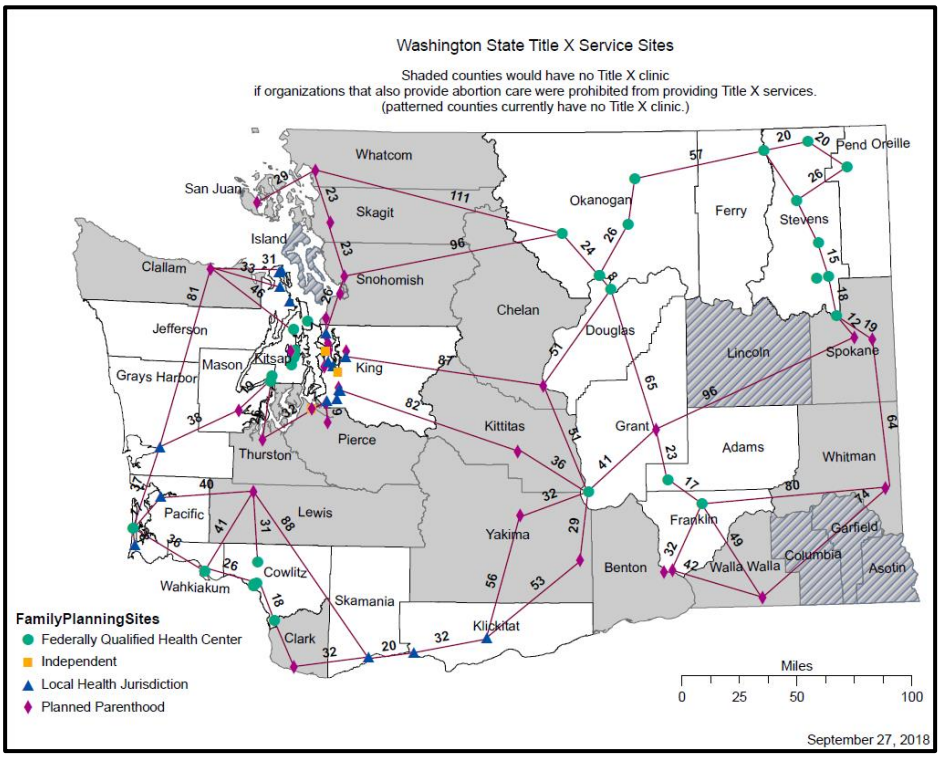
25. On January 14, 2019, DOH submitted an application for a new three-year Title X grant, to begin on April 1, 2019. My staff prepared this application, and before submission it is subject to three levels of review within DOH. Preparing this application, gathering the required materials, and ensuring its accuracy in every respect required over 300 hours of staff time.

4. Benefits to Washington from the Title X Program

26. DOH estimates that Washington's Family Planning Program services prevented 18,150 unintended pregnancies in 2017, 8,550 unplanned births, 6,140 abortions, and 1,090 unplanned preterm/low birth weight births. In addition, these services prevented 1,030 chlamydia infections, 60 gonorrhea infections, and 10 HIV infections. All Family Planning Program preventative services resulted in net cost savings to the state health care system of $113,267,480.

5. DOH's Title X grant subrecipients

27. As of September 1, 2018, there were sixteen Title X subrecipient organizations with a total of 85 clinic sites across Washington. The following map prepared by DOH shows all Title X service sites within the state:



Attached hereto as Exhibit 2 is a true and correct copy of an enlarged copy of the map above.

28. A number of Washington counties only have one Title X provider, including Adams, Benton, Clallam, Grays Harbor, San Juan, Wahkiakum, Lewis, Thurston, Jefferson, Whatcom, Skagit, Clark, Skamania, Kittitas, Chelan, Ferry, Pend Orielle, Whitman, and Walla Walla. The following five counties (of thirty-nine Washington counties) currently have no Title X provider: Island, Lincoln, Columbia, Garfield, and Asotin. Clients living in these counties have to travel to the nearest county that has a Title X provider to obtain Title X-funded services.

29. All but five of our subrecipients have more than thirty years' experience providing family planning services to their communities—four have provided these services for more than fifty years. All have experience providing high quality, confidential family planning services consistent with current, evidence-based national standards of care and current legal requirements. These services include comprehensive reproductive health exams—including questions about pregnancy intention or discussion of reproductive life plans; fertility counseling; contraceptive care, including a wide array of birth control methods—including long-acting reversible contraception such as intrauterine devices and implants, birth control pills, barrier methods like condoms, and natural family planning methods; preventative screenings for STIs and cancer;

reproductive health information, education and counseling; and community education and outreach.

30. All subrecipients also provide pregnancy testing and options counseling; level one infertility services; sexually transmitted disease testing, counseling, and treatment; and HIV testing and treatment referral. All subrecipients provide referrals for any type of medical care not provided through Title X that clients may need. All have demonstrated familiarity with, and ability to provide, family planning services and related preventive health care consistent with current recognized national standards of care and in compliance with applicable state and federal laws.

31. All of our subrecipients use certified Electronic Health Record systems that are interoperable. This is one of the requirements for joining our network.

6. Washington's Title X patients

32. Washington served 91,329 individual patients through Title X in 2017, with 128,409 patient visits. These numbers include patients who had other sources of payment such as insurance or Medicaid, but who received services in clinics within Washington's Family Planning Network according to HHS's Title X regulations. In 2017, 56% of Washington's Family Planning Program patients were at or below the federal poverty level, and 81% had incomes below

200% of the federal poverty level. Seventeen percent of clients were women of color. Nine percent of patients were under the age of eighteen.

33. Of those below 100% of the federal poverty level in Washington in 2012–2013, 34% were uninsured and 29% were underinsured. This population has the greatest need for publicly funded family planning services and associated preventative health services. Currently, 19.6% of Title X clients are uninsured, a much higher proportion than the state population as a whole. All Washington counties with the highest poverty and uninsured rates are rural. They have significantly smaller and less dense populations and fewer available health services.

7. Selection of Subrecipients

34. DOH selects subrecipients using robust criteria to ensure their capacity to provide large numbers of patients with a broad range of high-quality family planning services in a noncoercive, client-directed manner that respects and is appropriate to the populations in their communities.

35. Abortion care and sterilization services are not provided as part of Washington State's Title X Project.[1] Subrecipients' written policies must state

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[1] DOH maintains some state funds in an account separate from Title X funds that it allocates for abortion services and sterilizations. Providers bill DOH and are reimbursed for these services separately from any Title X services.

clearly and unequivocally that no Title X funds will be used for abortion services. This is a core element of our competitive selection process.

36. DOH initiates the selection process by widely distributing information about an upcoming competition for Family Planning Program funds toward the end of the preceding project period in geographic areas that, based on the Guttmacher Institute's identified areas of need and DOH data, are the most in need of subsidized family planning services. DOH uses objective reviewers to evaluate the applicants, based on objective criteria assessing their capability to best utilize the available funding to carry out Title X requirements. DOH also evaluates the applicant's qualifications (including its program structure, patient-service capacity, history of receiving and utilizing funds, and other factors); assesses the particular needs in the geographic area the applicant will serve; learns how the applicant will provide services and the types of services it will provide; reviews the applicant's policies, procedures, and protocols (including those on reporting suspected abuse, maintaining medical records, and providing nondirective care); receives contractual assurances indicating that federal funding will not be used for abortion as a method of family planning; reviews the applicant's training and orientation practices; evaluates the applicant's ability to educate the community and provide outreach; and investigates the clarity, detail, and reliability of the applicant's financial management systems.

37. We periodically invite interested organizations to apply to join our Family Planning Network (local public health organizations, federally qualified health centers and look-alikes, rural health centers, hospitals, and any other organization that requests notification). We typically time this opportunity to coincide with the project period of our federal Title X grant. In addition, we include further opportunities to apply as needed to maintain a comprehensive, sustainable Family Planning Network. This combination of sustaining existing subrecipients and recruiting new subrecipients supports a robust, sustainable statewide network of organizations providing Title X family planning services.

38. During our last recruitment period, summer 2018, we welcomed four new subrecipients into our network—two federally qualified health centers and two local public health organizations. These four new subrecipients, along with the two we added in 2016, brought our total number of subrecipients to 16. In all 15 new clinic sites began offering Title X services in September 2018. Our network has a vibrant mix of organizations providing Title X services—local public health organizations, federally qualified health centers, Planned Parenthood affiliates, and an independent non-profit women's health organization.

8. Staffing of Washington's Title X clinics

39. All Title X clinics in Washington have physicians on staff as medical directors, but nurse practitioners are the primary patient-care providers. All sites have nurse practitioners accessible during all business hours.

9. Contractual requirements and intensive monitoring of subrecipients

40. The Family Planning Program has ongoing responsibility for ensuring Title X services are provided in compliance with the Title X authorizing statute, regulations and guidance. As stated above, this starts with, and is a prominent aspect of, the subrecipient selection process. To fulfill our responsibility for ensuring the legal compliance, services, quality, cost, accessibility, reporting, and performance of our Network, we actively monitor and provide technical assistance to our subrecipients.

41. Washington subjects Title X providers to numerous contractual requirements, including: (1) they must be non-profit or public agencies; (2) they must meet reporting requirements (including the ability to extract data from their electronic medical records systems to report to the contracted data vendor); (3) they must follow all applicable laws and regulations; (4) they must ensure that abortion services are separate from Title X funding; and (5) they must have qualified personnel and licensed providers.

42. By signing the Family Planning Program contract with DOH, all subrecipients agree to enforce the same certifications, assurances, cost principles,

and administrative rules. That contract provides that the subrecipient does "not provide abortion as a method of family planning within the Title X Project (42 CFR 59.5(5))." All subrecipients signed assurances that their Title X funds are completely segregated from any abortion services and that they are in compliance with Section 1008. As explained more fully below, we ensure compliance through several levels of review, including: (a) review of documentation of expenses submitted with each invoice; (b) desk reviews of costs analyses, fee schedules, and contract deliverables; and (c) on-site reviews of policies and procedures and of subrecipient financial and management records.

43. To ensure compliance with federal regulations, DOH maintains and periodically updates the Washington Family Planning Manual. The Family Planning Manual is a compilation of guidelines applicable to all subrecipients made applicable to them in their contract with DOH. The Manual provides directions to clinics for ensuring Title X and state compliance, including guidelines for ensuring contractors' compliance with section 1008 prohibiting the use of Title X funds for abortion as a method of family planning.

44. In addition, DOH does three types of monitoring: administrative, clinical, and fiscal. As grant funds flow through the Family Planning Program to a subrecipient, the Family Planning Program maintains primary responsibility for ensuring compliance with federal and state requirements—both of which pertain to all subrecipients, as they receive both federal and state funds.

45. DOH monitors subrecipients every three years for administrative, clinical, and fiscal compliance with Title X regulations. The fiscal review looks at all of the subrecipient's expenses to determine that no Title X funds were used for abortion as a method of family planning.

46. DOH's On-Site Monitoring Tool, a checklist created by DOH based on the tool that the federal OPA uses to monitor us as the grantee, is used by DOH site consultants, the nursing consultant, and agency fiscal experts to perform on-site reviews at least every three years at each clinic. They conduct monitoring that includes ensuring that: (1) the clinic is in compliance with Title X regulations and quality standards, including section 1008; (2) the clinic's financial system maintains financial separation of Title X dollars and abortion services; (3) clinic personnel are informed that they could be prosecuted under federal law if they coerce, or try to coerce, anyone to undergo an abortion or a sterilization procedure, and the clinic has a policy in place to this end; (4) the clinic has written policies clearly stating that no Title X funds (or state funds associated with the Title X program) will be used to fund abortions; and (5) clinic staff members have been trained on practices to ensure that Title X funding is kept strictly separate from abortion services.

47. The site consultant verifies during an onsite visit that each of these requirements is met by reviewing the subrecipients' policies and procedures, personnel records, and accounting system. The consultant also interviews many

staff members, including CEOs, CFOs, human resources personnel, medical directors, clinicians, and front desk staff. DOH undertakes these extensive monitoring obligations because any failure to comply could jeopardize the federal funding the program relies on.

48. Currently, five subrecipients provide abortion services. Those subrecipients have extensive timesheet and cost allocation procedures to ensure that no Title X funds are used in programs providing abortion. Family Planning Program staff provide technical assistance on this issue and our site consultants coordinate with department fiscal experts and our nurse consultant during desk and site reviews to ensure compliance.

49. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule).

50. I anticipate the Final Rule will increase costs for the Department of Health as a whole. I am only referring to the DOH Family Planning Program in this declaration. DOH, the Family Planning Program and all related sub-recipients and will likely have negative impacts to the mission of agency and health care access in the State of Washington.

51. If this rule is implemented, it is unlikely that DOH would be able to apply for the Title X funding. It would be nearly impossible for subrecipients if they have to hire new staff. Abortion and sterilization are not paid for with the

federal Title X funds. However, subrecipient staff give information about those procedures and refer out for those services.

52. If subrecipient staff refuse to provide those services, they are withholding medical information that may be detrimental to the client. Withholding medically accurate information from patients is unethical and may be a breach of fiduciary duty. It limits patients' ability to evaluate and choose the health care that best benefits their own lives. And withholding information erodes trust and candor within the provider–patient relationship. Withholding referral to legal, safe, quality medical care will also increase negative health outcomes—particularly since the Final Rule's referral ban contains no exception for medically indicated abortion except in an "emergency."

53. I understand that the rule could be interpreted beyond abortion and sterilization. Hormonal (birth control pills, patches, and rings) and Long Acting Reversible Contraception (IUDs and Implants) are controversial to some people. If the subrecipient cannot ask upon hire whether a nurse practitioner, for example, would be able to provide those services to clients who want them, they would have to hire another person who would be able to provide them. Because they cannot ask upon hire, they may end up with two nurse practitioners who would not provide the services. This could go on and on with the result being that the subrecipient could not provide the services that it is their mission to provide.

54. Studies show that there are negative health consequences of

unwanted childbearing. Parents of unwanted childbearing have higher incidents of depression and are more likely to engage in neglect. Studies show that increased incidents of unwanted childbearing happens to those below the poverty line, even though the parents want the same number of children as those in higher economic demographics.

55. In the unlikely event that the State could keep HHS Title X funding under this rule, there would be a loss of program integrity to the point that many existing subrecipients would drop out of the program. In addition, it would simply be too costly to operate the program with the threat of employee lawsuits because they cite moral objection to providing the service. Theoretically, the rule would create the opening for organizations that provide coercive reproductive health services (i.e., only natural family planning and no abortion or sterilization referrals) to apply for subrecipient funding.

56. If the State opted out of the Title X program, the loss of $4 million in funding would result in fewer clients served. The increased pressure on the State side of the program would result in a lesser amount of funding provided to these agencies. Subsequently, fewer clients served will result in an increase of unintended pregnancies.

57. In either scenario, the costs to the State of Washington as a result of this will be well over $100 million. Analyses show that significant cost savings are achieved by funding family planning services. Nationally, an estimated $7.09

is saved for every dollar spent.[2] Based on that metric, in just the first year after the Final Rule goes into effect, Washington stands to lose more than $28 million in savings from the loss of federal dollars ($4 million in annual federal funds x $7.09). This figure does not even account for the additional costs associated with changing the State's administrative system for the provision of family planning services (of which would also be multiplied by $7.09 per dollar).

58. In addition, cervical cancers will not be diagnosed in early stages, and complications will occur due to untreated STIs. Unintended pregnancies not only lead to more abortions, but further health issues. Parents of children resulting from unintended pregnancies are more likely to suffer depression, anxiety, and feelings of unhappiness. The failure to diagnose cancers and STIs early can lead to further complications, and even death.

59. In sum, the Final Rule will have a devastating impact on Washington's Family Planning Program and wreak havoc on the provider network it has overseen and administered for over thirty-five years, massively disrupting the provision of family planning services to patients in need.

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[2]Jennifer J. Frost, *Return on Investment: A fuller Assessment of a Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, Milbank Quarterly, Vol. 92, No. 4, p. 668 (2014) (*available at* https://www.gutmacher.org/sites/default/files/pdfs/pubs/journals/MQ-Frost_1468-0009.12080.pdf).

60. In reality, Washington would no longer be able to administer its integrated, jointly funded Title X program subject to the Final Rule's requirements, because following the Final Rule would entail violating state law and preventing subrecipients from providing family planning services consistent with medical standards of care and ethical requirements. Washington will have to decline Title X funds altogether, give up on administering the integrated program it has overseen for decades, and build a new program from the ground up in order to reap the cost-saving and public health benefits of providing subsidized family planning services. The new program will take time and money to set up, and will necessarily be a diminished version of the current jointly funded program.

61. The Final Rule will immediately quantitatively and qualitatively reduce the benefits of Washington's Family Planning Program, causing negative health outcomes throughout the state—the effects of which will be felt for a generation.

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

DATED this 21st day of June, 2019, at MABTON, Washington.

Cynthia Harris

CYNTHIA HARRIS

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF MIKE KREIDLER IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

Myron Bradford "Mike" Kreidler, declares:

1. I am over the age of eighteen years old, have personal knowledge of all facts and matters in my Declaration, and am competent to testify to the matters below.

2. I was first elected Insurance Commissioner in 2000 and have served

continuously since then; I was re-elected to my fifth term in 2016. Before being elected Insurance Commissioner, I received a master's degree in public health from UCLA, was a doctor of optometry, and practiced with Group Health Cooperative for twenty years. I also served sixteen years in the Washington State Legislature and two years as a member of the United States House of Representatives.

3. As the elected Insurance Commissioner, I am responsible for managing Washington's Office of Insurance Commissioner (OIC), which protects Washington's insurance consumers and oversees and regulates the insurance industry. The OIC currently has approximately 246 employees and a statewide network of more than 400 volunteers. Among its responsibilities, OIC licenses and audits the 38 insurers domiciled in Washington; regulates and may revoke the authorization or registration of the more than 2,100 other insurers that do business in Washington; tests, licenses, and regulates the more than 182,000 individuals and businesses licensed to solicit insurance in Washington. As part of its regulation of health insurance, the OIC seeks to promote, among other goals, timely and non-discriminatory access to medical care and essential health benefits.

4. I am familiar with the recent regulatory action taken by the United States Health and Human Services (HHS) in the form of its proposed Final Rule, set forth in the Protecting Statutory Conscience Rights in Health Care;

Delegations of Authority, RIN 0945-AA10. Although I have many concerns about this particular Final Rule, there are four provisions which particularly threaten the right of Washington consumers to receive timely and affordable medical care or health coverage. Contrary to existing Washington and federal law, the Final Rule (a) significantly expands the scope of those who may object to providing health care; (b) allows a person, or institution, to unilaterally and absolutely refuse to provide medical care or health insurance coverage; (c) removes any obligation to refer the patient to alternative sources of, or even provide information about, other medical care, coverage, or options; and (d) does not require notice or disclosure of the reason for the refusal, even to the patient. These changes, individually and collectively, pose an immediate and irreparable harm to Washington's health care consumers. The following is a summary of the adverse consequences these changes in the Final Rule will likely have.

5. The Final Rule (a) will harm Washington insurance consumers, and patients, by delaying timely access to medical care; (b) will likely result in denial of access to medically necessary health care services; and (c) will likely increase unlawful discrimination against patients. These adverse consequences, and others, will likely have a disproportionate impact on (a) women; (b) those who live in rural communities or geographical areas with limited medical treatment options; (c) and members of the lesbian, gay, bisexual, transgender, queer or (LGBTQ) community. The following are some, but likely not all, of the adverse

effects the Final Rule will have on Washington's insurance consumers.

6. As noted, the Final Rule significantly broadens the scope of those who may refuse to provide medical care by extending it beyond medical providers, medical facilities, and other health care institutions (such as health care insurers). For example, in addition to allowing refusals to provide medical care by medical providers, the Final Rule will also extend this option to their employers and employees, such as call center staff, receptionists, or scheduling personnel. In addition to medical facilities, the Final Rule will also apply to third-party administrators. By extending the option to refuse medical care or provide health coverage, based on a personal bias against a particular medical service or patient, the Final Rule threatens the right of Washington consumers to receive either medical care of health coverage, or both.

7. The Final Rule threatens the fundamental right to be free from discrimination, as it interferes with enforcement of Washington State laws that prohibit discrimination on the basis of race, color, ancestry, marital status, sex, sexual orientation, gender, and gender identity.

8. The Final Rule creates a greater risk that millions of dollars of federal funding may be withheld if Washington does not comply with its mandate, in the judgment of HHS's Office of Civil Rights, despite the fact that such "compliance" is contrary to Washington, and federal, law.

9. As part of its regulation of health care coverage, OIC requires that

health insurers provide timely access to medical care. Health insurers submit their medical provider network data to OIC, which includes information about medical providers who are available to provide medical care to policyholders of that insurer. OIC also receives consumer calls, requests for information, and complaints from patients who encounter difficulty receiving timely access to medical care.

10. The Final Rule will likely make it more difficult for patients to access the care they need in a timely manner, given its expansive reach. When care is delayed or denied, it can result in more costly care at a later date, which can result in adverse medical outcomes. In addition to the increased medical risks and costs, the Final Rule will likely create greater confusion—for patients, providers, medical institutions, and health care insurers—given its conflict with already existing state and federal laws.

11. Should medical providers, or their non-medical staff, now exercise the discriminatory refusals of care invited, and protected, by the Final Rule, the medical provider networks of health care insurers may be not be able to provide timely access to specific, reasonable, or necessary medical care. As a result, these insurers will be required to arrange for care for their policyholders with out-of-network providers, action that will likely result in increased costs to the insurers (or their policyholders). In addition to the increased costs, patients forced to seek out-of-network medical care may pay uncovered higher costs directly.

12. Concerns about access to necessary and timely health care are not hypothetical. Throughout my medical and public service careers I have heard from and spoken with many people who have experienced difficulty getting access to medical care because of who they are or because of the type of medical care they needed.

13. Since 2014, I have made it clear to health carriers in Washington that they cannot arbitrarily exclude treatment for gender affirmation services, such as hormone therapy, mental health services, and surgical care. Any treatments for gender dysphoria must be offered in parity with other medical services. Although state law prohibits discrimination on the basis of gender identity, as Washington's Insurance Commissioner, I am concerned that the Final Rule threatens coverage for this type of medical care and may encourage others to engage in such discriminatory conduct by refusing to provide medical care.

14. As Washington's Insurance Commissioner, I am responsible for enforcing the federal Affordable Care Act (ACA) and state laws that require health care insurance policies to provide coverage for preventative care. The Final Rule will likely interfere with the ability of women to get access to, or even information about, the full range of reproductive health services that the must be covered by health insurance.

15. It is likely that the Final Rule will create more difficulties for women who seek to timely and consistently fill their prescriptions for contraceptives each

month. As a consequence, it is likely that some women will became unintentionally pregnant, despite having a prescription for contraceptives. By allowing more pharmacists or others to interfere with access to contraceptives, the Final Rule will impose increased, and unfair, hardships on women, some of whom will then face unintended pregnancies or abortions that would otherwise not have occurred.

16. The Final Rule will likely limit access to medical services for victims of sexual assault who are seeking treatment to prevent pregnancy. A delay of such treatment can result in unintended pregnancies. For example, it can reasonably be anticipated that some of victims of sexual assault will be transported from one emergency room to another, and to a more distant and inconvenient one at that, so that they may receive the medical care needed. In addition to the trauma of such an experience, there is the increased risk of an unwanted pregnancy.

17. Aside from pre-pregnancy contraceptive care, the Final Rule will disproportionately and unfairly impact women who seek access to abortion services. When access to abortion services is delayed, the type of procedure that will be medically appropriate may change, and may result in greater cost.

18. One of the most troubling aspects of the Final rule is that by expanding the objection rights of insurance carriers, providers, and employers, it threatens to unravel the careful balance our state Legislature created under

RCW 48.43.065, commonly referred to as the Conscience Clause. This statute gives carriers, providers, and employers, the right to object to providing mandated coverage on the basis of religious or conscience. However, the rights of individual enrollees remain protected. If a provider, employer or carrier objects to coverage of a particular service, then the carrier (when the employer or provider objects) or the employer (when the carrier objects) must provide information to enrollees about how they can access services they are entitled to under state law.

19. The Final Rule not only allows objectors to refuse to provide services, but also allows them to refuse to refer consumers back to their carrier or employer who could provide crucial and time sensitive information on how to access services. Even worse, the Final Rule appears to allow carriers and employers themselves to refuse to provide enrollees with the information they need to access services.

20. It is likely that the Final Rule will also limit access to medical services in rural communities and other geographical areas where there are limited numbers of health care providers, a circumstance which will endanger patients. This is a real risk in Washington, as many parts of our State are sparsely populated and have limited access to medical providers or facilities.

21. Although the Final Rule provides that ". . . patients in rural areas are more likely than patients in urban areas to suffer adverse health outcomes as a

result of being denied care" (84 Fed. Reg. at 23253), it has simultaneously promulgated a number of provisions which expand those who can, and under what circumstances are able to, interfere with a patient's need for timely and necessary medical care.

22. As noted, many parts of Washington consist of rural communities, which have fewer options for access to primary care doctors and specialists. For those enrolled in employer funded or "self-insured" plans, this impact will be even more dangerous. Individuals enrolled in a fully insured plan can always contact their carrier for information about how to access the coverages they are entitled to receive under state law and the terms of their health plan. But for self-insured employer plans, there is no health carrier for individual enrollees to call if their employer refuses to pay for coverage that those enrollees are seeking. Therefore, those enrollees may have even greater obstacles in obtaining medically necessary treatment.

23. The effects of the Final Rule will likely prove to be disproportionately harmful in areas where there are smaller numbers of medical providers or insurers, as the challenges to timely access to necessary medical care are greater. Some of these challenges include substantially increased driving distances, increased transportation and travel costs, and increased delay. Worse, others may not be able to afford these increased costs, and have to forego (or at least delay) the medical care they need, circumstances which can result in even

greater illness.

I declare under penalty of perjury under the laws of the State of Washington and the United States of America that the information in my Declaration is true and correct.

DATED this 20th day of June, 2019, at Olympia, Washington.

MIKE KREIDLER

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF BILL MOSS IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Bill Moss, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am the Assistant Secretary to the State of Washington, Department of Social and Health Services (DSHS), Aging and Long-Term Support Administration (ALTSA). I was appointed the Assistant Secretary of ALTSA by the Secretary of the Department of Social and Health Services in February of

2013 and serve at the pleasure of Governor Jay Inslee. The Assistant Secretary is a member of the Department's Secretary's Cabinet. My duties as the Assistant Secretary of ALTSA include supervising the ALTSA divisions in administering and overseeing state programs for long-term services and supports that serve our state's aging population and adults with disabilities.

2. Over the past two decades, I have provided leadership in a number of positions within DSHS and ALTSA, which include Director of the Home and Community Services Division, Office Chief for Home and Community Programs, and Assistant Regional Administrator for Home and Community Services. In 2017, Governor Jay Inslee appointed me to hold the interim seat as the Acting Secretary for DSHS. I participate on a number of state and national boards and workgroups, including the Training Partnership, which delivers innovative training for long-term care workers in Washington; as Vice Chair for the Health Benefits Trust Board, which provides advisory oversight of affordable benefits for long-term care workers; as Chair of the State of Washington's Dementia Action Collaborative Working Group; Health Care Apprenticeship Program Board (HCAP), and as a previous board member on the National Association of State Units on Aging and Disabilities (NASUAD) (Region X Regional Representative).

3. DSHS provides Washington residents assistance with employment, food, cash and medical care, long-term care for adults, rehabilitation services for

youth, support and vocational rehabilitation for individuals with disabilities, and psychiatric care for adults and children. These services are provided through seven different administrations. Each administration contributes to DSHS's mission to Transform Lives. Those administrations are the Aging and Long-term Support Administration (ALTSA), the Behavioral Health Administration (BHA), the Developmental Disabilities Administration (DDA), the Economic Services Administration (ESA), the Rehabilitation Administration (RHA), the Financial Services Administration (FSA), and the Services and Enterprise Support Administration (SESA). The estimated total amount of DSHS funding at risk is for State Fiscal Year 2020 is $2,529,082,000 and for State Fiscal Year 2021 is $2,765,114,000.

4. ALTSA is comprised of the Office of the Assistant Secretary, the Office of Communication, Government and External Relations, the Office of Deaf and Hard of Hearing Residential Care Services Division, Management Services Division, Home and Community Services Division, and the Adult Protective Services Division. More than 2,450 staff work for the administration at the state headquarters in Olympia and in regional offices throughout the state. ALTSA also contracts with the thirteen statewide Area Agencies on Aging that provide in-home services to individuals sixty years of age and older and clients with disabilities that meet the nursing facility level of care criteria, and their families.

5. In addition to the programs and services provided through ALTSA, DDA provides services to approximately 34,000 Washingtonians. DDA provides services and supports to eligible individuals with developmental and intellectual disabilities, administering programs designed to assist individuals and their families to obtain services in their homes and communities. DDA also provides services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and State Operated Nursing Facilities that offer 24-hour housing support and training in daily living skills for clients with disabilities.

6. DSHS is tied together by a single mission: to transform lives. Each administration within DSHS has a refined focus on this mission. The development of vision and core value statements within DSHS administrations took place years ago in an effort to unify the Department under one mission. As a result, each administration's mission is aligned with the overall mission of DSHS.

7. Individually we have the following missions:

a. ALTSA: To transform lives by promoting choice, independence and safety through innovative services. ALTSA's vision is to support seniors and people with disabilities to live with good health, independence, dignity, and to have control over the decisions that affect their lives. Our core values include: collaboration, respect, accountability, compassion, honesty and

integrity, pursuit of excellence, open communication, diversity and inclusion and commitment to service.

b. DDA: To transform lives by providing support and fostering partnerships that empower people to live the lives they want.

8. Like other administrations within DSHS, DDA convened workgroups of DDA leaders representing a breadth of program areas, vetted drafts through varied stakeholder groups, and published a vision statement and set of core values tailored to reflect DDA's commitment to the clients and families we support. DDA's vision is to:

a. Supporting individuals to live in, contribute to, and participate in their communities;

b. Continually improving supports to families of both children and adults;

c. Individualizing supports that will empower individuals with developmental disabilities to realize their greatest potential;

d. Building support plans based on the needs and the strengths of the individual and the family; and

e. Engaging individuals, families, local service providers, communities, governmental partners and other stakeholders to continually improve our system of supports.

DDA's Core Values are:

a. Respect gained through positive recognition of the importance of all individuals;

b. Person-Centered Planning to support each person to reach their full potential;

c. Partnerships between DDA and clients, families and providers in order to develop and sustain supports and services that are needed and desired;

d. Community Participation by empowering individuals with developmental disabilities to be part of the workforce contributing members of society.

ALTSA and DDA Provide Critical Home- and Community-Based Services to Washingtonians in Need

9. ALTSA and DDA support clients through Medicaid state plan services, including the 1915k Community First Choice option, Private Duty Nursing, 1915c, and 1115 waivers.

10. The majority of ALTSA's home and community-based services are funded partially or entirely by HHS, including Medicaid State Plan and Medicaid waiver services, and the Older Americans Act. The range of residential care options funded at least in part by HHS includes nursing homes, which provide 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board and laundry; assisted living

facilities, which are facilities in a community setting where staff assume responsibility for the safety and well-being of an adult; and adult family homes, which are regular neighborhood homes where staff assume responsibility for the safety and well-being of an adult. Services also include in-home personal and nursing care and adult day care, which is a supervised nonresidential program that includes services appropriate for adults with medical or disabling conditions. Individuals attending may receive assistance with personal care, counseling, general therapeutic/recreational activities, general health monitoring and nutritious meals.

11. Services that may be offered in the above settings or in the community include information and assistance, environmental modifications, nutrition services, legal services, family caregiver supports, wellness/prevention, specialized medical equipment and supplies, community choice guides, supported employment, supported housing, elder abuse prevention and long-term care ombudsman services.

12. Area Agencies on Aging work with local communities and tribal nations to develop and prioritize a menu of additional services that meet the needs of individuals in their area. These may include transportation, adult day care, minor home repairs, foot care, and many more services unique to the needs in the local area.

13. DDA services include in-home, residential, employment and facility-based services such as personal care services, respite care, alternative living services, companion home services, skills acquisition training, personal emergency response, nurse delegation, nursing services, nursing assessment, community transition services from institutional care, ICF/IID, children's behavior support services, community protection services, adult day care, attendant care, child care for foster children, child development services, chore services, information and education, medical and dental services, overnight planned respite services, psychological counseling, recreational counseling, community guide, environmental adaptations, occupational therapy, physical therapy, positive behavior support and consultation, risk assessment, psychiatric services, speech, hearing, and language services, staff and family consultation and training services, transportation and wellness education.

The Final Rule Jeopardizes Every Person Served by DSHS

14. Based on my review of Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule), the Final Rule will have significant impacts on DSHS.

15. The Final Rule creates a categorical right by providers to refuse to provide information or services to which they have a religious or moral objection. This would include a provider's objection to an individual's socioeconomic

status, race, color, gender/gender identity, sexual orientation, religion, national origin, language spoken, political preference, etc. The Final Rule does not specifically identify which religious values are protected and puts all people in Washington at grave risk as it will decrease access to providers.

16. The lack of direction in the Final Rule increases the likelihood of harm or death since it permits a personal objection at the time of service, including the front door to any service. This jeopardizes every person served by the Washington DSHS. As an example, without advance documentation of an individual employee's objection to a service, a denial at the time of service puts those we serve at extreme risk of losing essential services without access to alternatives. This also creates an environment where front door staff may refuse access when skilled providers are not aware that services are being denied by their practice.

17. Washington and the nation are in the midst of a massive long-term care services and healthcare workforce shortage. Seventy percent of Washingtonians over age sixty-five will need long-term services and supports in their lifetime. By 2035, the number of individuals age seventy-five and older will increase by approximately 150%.[1]

18. The Final Rule allows providers to deny service to individuals at their moral or religious discretion. As a result, facilities that are already

[1] Source: DSHS Research and Data Analysis.

short-staffed will experience an increased strain when employees choose not to care for an individual. This presents safety concerns for understaffed teams that are unable to adequately care for patients, especially in emergency situations. Conflict between staff may occur when providers deny service during busy times when staff are already feeling overworked. These additional pressures will lead to a higher turnover rate, perpetuating the shortage of long-term care and healthcare workers. This could also result in health and safety risks for clients.

19. There simply are not enough workers to fill this gap. Allowing providers to refuse services to individuals based on a personal objection greatly reduces the overall pool of available providers to serve everyone in need.

20. The lack of providers negatively impacts our healthcare system as a whole. When providers refuse necessary services to individuals that help them maintain their health, individuals are left to seek costly care through emergency room visits. This creates an overflow in our hospitals and turns our emergency rooms into care facilities. The overflow creates an increased risk for staff and takes away necessary professionals from tending to other emergency patients. Increased emergency room visits results in a detrimental financial burden to individuals, families and taxpayers to cover costly care. Family caregivers and persons in need of care may also feel forced to seek treatment through alternate systems that will lack the regulatory oversight necessary for safe care.

21. Washington has many rural regions that lack a variety of providers. If there are only a few providers in the area and some are refusing services, this reduces an individual's choice of provider, which is in violation of the federal regulation 431.51, requiring states to offer free choice of providers for Medicaid home- and community-based services. According to CMS regulations, states must ensure participants are afforded "choice among settings, and regarding services and supports and who provides them." When the only local provider refuses service as a result of a personal objection, individuals in that area will not be served, creating increased health disparities between our communities. It is more than just a slight inconvenience for people—it is depriving them of critical, lifesaving services and supports needed to maintain their health and well-being.

22. Trust is the cornerstone of the provider-client relationship. People should not have to worry if they will get the best quality care because of a provider's personal beliefs.

The Final Rule Puts Range of Long-Term Care Options at Risk

23. I have reviewed our funding sources to determine where we receive funds. Total funding from HHS (and potentially Department of Education and/or Department of Labor) for the next two years are:

State Fiscal Year 2020	$2,529,082,000
State Fiscal Year 2021	$2,765,114,000

24. HHS funding is used to support over 100,000 individuals living in Washington State to offer a wide range of services and supports to promote choice so that individuals may remain independent in the community settings of their choice to the greatest extent possible. While some of the funding is used for direct service (such as the Developmental Disabilities Administration's Residential Habilitation Centers and state psychiatric hospitals), most funding goes to contracted service providers for direct care services and to local Area Agencies on Aging. Contracted service providers include nursing homes, adult family homes, assisted living facilities, individual providers, private duty nurses and nurse delegation providers. The local Area Agencies on Aging receive funds to provide case management, plan and administer Older Americans Act programs (such as meal delivery), and contract with home care agencies. HHS funding is also issued to Tribal Nations for administration of tribal health programs. A small portion of funds are paid directly to clients for reimbursement for goods and services through the New Freedom program.

25. If a sub-recipient includes all of our contracted providers, then the following ALTSA sub-recipients would be impacted:

a. 43,000 Individual Providers. Individual providers are home care aides that serve clients in their own homes and are employed by the individual receiving care. They assist with activities of daily living, including bathing, toileting, grooming, and transportation

to medical appointments, walking, standing and more. Individual providers work one-on-one with the client and require a high level of trust.

b. 3,800 licensed and certified facilities, including nursing facilities, adult family homes and assisted living facilities. Nursing facilities provide 24-hour supervision, nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board and laundry. DSHS works with the Centers for Medicare and Medicaid Services to oversee these facilities. Adult family homes are regular neighborhood homes where staff assume responsibility for the safety and wellbeing of their residents. A room, meals, laundry and supervision and varying levels of assistance are provided. These homes can have up to six residents. Assisted living facilities are in a community setting where staff provide housing, meals, laundry, supervision and assistance. These facilities can have seven or more residents.

c. Forty-six home care agencies are contracted with our department and employ home care aides to assist clients in their own homes with daily tasks such as meal preparation, medication reminders,

laundry, light housekeeping, errands, shopping, transportation, and companionship.

d. 456 Care Coordinators. The Health Home Program was created by the federal Affordable Care Act. It allows states to provide Health Home services, including care coordination and comprehensive care management to individuals who are eligible for (a) Medicaid or (b) both Medicare and Medicaid. The purpose of the Health Home program is to improve outcomes, reduce future health care costs, and improve the experience of care. Care Coordinators assist these individuals in coordinating medical care, long-term services and supports, and behavioral health services.

26. If the definition of healthcare is interpreted narrowly, this could apply to DDA state operated service settings and contracted providers who are enrolled or contracted to provide strictly traditional medical services such as nursing, counseling, physical therapy, speech, hearing and regional crisis teams. Examples of state staff with medical credentials include doctors, dentists, psychologists and nurses. Conversely, if the definition of healthcare is interpreted more broadly, as we assume it is, it would apply to the traditional medical services as well as all of the waiver and state plan services administered by the DDA.

27. All of these providers serve our clients with necessary assistance for daily life. Without these providers and services, individuals would not receive adequate care that would result in increased cases of neglect and self-neglect.

The Final Rule will Impact DSHS's Ability to Dependably Provide Required Medical Services

28. Members of our team at ALTSA are dedicated to finding suitable providers for our clients. The process is challenging and requires careful coordination of what environment will best suit the client, availability, proximity to their home community, and services needed. The ability for providers to deny services to individuals adds an additional element of complexity to the process. Staff will be presented with a smaller pool of providers to choose from. Additionally, staff will need to address denials that prevent individuals from receiving care or that withdraw pre-determined services. These added challenges will slow down the process of matching individuals with services and prevent them from receiving care in a timely manner.

29. This will result in the loss of health care and services for some of our most vulnerable clients. Providers or direct support professionals could be unwilling to provide necessary transportation and coordination for both medical or pharmacy services related to birth control or abortion services.

30. Abortions will take place in unhealthy, unsterile environments without health care, counseling, or other supportive services available. The inability to provide birth control exacerbates the number of abortions attempted

in unhealthy conditions. It also does not take into account individuals with disabilities who utilize birth control to prevent pregnancies because they are dangerous to their overall health.

The Final Rule Directly Conflicts with Anti-Discrimination Laws and Policies

31. ALTSA and DDA exist for the purpose of helping people to achieve a better quality of life. Being lesbian, gay, bisexual, transgender or queer (LGBTQ) is not a choice, a behavior, or a lifestyle. Rather, it is an integral part of who individuals are at their very core. It is not up to a government entity or its employees or contractors to make philosophical, theological, or political judgments about personal identities. However, we do have a professional, legal, and ethical obligation to put personal opinions or biases aside and provide the very best care to those we serve. Rejecting behaviors toward LGBTQ people can have catastrophic consequences. Those who work in human services must make every effort to ensure safety and acceptance for LGBTQ people.

32. DSHS is committed to identify avenues of opportunity that allow for our department to grow and improve, so that we may professionally and adequately support all persons regardless of who they are or who they love. As such, in an effort to show our acceptance of all persons, ALTSA flies the Pride Flag during the month of June, has worked with the University of Washington on LGBTQ issues such as recommendations on how to collect sexual orientation and gender identity data. We are co-sponsors on conferences targeted for LGBTQ

populations. We changed rules to reflect state-registered domestic partners including our nursing home regulations which now allow these residents to share a room if they desire. We have created an atmosphere where people can be themselves. Our programs and services are open to everyone. The Federal Rule undoes all of this and takes us backwards from the forward progress we have made.

33. The Federal Rule directly conflicts with Washington state law (Wash. Rev. Code 49.60.030) and DSHS policy which prohibit discrimination on the basis of sexual orientation and gender identity. DSHS Administrative Policy 7.22 goes further to require respect for everyone with whom we interact regardless of difference.

34. Those who identify as LGBTQ are presently at a higher risk for discrimination, prejudice, denial of civil and human rights, harassment, and family rejection. The Final Rule puts this already vulnerable population, prone to hardship and heartache, at further risk. People who are LGBTQ may feel unsafe asking for support, services, or even worse, be denied the assistance and compassion they deserve simply because of who they are. The Final Rule will have dire consequences for our LGBTQ community, particularly as they reach an age where they will, like any person, need supportive services that develop as one ages. We may see our LGBTQ sisters, brothers, friends, family, and neighbors denied support with access to meal preparation and eating,

transportation to healthcare appointments, a safe and supportive living environment in a community setting of their choice, bathing and dressing assistance, and social and human interaction.

35. The Final Rule is asking this vulnerable group of people to not be themselves while purporting to protect peoples' freedoms. What the Final Rule ultimately does is jeopardize the safety and well-being of people who are LGBTQ—putting them at risk for abuse, neglect and possibly even death if ultimately denied the supports and services they need.

36. In 2008, Washington passed the Death with Dignity Act, which went into effect March 5, 2009. The Act, under the purview of the Department of Health, allows terminally ill adults to end their life with lethal doses of medication prescribed by medical or osteopathic physicians. Individuals self-administer, but the Final Rule likely may cut off the source of the medication. Today, participation by physicians and health care companies in Washington is voluntary; however, this could lessen or deplete the pool of physicians and pharmacies willing to participate. It may also remove the grievance process that allows patients to lodge complaints against a physician who violates the Act and the protections surrounding the individual's life, health and accident insurance. ALTSA has clients who choose to utilize these services, and they will no longer have this choice. Additionally, service providers may have a conflict in

supporting the implementation of care identified in advanced directives, hospice services, or Physician's Orders for Life-Sustaining Treatment (POLSTs).

37. The Final Rule generates an opportunity for providers to not recognize a spouse or significant other as the decision-maker for a person in need of care if they are part of a same sex marriage or partnership with that person. As an organization, ALTSA strives and believes that one's end of life wishes, preferences and healthcare decisions should be accommodated regardless if they are heterosexual or LGBTQ. The strongest and best advocate a person can have is often their spouse or partner, but this Final Rule builds a potential barrier where providers can opt to not recognize a person as a spouse or partner simply because they may be LGBTQ. Additionally, service providers may have a conflict in supporting the implementation of care identified in advanced directives, hospice services, or POLSTs.

38. This will have a devastating impact on the lives of many during a time when we, as a state organization, should be doing our best to ensure a person is supported, comfortable and receiving the highest quality of care possible in a setting without judgement, harassment, or fear.

39. The Final Rule appears to conflict with the Nightingale and Hippocratic Oaths to do no harm and protect patient's safety.

40. DSHS has calculated an estimate of costs for staffing related for ALTSA and DDA combined to implement and comply with the Final Rule, half

for each administration. These costs include program managers, administrative support positions, staffing for additional time spent by case managers, supervisors, residential surveyors, investigators, record keeping and public disclosure, as well as human resources and information technology support for the increased staffing. These costs also include the cost of creating and sending poster and brochures to all employees and subcontractors.

State fiscal year 2020	114.4 FTE	$14,574,000
State fiscal year 2021	115.8 FTE	$14,438,000

41. This includes changes to websites, policies and applications for both employees, subcontractors and recipients; Management Bulletins to Area Agencies on Aging; notices to Individual Providers; Provider Letters to all licensed and certified community residential providers; notices to employees; and training of employees, subcontractors and recipients. The cost to print and distribute posters and brochures to external subcontractors and recipients and to employees is estimated to be nearly $80,000 ($78,168.16).

42. DSHS estimates that, to implement the Final Rule in the next twelve months, the cost is $14,574,000 for ALTSA and DDA.

43. Currently, DSHS serves all people regardless of race, sexual orientation or identification or socioeconomic status. Therefore, we do not currently have policies, procedures or personnel in place to document information regarding religious or moral denials made by providers.

44. The Final Rule will impose an immediate cost on DSHS due to its notice, assurance and certification, record keeping and reporting requirements. This requires us to restructure our system and add additional staff and technology to appropriately manage recordkeeping of denials.

45. Providers denying services to individuals will result in an increased number of cases of abuse and neglect. According to Washington law (Wash. Rev. Code 74.34.020), "abandonment means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care" and "neglect means a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100." Each time a provider refuses service of a vulnerable adult, they are committing abuse or neglect.

46. In 2018, Adult Protective Services investigated more than 60,000 cases of abuse and neglect. Provider denials will cause cases to exponentially grow, causing an increased strain on staff members. As a result, Washingtonians

will suffer from inadequate services in response to abuse and neglect. To meet the increased demand and maintain fair service, we would have to hire additional investigators and social workers, which would create an increased budget strain on the state and its taxpayers.

47. We believe that it is the right of all residents to receive services without discrimination. We have worked diligently to provide services that adequately meet the needs of various populations and help reduce health disparities. Our residents trust that they can and will receive the best care available, regardless of who they are. The Rule undermines this belief and allows for certain populations to easily become marginalized. As a result, our department will see an increased number of discrimination lawsuits. Each lawsuit requires special attention, staff time and results in monetary losses.

48. The following are the types of sub-recipients or "any person, or any entity to whom there is a pass-through of federal financial assistance [through DSHS] from HHS":[2]

a. Over 56,000 people receive Meal Assistance such as home-delivered meals

b. 63,400 Medicaid clients receive services in a variety of settings

[2]This includes foreign governments, but does not include ultimate beneficiary. Note that there is an exception in certification section 88.4 (c)(4) for tribes.

i. 40,700+ served at home

ii. 12,500 served in adult family homes and assisted living facilities

iii. 600 receive managed care

iv. 9,500 served in nursing homes

c. 600 people receive ODHH case management to obtain needed services through coordination of services, translation of documents, advocacy, and/or the teaching of new abilities and skills

d. Licensing and inspections of long-term care facilities

i. 3,600 licensed adult family home, nursing home, enhanced service facility, and assisted living providers

ii. 70,600 licensed beds in the above facilities

iii. 2,600 annual inspections, surveys and certifications of the above facilities

ALTSA clients are served by a variety of facilities, organizations and individuals that provide a broad menu of services to meet those clients' needs and preferences. This range of services and supports are integral to the department's mission of promoting choice, independence and safety through innovative services with a vision of supporting seniors and people living with disabilities to live with good health, independence, dignity and control over the decisions that

affect their lives. The Final Rule jeopardizes this range of services and supports, which are provided by the following facilities, organizations, and individuals.

1. Area Agencies on Aging (AAAs)–Thirteen Total

49. Area Agencies on Aging are local government organizations designated by the Aging and Long-Term Support Administration to provide a network of in-home and community services, support programs and assistance to older adults, adults with disabilities and family caregivers.

2. Adult Family Homes–3,022 Total/2,662–Adult Family Home Providers with Contracts

50. Adult Family Homes (AFHs) are regular residential homes licensed to care for two to six residents. The homes are private businesses and provide the residents with a room, meals, laundry, supervision, and personal care. The services provided to residents depend on the needs of each individual resident and the skill level of the provider. Some homes are able to provide nursing services or other special care and services.

3. Assisted Living Facilities–545 Total/315 with Contracts, 230 Without Contracts

51. An assisted living facility (ALF), is a community setting licensed by DSHS to care for seven or more residents. The majority are privately-owned businesses. ALFs provide housing, basic services and assume general responsibility for the safety and well-being of the resident. ALFs allow residents

to live an independent lifestyle in a community setting while receiving necessary services from staff.

4. Enhanced Services Facilities–4 Total

52. The Washington State Legislature developed Enhanced Services Facilities (ESF) to provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting. Rather than extended and unnecessary stays in state psychiatric hospitals, individuals who are not eligible for inpatient psychiatric treatment or who are assessed as discharge-ready can live in an ESF

5. Home Care Agencies–46 Contracted With DSHS

53. Home care agencies provide non-medical services to ill, disabled or vulnerable people with functional limitations, enabling them to maintain their highest level of independence and remain in their homes.

6. Individual Providers–37,000 Total

54. An individual provider is a personal aide who, under an individual provider contract with the department or as an employee of a consumer directed employer, provides personal care or respite care services to persons who are functionally disabled or otherwise eligible under programs authorized and funded by the Medicaid state plan, Medicaid waiver programs or similar state-funded in-home care programs.

7. Nurses–172 Total

55. Our ALTSA nurses work as nurse compliance specialists, field managers, regional administrators, nursing consultants, nursing care consultants, program managers, assistant director and as a director. Our nurses help improve the quality of care provided and assist in ensuring the safety and well-being of clients in long-term care facilities and in their own homes across our state. ALTSA nurses are integral to our work of transforming lives by promoting choice, independence and safety through innovative services.

8. Nursing Homes–215 Total

56. ALTSA licenses nursing facilities in Washington State. A nursing facility (NF), or nursing home, provides 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. The majority are privately-owned businesses.

9. Regional Service Centers–8 Total

57. In partnership with the ALTSA, the Office of the Deaf and Hard of Hearing regional service centers provide educational, technical and social support for individuals who are deaf, deaf-blind or experiencing hearing loss.

10. Adult Day Services (Adult Day Care and Adult Day Health)

58. Adult Day Care (ADC) is a supervised nonresidential program. Services are appropriate for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist. Individuals attending may receive assistance with

personal care, counseling on a consultation basis, general therapeutic/recreational activities, general health monitoring and a nutritious meal.

59. Adult Day Health (ADH) is a structured program, lasting at least four hours, that provides skilled nursing and rehabilitative therapy. Skilled nursing or rehabilitative therapy must be provided on each attendance day. Individuals may also receive counseling services, personal care, general therapeutic/recreational activities, and a nutritious meal.

11. ALTSA Staff–Over 2,450 Across the State

60. Staff and contractor resources would be significantly impacted by the Final Rule. The State would need to create a process and system for documenting service denials, which would include both documenting within a client's record and tracking the denials in a centralized location. Training and preparation materials would need to be developed and administered for both staff and contractors.

61. Because contractors would have a new obligation to document their objections to providing service, the State would need to develop and implement policies and procedures to address the new rules. All service and support contracts through the State and local Area Agencies on Aging would need to be amended to include new requirements for reporting refusals of service and other exemptions. This Final Rule would also require additional contract monitoring and investigation to ensure compliance with the new policies and procedures.

62. To track denials centrally, the State would need to invest in the development of an IT system that contractors would use to document service refusals, or develop a paper-based system, which would require the State to enter the data into an internal system. The State would also need personnel and technology to query, track and trend the data.

63. Because providers would not have an obligation to provide referrals to clients to whom they have refused services, the State would need additional capacity to follow up will all clients to whom services were refused to offer counseling and referral. This would be an additional impact on the State.

64. Cost of posting notices about the rule—this is voluntary, but will be used as non-dispositive evidence of compliance: The cost will be $156,000 in the first twelve months, then $16,000 per year thereafter.

DATED this 24 day of June, 2019, at Olympia, Washington.

BILL MOSS

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
Martha Rodríguez López, WSBA #35466
Paul Crisalli, WSBA #40681
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF MICHAEL SCHAUB IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Michael Schaub, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my own knowledge.

2. I am the Senior Staff Consultant for the Statewide Accounting

Division of the Office of Financial Management (OFM) and have served in that position for over three years. I serve as deputy assistant director of the Statewide Accounting Division of OFM and report directly to the Assistant Director of Statewide Accounting. My duties and responsibilities include creating and monitoring compliance with statewide accounting and administrative policies, overseeing the creation of the state's annual financial report, and oversight and creation of the state's single audit report. Prior to the position I hold now, I was Senior Financial Consultant Coordinator for the Statewide Accounting Division and held similar responsibilities. I have held other positions in the Statewide Accounting Division since 2004. Before moving to OFM, I held positions in operations and financial management at the Department of Revenue beginning in 1994. I hold a degree in finance from Pacific Lutheran University.

3. OFM performs an ongoing role in the planning, analysis, and implementation of the state's operating, transportation, and capital budgets. It has the primary responsibility for making budget recommendations to the Governor and presenting the Governor's budget proposal to the Legislature and the public. After budgets are approved and signed into law by the Governor, OFM monitors state agency activities for conformance with budget provisions. OFM also maintains the state administrative and accounting policies and systems, provides financial consulting, monitoring, and training services, and prepares statewide financial reports.

4. OFM maintains the Agency Financial Reporting System (AFRS). AFRS is Washington State's central hub for accounting information. This system interfaces with numerous budget and accounting systems, and is used by Washington state agencies and higher education institutions. AFRS includes data on agency revenues and expenditures. Agencies must input all financial revenue into the system, including federal revenue. Agencies must identify revenue sources using both a major source code, which identifies the primary entity, and a source code, which identifies subsidiary entities.Agencies may enter a subsource code to further identify the program to which the funds are being applied.

5. I accessed AFRS on June 19, 2019. I used a software application to run a report from the system. For all state agencies and all funds, I identified revenue from the federal government using the major source code. I narrowed my search to include only revenue from the Departments of Labor, Education, and Health and Human Services by using the source code for those agencies. I further identified specific programs receiving funding by using the subsource code.

6. According to the report obtained from AFRS, in Fiscal Year 2018, Washington received over $10.5 billion in federal funding from Department of Health and Human Services, over $1.1 billion from the Department of Education, and over $225 million from the Department of Labor. These numbers include

cash revenue and accrued revenue for Fiscal Year 2018; when we produce our official financial reports, these are the amounts we report receiving from the federal government.

7. Exhibit 1 to this Declaration is a true and complete copy of the data retrieved from AFRS on June 19, 2019. The tables identify the fiscal year that applies to the data, the agency that submitted the data, and the amount of revenue broken down by the major source, source, and subsource as described above.

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

DATED this 20th day of June, 2019, at Olympia, Washington.

MICHAEL SCHAUB

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
Martha Rodríguez López, WSBA #35466
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF ELLEN B. TAYLOR, Ph.D, IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Ellen B. Taylor, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my own knowledge.

2. I am the Associate Vice President for Student Engagement for Washington State University (WSU). I have the held this position since July 11,

2018.

3. As Associate Vice President, I lead WSU's efforts in the areas of access and opportunity, health and wellness, and student leadership. As part of my duties, I oversee Cougar Health Services, which includes student health services and the counseling and psychology clinic on the main WSU campus in Pullman, Washington. I also have leadership responsibility for student health care system-wide. Previously, I was the Assistant/Associate Vice President for Student Life at the University of Washington for eight years, where I led institution-wide efforts related to the mental, physical, and social well-being of students. Although I am not currently licensed, I have a doctorate in clinical psychology from the University of Illinois at Urbana-Champaign and worked for twenty years as a mental health care provider in university counseling centers, including as the Director of Counseling and Psychological Services at Oregon State University.

4. WSU is Washington State's land grant university with a total student enrollment of 31,478 at its six campuses statewide, including its online campus. WSU also has thirty-nine county extension offices and four research and extension centers statewide. WSU's largest campus is in Pullman, Washington, with 21,022 students, the significant majority of which live on or adjacent to the campus. Pullman is located in rural Whitman County in eastern Washington. The nearest urban area is Spokane, Washington, more than seventy miles away.

5. The Washington State Department of Health, in partnership with the federal government, has determined that Whitman County is a Designated Health Professional Shortage Area, meaning its population is significantly underserved in the areas of primary medical care, mental health care, and primary dental care. (https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/PrimaryCareOffice/HealthProfessionalShortageAreas). The lack of health care infrastructure in the surrounding community impacts the ability of WSU health care providers to refer students out for care.

6. WSU has current federal grant funding from the Department of Health and Human Services (HHS) and its sub-agencies, including HHS funding flowing to WSU through other entities, totaling over $100 million. These grants fund a wide range of research programs and projects geared toward improving human health, such as studies relating to sleep, obesity, disease, substance abuse, and suicide prevention. HHS grants also fund studies and research programs geared towards improving lives in rural areas, Native American communities, and other underserved populations.

7. Other HHS funding includes third-party Medicaid reimbursements received by WSU for student health care services. During the 2018–19 academic year, approximately 11.5% of WSU students were on Medicaid, and WSU received approximately $317,754 in Medicaid reimbursements.

8. WSU also is a recipient of federal financial aid funding, such as Pell

Grants, which 32% of WSU students are eligible to receive. In addition, WSU has numerous federally-funded programs for students, such as TRIO Student Support Services and TRIO Upward Bound, which are funded by the Department of Education and provide academic tutoring, mentoring, personal counseling, financial guidance, and other services to first generation of low income students. In 2018, 778 students at WSU relied on these programs.

9. I am familiar with the rule entitled Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule).

10. Because the Final Rule grants a categorical right to health care providers and employees to deny medical information and care on the basis of religious tenets, Cougar Health Services and student health services on WSU's other campuses will be forced to accommodate a greater number of religious objections from a broad range of employees involved in student health care. I anticipate the Final Rule will increase staffing costs for WSU and will likely have negative impacts on WSU's ability to provide needed health care services to its students, including psychological services. In addition, the Final Rule will likely create situations that make it difficult if not impossible for WSU to comply with its policies prohibiting discrimination on the basis of protected categories including sex/gender, sexual orientation, gender identity and expression, creed, and marital status.

11. WSU Pullman's rural location makes it difficult to recruit and retain health care providers. At any given time, WSU's Cougar Health Services has a very limited number of health care providers in all areas of care available to treat students. For example, during the academic year we have between eight and eleven health care providers working at the clinic on any given day, excluding psychologists. As noted above, these practitioners serve a student population of over 21,000.

12. In addition, because of the average age of our student population, a significant percentage of our services involve those that an individual might refuse to provide based on a religious belief, such as the provision of reproductive health services, including information and referral for services not provided at WSU, and prevention, testing, and treatment of sexually transmitted infections. For example, during the one-year period from June 1, 2018, through May 31, 2019, Cougar Health Services ordered over 3,000 screenings for STIs and had approximately 1,700 visits related to birth control. We also serve a large LGBTQ population and a significant number of transgender students. It is likely that if an employee refused to treat a student based on a religious objection, it would be difficult to find another individual in the local area to treat that student in a timely manner. This could force WSU to violate its anti-discrimination policies in some cases and could jeopardize student safety, particularly in an emergency situation.

13. The Final Rule will impose both immediate and long-term costs on

WSU in the form of additional staffing and contractor resources to fulfill the many recordkeeping and compliance activities required, including but not limited to:

a. changes to WSU's policies, employee manuals, student handbooks, and webpages on all campuses;

b. preparation and physical posting of notices at all WSU locations for both students and for WSU employees;

c. additional oversight and training of supervisors, managers, and others both with respect to handling employee refusals to provide care and with respect to hiring practices, as the Final Rule prohibits inquiries into an applicant's potential religious objections to providing care;

d. maintaining complete and accurate records of compliance with the Final Rule;

e. tracking all accommodation requests and complaints across programs and campuses;

f. facilitating any investigation of WSU in the event of a compliance review, complaint, or any corrective action required under the Rule; and

g. increased regular and on-call staffing for all aspects of Cougar Health Services, including office and maintenance staff who may

refuse to support a particular procedure or student on the basis of a religious belief, as well as increased staffing for student health services on WSU's five other campuses, to ensure that students receive needed medical care and support functions are met.

14. As a preliminary estimate, I estimate that these activities will require additional personnel and administrative costs of a minimum of $500,000 the first year, with ongoing additional costs of up to $300,000 per year going forward for additional staffing.

15. In addition to direct costs and consequences, I am deeply concerned about the impact the rule has on WSU's Vision, Mission, and Values as well as the values of Cougar Health Services specifically. WSU's values statement includes a commitment to ensuring trust and respect for all persons. In addition, WSU embraces a worldview that recognizes the importance of diversity. These values are critical to WSU's mission. In addition, Cougar Health Services works hard to create a welcoming, inclusive environment for all students. All providers participate in ongoing diversity training, and respect for diversity is expected of every provider. The Final Rule directly contravenes these efforts by empowering individuals to refuse to provide specific treatments or to even refuse to provide any treatment to entire groups, including groups that desperately need support and are particularly at risk.

16. The Rule also places at risk all federal funds WSU receives, in the

event there is an alleged incident of non-compliance. The loss of these funds would potentially be catastrophic for WSU given the critical importance of federal grant funding to WSU's research mission, as well as the significant number of students eligible for Medicaid reimbursement for health services.

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

DATED this 18th day of June, 2019, at Pullman, Washington.

ELLEN B. TAYLOR, Ph.D

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Jeffrey T. Sprung, WSBA #23607
Martha Rodríguez López, WSBA #35466
Paul Crisalli, WSBA #40681
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF CHRISTOPHER M. ZAHN, MD IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Christopher M. Zahn, MD, declare:

1. I am the Vice President, Practice Activities at the American College of Obstetricians and Gynecologists (ACOG). I received my medical degree from Uniformed Services University of the Health Sciences and I am a retired Air Force Officer. Prior to working at ACOG, I was a Professor and Chair of

Obstetrics and Gynecology at the Uniformed Services University of the Health Sciences (USUHS), and a staff physician in the Departments of Obstetrics and Gynecology and Pathology at Walter Reed National Military Medical Center in Bethesda, Maryland.

2. ACOG is the specialty's premier professional membership organization dedicated to the improvement of women's health. With more than 58,000 members, the College is a 501(c)(6) organization and its activities include producing practice guidelines and other educational material.

3. ACOG periodically releases Committee Opinions. Committee Opinions represent an ACOG committee's assessment of emerging issues in obstetric and gynecologic practice and are reviewed regularly for accuracy.

4. ACOG Committee Opinion 385, "The Limits of Conscientious Refusal in Reproductive Medicine" was released by the ACOG Committee on Ethics in November 2007 and was reaffirmed in 2016. A true and correct copy of Committee Opinion 385 is attached as Exhibit 1.

5. Per Committee Opinion 385, "[t]hose who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest."

6. Per Committee Opinion 385, "[p]roviding complete, scientifically

accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves."

7. Per Committee Opinion 385, "[p]atients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence."

8. Per Committee Opinion 385, "[p]ersons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not

realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources."

9. Per Committee Opinion 385, "the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples."

10. Per Committee Opinion 385, "[l]egitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally."

11. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[i]n the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the

patient can be fulfilled."

12. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[h]ealth care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services."

13. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[w]here conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments."

14. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[p]hysicians and other health care professionals 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 their patients request."

15. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[i]n an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."

16. In Committee Opinion 385, the ACOG Committee on Ethics makes the recommendation that "[i]n resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physicians does not wish to provide."

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

DATED this 20th day of June, 2019, at Washington, D.C.

CHRISTOPHER M. ZAHN, MD
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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

Exhibit 1

ACOG COMMITTEE OPINION

Number 385 • November 2007

The Limits of Conscientious Refusal in Reproductive Medicine

Committee on Ethics

Reaffirmed 2016

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. 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. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. *Conscience* has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her *moral integrity*—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider–patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clear-

ly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice.

Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the *distributive paradigm*, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and

professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals 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 their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	No. 2:19-cv-00183-SAB DECLARATION OF ALEXA KOLBI-MOLINAS NOTED FOR: November 7, 2019 With Oral Argument at 10:00 AM Location: Spokane, Washington

I, ALEXA KOLBI-MOLINAS hereby declare as follows:

1. I am over the age of 18 and have personal knowledge of all the facts stated herein.

2. I am a Senior Staff Attorney at the ACLU's Reproductive Freedom Project, where I have worked since 2007. I am currently lead counsel in *National*

Family Planning and Reproductive Health Association et al. v. Azar et al., No. 19-civ-5435, SDNY (filed June 11, 2019), challenging the health care refusal rule issued by the U.S. Department of Health and Human Services (HHS), *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170 (May 21, 2019). This case has been consolidated with *New York v. U.S. Dep't of Health and Human Servs.*, No. 1:19-Civ-04676, and *Planned Parenthood Federation of America et al. v. Azar*, No. 19-CV-05433. As part of this litigation, I worked with a team of co-counsel from the consolidated cases to assess the comments contained in the Administrative Record, which HHS has relied on as justification for the Final Rule for purposes of opposing defendants' motion for summary judgment and in support of our cross-motion for summary judgment.

3. I have been advised by counsel for the State of Washington that Washington has filed a case similar to the consolidated New York cases challenging the Final Rule. I submit this declaration to explain for the Court the process by which the data in the accompanying exhibits, which I understand Washington is relying on in support of their Motion for Summary Judgment and Opposition to Defendants' Motion to Dismiss or for Summary Judgment, were developed.

A. First Production of the Administrative Record

4. In the consolidated cases pending in New York, the current

administrative record consists of two productions. HHS and its counsel made an initial production on July 22, 2019, accompanied by a certification that the initial production comprised the complete record.[1] However, the initial production was incomplete, notwithstanding Defendants' first certification.[2]

5. In addition to missing various documents, Defendants' first production did not permit the New York Plaintiffs to determine whether it contained all of the complaints that the Final Rule asserts were received by HHS's Office of Civil Rights (OCR).[3] This was because Defendants "produce[d] the list of complaints [they] claim[ed] to have considered by complaint number . . . but . . . produc[ed] the underlying complaints themselves with missing or redacted complaint numbers . . . making it impossible for plaintiffs to determine that the complaints included in the A.R. match[ed] the complaints listed on the index."[4] The original index for the record and list of complaints

[1] Defs.' Certification of the Administrative Record, No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 132-2. HHS filed a similar certification in this action. *See* No. 2:19-cv-00183-SAB (E.D. Wash.), ECF No. 33-2.

[2] *See* Pls.' Joint Letter Mot. to Compel Completion of the Record, No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 157.

[3] *Id.* at 3 n.1.

[4] *Id.*

produced by Defendants are attached hereto as Exhibits A and B.[5] Plaintiffs' review was further hindered by the Final Rule's confusing characterization of the number of complaints it received—*i.e.*, that OCR received 34 complaints between November 2016 (after the election) and January 2018,[6] and 343 during fiscal year 2018.[7] Because these two periods of time overlap (with the first period ending sometime in January 2018 and the second period beginning on October 1, 2017),[8] the New York Plaintiffs inferred, but were unable to confirm, that some number of the 34 complaints were also counted in the 343 complaints the agency claimed to receive in fiscal year 2018.

6. Also adding to Plaintiffs' difficulty was that the record contained a substantial number of non-complaint documents that were intermingled with the

[5] I am advised that HHS filed a substantially identical index in this case, No. 2:19-cv-00183-SAB (E.D. Wash.), ECF No. 33-1, and served on Washington's counsel a similar list of OCR complaints.

[6] *See* 83 Fed. Reg. at 3886 (stating that OCR received 34 complaints "since the November 2016 election"); *id.* at 3887 ("OCR has received thirty-four complaints between November 2016 and *mid*-January 2018.").

[7] 84 Fed. Reg. at 23,229.

[8] The federal government's fiscal year goes from October 1 to September 30 of the following year; thus, FY 2018 covers October 1, 2017–September 30, 2018. https://www.usa.gov/budget.

actual complaints. While it appeared that these documents were, in some way, *related* to the complaints, Plaintiffs were unable to discern which non-complaint documents were associated with which complaints. And in some instances, it was difficult to tell whether a given document was a complaint, or merely a document that was related in some way to a complaint.[9] In sum, Plaintiffs were faced with more than 700 documents, *see* Ex. A at 6 (noting complaints at AR bates range 541798 to 546163), with no means of determining which of these documents were the 34 complaints that HHS purportedly received between the November 2016 election and January 2018, which were the 343 that HHS purportedly received in fiscal year 2018, and which were merely supporting documents.

7. Despite repeated attempts to get clarification on these documents, the New York Plaintiffs received no response from Defendants and were forced to file a motion to compel completion of the record.[10]

B. Supplemental Record Production

8. Following the New York District Court's order to complete the

[9] *See, e.g.*, AR 542217 (letter addressed to the President alleging discrimination based on letter-writer's religious beliefs regarding vaccinations).

[10] *See* Pls.' Joint Letter Mot. to Compel Completion of the Record (No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 157) and accompanying Exhibits 3–5.

record,[11] Defendants produced approximately 3,800 pages of new material on August 19, 2019.[12] Among these documents were additional complaints, which Defendants noticed were missing from the initial production while preparing their supplemental production.[13] Defendants also produced a revised list of OCR complaints and their related documents, attached hereto as Exhibit C.[14] Listing more than 750 documents from the record (including the new complaints from the supplemental production), the revised list provides each document's AR bates number, the OCR complaint ID number that the document is associated with, and a "description" of the document. In the description section, the revised list labels approximately 735 documents as "complaint," with the remaining 23 labeled

[11] No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 158.

[12] *See* Defs.' Notice of Filing, 1:19-Civ-04676, ECF No. 161. I am advised that on August 19, 2019 HHS filed substantially the same Notice of an additional production in this case. No. 2:19-cv-00183-SAB (E.D. Wash.), ECF No. 43.

[13] *See id.*

[14] *See* Defs.' Letter response to Plaintiffs' joint letter motion to compel completion of the Administrative Record, No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 160, and the New York Court's August 16, 2019 Order, No. 1:19-Civ-04676 (S.D.N.Y.), ECF No. 158 at at 2 (describing list to be produced on August 19, 2019). I am advised that HHS served a substantially identical list of OCR complaints and related documents on counsel for Washington.

otherwise.[15]

9. While the revised list was an improvement, it still did not facilitate an efficient review. For example, the revised list did not provide the date that complaints were filed. And while it stated which complaint ID each document was associated with, it did not distinguish between actual complaints and supporting documents. Absent that information, it was quite difficult to quickly ascertain how many complaints were in the record. And without the date each complaint was filed, it was difficult to confirm whether HHS actually received the number of complaints it asserted it received in various time periods, including the 34 complaints that HHS purportedly received between the November 2016 election and January 2018.

C. The Plaintiffs' Subsequent Review

10. To achieve clarity on these issues, and to determine whether the record supports the Final Rule's assertion that there was a "significant increase in complaints . . . alleging violations of the [Refusal Statutes],"[16] including 34 complaints received between November 2016 and January 2018 and 343 complaints received between October 1, 2017 and September 30, 2018,[17] Counsel

[15] Some documents, for example, are described as "initiation" or "PIMs." Ex. C (HHS's revised list of OCR complaints).

[16] 84 Fed. Reg. at 23,175.

[17] *Id.* at 23,229.

for the New York Plaintiffs reviewed all documents listed in HHS's revised list of OCR complaints, which listed more than 750 documents. The results of this review are presented in Exhibits D–H.

11. **Exhibit D.** Plaintiffs' review revealed that HHS's revised list of complaints contained 367 complaints with unique complaint ID numbers, with nine that predate the November 2016 election and 358 that were received between the November 2016 election and the end of fiscal year 2018. Exhibit D lists the 358 complaints that were received after the November 2016 election. It also tracks the date of the complaint, the AR bates number of each *actual* complaint, and the AR bates numbers of documents related to each complaint (which were not consistently produced in a sequential manner).

12. **Exhibit E**. Plaintiffs' review also revealed that 22 of the 358 complaints listed in Exhibit D were duplicates. That is, despite having unique complaint ID numbers, these 22 complaints were identical copies of another complaint (not multiple complaints discussing a similar issue or event). Specifically, there were 21 duplicates of complaint ID 18-316488 (found at AR 544728) and one duplicate of complaint ID 18-294058 (found at AR 542627). The 22 duplicate complaints are listed in Exhibit E.

13. This means that there are in fact only *336* unique post-2016 election *complaints* in the record (which is different than Defendants' assertion that it relied on 343 complaints in fiscal year 2018 alone).

14. **Exhibits F–G.** Plaintiffs also reviewed the substance of each of the 336 unique post-election complaints. This review revealed that 315 complaints—or 94% of the 336 unique post-election complaints—do not allege violations of the Refusal Statutes. The results of Plaintiffs' substantive review are shown in Exhibits F and G.

15. Exhibit F lists 266 complaints that relate to vaccination requirements. Such complaints—which amount to 79% of the 336 unique post-2016 election complaints—therefore do not allege violations of the Refusal Statutes. *See* 84 Fed. Reg. at 23181 (responding to comments that the Rule may interfere with vaccination requirements).

16. Exhibit G lists an additional 49 non-vaccination related complaints that do not allege violations of the Refusal Statutes for other reasons or otherwise cannot be counted as a complaint alleging a violation. These reasons include:

a. The complaint expresses *opposition* to the proposed rule.[18]

b. The complaint does not allege discrimination/conduct prohibited by the Refusal Statutes.[19]

[18] *See, e.g.*, Ex. G at Row 21; AR 542422.

[19] *See, e.g.*, Ex. G at Row 41; AR 544465–544473 (individual filed complaint because state attorneys refused to prosecute another person who "continually commits acts of voyeurism" against complainant); Row 40; AR

c. The complainant (whether the complaint is brought by the complainant directly, or is represented by a third party) is not a protected entity under the Refusal Statutes.[20]

d. The complaint is against an entity that is not regulated by the Refusal Statutes.[21]

e. Other (not an actual complaint; complaint based on Title X regulations, addressed by HHS, *see* 84 Fed. Reg. 23,191 n.64.)

17. Collectively, Exhibits F and G demonstrate that only 21 of the 336 unique complaints Plaintiffs found in the record—6%—even allege conduct that could be potentially covered by the refusal statutes.[22]

544399–544407 (complaint alleges discrimination based on complainant's sex, race, and mental illness).

[20] *See, e.g.*, Ex. G at Row 22; AR 542627–542636 (complaint filed by aspiring entrepreneur because federal agencies forced complainant to remove social media ads for "divine cure for cancer").

[21] *See, e.g.*, Ex. G at Row 21; AR 542607–542615 (complaint accuses an unnamed "man" and "other people" of attempting to take complainant's inheritance).

[22] By placing these 21 complaints in this category, Plaintiffs do not concede that the conduct alleged violates the Refusal Statutes, that the complainants are protected entities under the Refusal Statutes, and/or that the

18. **Exhibit H.** Finally, Plaintiffs also reviewed the complaint-related documents in the record for any evidence regarding whether HHS investigated or resolved any complaints. The results of this review are captured in Exhibit H, which identifies evidence that 14 unique complaints were resolved by the agency. Only one of those complaints was filed in fiscal year 2018. Plaintiffs did not find any other evidence in the record regarding whether HHS attempted to investigate and/or resolved any of the other complaints filed in fiscal year 2018.

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

DATED this 19 day of September, 2019, at New York, NY.

ALEXA KOLBI-MOLINAS

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complainants are protected entities under the Refusal Statutes, and/or that the complaints are against entities that are regulated under the Refusal Statutes. These are merely complaints that, based on the allegations contained therein, an agency might investigate further in order to determine whether any violation occurred.

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 20th day of September, 2019, at Tumwater, Washington.

/s/ Jeffrey T. Sprung
JEFFREY T. SPRUNG, WSBA #23607
Assistant Attorney General

Exhibit E

Duplicate Complaints Filed After November 2016 Election					
Count	OCR Complaint ID	Date	Bates No. of Complaint	Bates No. of Related Documents	Complaint ID and Bates No. of Original Complaint
1	18-294061	1/23/2018	000542638	000542646 000542647	Duplicate of complaint ID 18-294058, found at Bates Number 000542627.
2	18-316851	8/24/2018	000544745		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
3	18-316943	8/24/2018	000544772		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
4	18-316946	8/24/2018	000544780		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
5	18-316947	8/24/2018	000544788		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
6	18-316949	8/24/2018	000544796		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
7	18-316953	8/24/2018	000544804		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
8	18-316955	8/24/2018	000544812		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
9	18-316956	8/24/2018	000544820		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
10	18-316979	8/24/2018	000544828		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
11	18-316982	8/24/2018	000544836		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
12	18-316984	8/24/2018	000544844		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
13	18-316985	8/24/2018	000544852		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
14	18-316987	8/24/2018	000544860		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
15	18-316989	8/24/2018	000544868		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
16	18-316990	8/24/2018	000544876		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
17	18-316992	8/24/2018	000544884		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
18	18-316997	8/24/2018	000544892		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
19	18-317000	8/24/2018	000544900		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
20	18-317003	8/24/2018	000544908		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
21	18-317004	8/24/2018	000544916		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.
22	18-317007	8/24/2018	000544924		Duplicate of complaint ID 18-316488, found at Bates Number 000544728.

Exhibit F

Anti-Vaccination Complaints Filed After November 2016 Election				
Count	Date of Complaint	OCR Complaint ID	Bates No. of Complaint	Bates No. of Related Documents
1	4/12/2017	18-289810	000542217	000542219 000542221
2	7/2/2017	17-277069	000546049	000546088
3	7/14/2017	17-276010	000546040	000546048
4	11/20/2017	18-290543	000542223	
5	12/5/2017	18-289617	000546091	000546099 000546100 000546102
6	1/15/2018	18-293929	000542533	000542532 000542534
7	1/18/2018	18-293612	000542396	000542404
8	1/18/2018	18-293621	000545439	
9	1/19/2018	18-293651	000542405	000542413
10	1/19/2018	18-293713	000542431	000542439
11	1/19/2018	18-293763	000542440	000542448
12	1/20/2018	18-293790	000542458	000542466
13	1/20/2018	18-293820	000542467	000542475
14	1/21/2018	18-293834	000542476	000542484
15	1/21/2018	18-293839	000542485	000542493
16	1/21/2018	18-293847	000542494	000542502
17	1/21/2018	18-293857	000542503	000542511
18	1/21/2018	18-293863	000542513	000542521
19	1/22/2018	18-293925	000542522	000542530
20	1/22/2018	18-293935	000542535	000542543
21	1/22/2018	18-293954	000542544	000542552
22	1/22/2018	18-293966	000542553	000542561
23	1/22/2018	18-293974	000542562	000542570
24	1/22/2018	18-293976	000542571	000542579
25	1/22/2018	18-293989	000542580	000542588
26	1/23/2018	18-294002	000542589	000542597
27	1/23/2018	18-294017	000542598	000542606
28	1/23/2018	18-294057	000542616	000542624 000542626
29	1/23/2018	18-294065	000542649	000542657
30	1/24/2018	18-294138	000542667	000542675
31	1/24/2018	18-294142	000545416	000545424
32	1/24/2018	18-294145	000542685	000542693
33	1/24/2018	18-294148	000542694	000542702
34	1/24/2018	18-294154	000542703	000542711
35	1/24/2018	18-294191	000542712	000542720
36	1/24/2018	18-294197	000542721	000542729
37	1/24/2018	18-294203	000542730	000542738
38	1/24/2018	18-294211	000542739	000542747

39	1/24/2018	18-294212	000542748	000542756
40	1/24/2018	18-294216	000542757	000542765
41	1/24/2018	18-294228	000542766	000542774
42	1/24/2018	18-294250	000542775	000542783
43	1/24/2018	18-294257	000542784	000542792
44	1/24/2018	18-294264	000542793	000542801
45	1/25/2018	18-294268	000542802	000542810
46	1/25/2018	18-294274	000542811	000542819
47	1/25/2018	18-294275	000542820	000542828
48	1/25/2018	18-294276	000542829	000542837
49	1/25/2018	18-294299	000542838	000542846
50	1/25/2018	18-294305	000542847	000542855
51	1/25/2018	18-294328	000542856	000542864
52	1/25/2018	18-294329	000542865	000542873
53	1/25/2018	18-294331	000542874	000542882
54	1/25/2018	18-294335	000542884	000542892
55	1/25/2018	18-294350	000542893	000542901
56	1/25/2018	18-294372	000542902	000542910 000542911 000542913 000542915
57	1/25/2018	18-294378	000542917	
58	1/25/2018	18-294390	000542925	000542933
59	1/25/2018	18-294399	000542934	000542942
60	1/25/2018	18-294401	000542943	000542951
61	1/25/2018	18-294403	000542952	000542960
62	1/25/2018	18-294406	000542961	000542969
63	1/25/2018	18-294408	000542970	000542978
64	1/25/2018	18-294419	000542979	000542987
65	1/25/2018	18-294420	000542988	000542996
66	1/25/2018	18-294423	000542997	000543005
67	1/25/2018	18-294433	000543006	000543014
68	1/25/2018	18-294434	000543016	000543024
69	1/25/2018	18-294436	000543025	000543033
70	1/25/2018	18-294437	000543035	000543043
71	1/25/2018	18-294441	000543044	000543052
72	1/25/2018	18-294446	000543054	000543062
73	1/25/2018	18-294447	000543063	000543071
74	1/25/2018	18-294449	000543072	000543080
75	1/25/2018	18-294457	000543091	000543099
76	1/26/2018	18-294460	000543100	000543108
77	1/26/2018	18-294461	000543110	000543118
78	1/26/2018	18-294462	000543119	000543127
79	1/26/2018	18-294463	000543129	000543137
80	1/26/2018	18-294465	000543139	000543147

81	1/26/2018	18-294466	000543148	000543156 000543157 000543158
82	1/26/2018	18-294469	000543159	000543167
83	1/26/2018	18-294470	000543168	000543176
84	1/26/2018	18-294474	000543177	000543185
85	1/26/2018	18-294477	000543186	000543194
86	1/26/2018	18-294509	000543195	000543203
87	1/26/2018	18-294515	000543204	000543212
88	1/26/2018	18-294516	000543213	000543221
89	1/26/2018	18-294518	000543222	000543230
90	1/26/2018	18-294528	000543231	000543239
91	1/26/2018	18-294529	000543240	000543248
92	1/26/2018	18-294531	000543250	000543258
93	1/26/2018	18-294540	000543259	000543267
94	1/26/2018	18-294567	000543268	000543276
95	1/26/2018	18-294570	000543277	000543285
96	1/26/2018	18-294574	000543286	000543294 000543295 000543296 000543298 000543301 000543306 000543314 000543315 000543317
97	1/26/2018	18-294587	000543323	000543331
98	1/26/2018	18-294596	000543332	000543340
99	1/26/2018	18-294600	000543342	000543350
100	1/27/2018	18-294608	000543351	000543359
101	1/27/2018	18-294609	000543361	000543369
102	1/27/2018	18-294610	000543370	000543378
103	1/27/2018	18-294611	000543379	000543387
104	1/27/2018	18-294612	000543388	000543396
105	1/28/2018	18-294630	000543397	000543405
106	1/28/2018	18-294633	000543406	000543414
107	1/28/2018	18-294634	000543415	000543423 000543424
108	1/28/2018	18-294658	000543427	000543435 000543436
109	1/28/2018	18-294668	000543438	000543446
110	1/28/2018	18-294674	000543447	000543455
111	1/28/2018	18-294675	000543456	000543464
112	1/28/2018	18-294676	000543465	000543473
113	1/29/2018	18-294701	000543474	000543482
114	1/29/2018	18-294704	000543483	000543491
115	1/29/2018	18-294713	000543492	000543500

116	1/29/2018	18-294782	000543501	000543509
117	1/30/2018	18-294795	000543510	000543518
118	1/30/2018	18-294881	000549933	000545396
119	1/30/2018	18-294884	000545397	000545405
120	1/30/2018	18-294917	000543529	000543537
121	1/30/2018	18-294931	000543538	000543546
122	1/30/2018	18-294933	000543547	000543555
123	1/30/2018	18-294935	000543556	000543564
124	1/30/2018	18-294936	000543565	000543573
125	1/30/2018	18-294939	000543574	000543582
126	1/30/2018	18-295802	000543690	
127	1/31/2018	18-294947	000543583	000543591
128	1/31/2018	18-295021	000545387	000545395
129	1/31/2018	18-295084	000543592	000543600
130	1/31/2018	18-295094	000543601	000543609
131	2/1/2018	18-295101	000543610	000543618
132	2/1/2018	18-295181	000545378	000545386
133	2/1/2018	18-295207	000545369	000545377
134	2/2/2018	18-295220	000543619	000543627
135	2/2/2018	18-295221	000543628	000543636
136	2/2/2018	18-295351	000545351	000545359
137	2/2/2018	18-295352	000545360	000545368
138	2/3/2018	18-295386	000545333	000545341
139	2/3/2018	18-295387	000545342	000545350
140	2/3/2018	18-295389	000543637	000543645
141	2/6/2018	18-295402	000543646	000543654
142	2/6/2018	18-295643	000543681	000543689
143	2/6/2018	18-295804	000545330	
144	2/7/2018	18-295820	000543692	000543700
145	2/8/2018	18-295619	000543672	000543680
146	2/8/2018	18-295840	000543702	000543710
147	2/10/2018	18-296124	000545312	000545320
148	2/10/2018	18-296126	000543711	000543719
149	2/10/2018	18-296136	000545321	000545329
150	2/12/2018	18-295438	000543656	000543655 000543664
151	2/12/2018	18-296347	000543731	000543739
152	2/12/2018	18-297802	000544053	
153	2/14/2018	18-296546	000543749	000543757
154	2/14/2018	18-296571	000545451	000545459
155	2/15/2018	18-296627	000543758	000543766
156	2/15/2018	18-296632	000543767	000543775
157	2/15/2018	18-296633	000543776	00543784
158	2/15/2018	18-296636	000543785	000543793
159	2/15/2018	18-296637	000543794	000543802
160	2/15/2018	18-296638	000543803	000543811
161	2/15/2018	18-296644	000543812	000543820

162	2/15/2018	18-296646	000545532	000545540
163	2/15/2018	18-296673	000543821	000543829 000543831
164	2/15/2018	18-296674	000543832	000543840 000543842
165	2/15/2018	18-296691	000543843	000543851
166	2/16/2018	18-296709	000545245	000545253 000545291 000549932
167	2/16/2018	18-296724	000543852	000543860
168	2/16/2018	18-296728	000543861	000543869
169	2/16/2018	18-296731	000543870	000543878
170	2/16/2018	18-296735	000543883	000543891
171	2/16/2018	18-296754	000543892	000549905
172	2/16/2018	18-296761	000545523	000545531
173	2/16/2018	18-296773	000543900	000543908
174	2/16/2018	18-296835	000543927	000543935
175	2/16/2018	18-296836	000545218	000545226 000545227 000545235
176	2/18/2018	18-296887	000549906	000543936 000543937
177	2/20/2018	18-297136	000543938	000543946
178	2/21/2018	18-297161	000543947	000543955
179	2/21/2018	18-297213	000543961	000543969
180	2/21/2018	18-297287	000545514	000545522
181	2/23/2018	18-297429	000543970	000543978
182	2/23/2018	18-297463	000543979	000543987
183	2/24/2018	18-297580	000543989	000543988 000543997
184	2/24/2018	18-297582	000543998	000544006 000544007
185	2/25/2018	18-297593	000544008	000544016
186	2/25/2018	18-297605	000544017	000544025
187	2/25/2018	18-297714	000544026	000544034
188	2/25/2018	18-298020	000544158	
189	2/26/2018	18-297764	000545505	000545513
190	2/27/2018	18-297798	000544044	000544052
191	2/27/2018	18-297945	000545496	000545504
192	2/27/2018	18-297946	000545487	000545495
193	2/28/2018	18-297979	000544149	000544157
194	3/2/2018	18-298297	000545478	000545486
195	3/4/2018	18-298344	000544161	000544169
196	3/5/2018	18-298379	000544179	000544187
197	3/6/2018	18-298639	000544208	000544216
198	3/8/2018	18-298850	000544226	000544234

199	3/9/2018	18-298957	000545425	000545433 000545437 000545438
200	3/11/2018	18-299109	000544244	000544252
201	3/11/2018	18-299118	000544253	000544261
202	3/11/2018	18-299141	000544262	000544270
203	3/15/2018	18-299571	000544271	000544279
204	3/15/2018	18-299658	000545442	000545450
205	3/20/2018	18-300085	000544280	000544288
206	3/21/2018	18-300254	000544291	000544299
207	3/22/2018	18-300275	000544300	000544308
208	3/22/2018	18-300279	000544309	000544317
209	3/22/2018	18-300324	000544318	000544326
210	3/23/2018	18-300386	000545460	000545468
211	3/23/2018	18-300388	000544327	000544335
212	3/23/2018	18-300491	000544336	000544344
213	3/25/2018	18-300537	000544345	000544353
214	3/25/2018	18-300568	000544354	000544362
215	3/26/2018	18-300622	000544363	000544371
216	3/26/2018	18-300653	000544372	000544380
217	3/26/2018	18-300657	000544381	000544389
218	3/26/2018	18-300699	000544390	000544398
219	3/31/2018	18-301226	000544408	000544416 000544417
220	4/3/2018	18-301461	000544424	000544432 000544433 000544434
221	4/3/2018	18-301532	000544447	000544455
222	4/5/2018	18-301788	000544456	000544464
223	4/6/2018	18-302417	000544474	
224	4/12/2018	18-302437	000544500	000544508
225	5/14/2018	18-310061	000544651	
226	6/15/2018	18-308974	000544624	000544632 000548439 000549914 000549922
227	6/15/2018	18-308995	000544642	000544650
228	7/6/2018	18-310972	000544669	
229	7/6/2018	18-314425	000544682	
230	7/20/2018	18-321033	000545200	000545208
231	8/30/2018	18-315669	000544692	000544700 000544701 000544704
232	9/1/2018	18-315794	000544710	000544718
233	9/5/2018	18-315969	000544719	000544727
234	9/6/2018	18-326152	000545209	000545217
235	9/13/2018	18-316890	000544763	000544771

236	9/15/2018	18-317042	000544932	000544940 000544944
237	9/18/2018	18-320798	000545601	000545169
238	9/19/2018	18-317417	000544985	000544993
239	9/23/2018	18-317797	000544994	000545002
240	9/23/2018	18-317809	000545003	000545011 000545012
241	9/24/2018	18-230812	000545179	000545187 000545188
242	9/24/2018	18-317903	000545015	000545023
243	9/24/2018	18-317927	000545024	000545032
244	9/24/2018	18-320805	000545170	000545178
245	9/25/2018	18-318010	000545033	000545041
246	9/25/2018	18-318021	000545046	000545042 000545043 000545044 000545045
247	9/25/2018	18-318030	000545054	000545062
248	9/25/2018	18-318035	000545063	000545071
249	9/25/2018	18-318049	000545072	000545080
250	9/25/2018	18-318078	000545081	000545089
251	9/25/2018	18-318086	000545091	000545090 000545099
252	9/25/2018	18-318093	000545106	000545114
253	9/25/2018	18-318131	000545115	000545123
254	9/25/2018	18-318134	000545124	000545132
255	9/25/2018	18-318139	000545133	000545141
256	9/25/2018	18-318176	000545142	000545150
257	9/26/2018	18-318268	000545151	000545159
258	9/26/2018	18-318343	000545160	000545168
259	9/26/2018	18-318349	000549924	000545571
260	9/26/2018	18-320830	000545191	000545199
261	9/29/2018	18-318669	000545583	000545591
262	9/29/2018	18-318678	000545592	000545600
263	undated	18-294141	000542676	000542684
264	undated	18-296263	000543720	000549904
265	undated	18-304544	000544509	000544510 000544512 000544513 000544514 000544515
266	undated	18-318462	000545563	000545572 000545580 000545582

Exhibit G

Other Irrelevant Complaints Filed After November 2016 Election					
Count	OCR Complaint ID	Date	Bates No. of Complaint	Bates No. of Related Documents	Reason Complaint is Irrelevant
1	17-259696	1/19/2017	000545774	000545782 000541967 000541969 000541970	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complainant is not entity covered by the Refusal Statutes
2	17-260802	1/31/2017	000546113	000546121	Complainant is not protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
3	17-264789	3/10/2017	000545783		Complainant is not protected entity under the Refusal Statutes
4	17-272987	4/14/2017	000546122	000546130	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complainant is not protected entity under the Refusal Statutes
5	17-271523	5/23/2017	000546104	000546112	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complainant is not protected entity under the Refusal Statutes
6	17-281650	9/8/2017	000546131	000546139	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not a protected entity under the Refusal Statutes.
7	18-284790	10/11/2017	000542026	000542034	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not a protected entity under the Refusal Statutes.

8	18-288083	10/21/2017	000542047		Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
9	18-292650	1/9/2018	000542260	000542268	Complainant is not a protected entity under the Refusal Statutes
10	18-292652	1/9/2018	000545236	000545244	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes.
11	18-293709	1/9/2018	000542423		Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited under the Refusal Statutes
12	18-292692	1/10/2018	000542269	000542277	Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complaint is against entity not regulated under the Refusal Statutes
13	18-293023	1/11/2018	000542334		Complainant is not an entity protected under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited under the Refusal Statutes
14	18-292940	1/11/2018	000542307	000542315 000542333	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complainant is not a protected entity under the Refusal Statutes

15	18-292941	1/11/2018	000542316	000542324	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes.
16	18-292944	1/11/2018	000542325	000549903	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes.
17	18-292877	1/11/2018	000542298	000542306	Complaint is against entity not regulated under the Refusal Statutes.
18	18-293400	1/17/2018	000545541	000545549 000545550	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not a protected entity under the Refusal Statutes.
19	18-293598	1/18/2018	000542387	000542395	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
20	18-293613	1/18/2018	000545469	000545477	Complaint is against entity not regulated under the Refusal Statutes.
21	18-294047	1/23/2018	000542607	000542615	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes Complaint is against entity not regulted under the Refusal Statutes

22	18-294058	1/23/2018	000542627	000542635 000542636	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
23	18-294118	1/24/2018	000542658	000542666	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
24	18-294456	1/25/2018	000543082	000543090	Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
25	18-296286	1/28/2018	000543721		Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
26	18-296104	2/9/2018	000545551	000545559 000545562	Complaint is against entity not regulated under the Refusal Statutes.
27	18-297210	2/10/2018	000543956		Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
28	18-296732	2/13/2018	000543879		Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
29	18-296469	2/14/2018	000543740	000543748	Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
30	18-296822	2/16/2018	000543918	000543926	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.

31	18-296789	2/16/2018	000543909	000543917	Complaint does not state facts supporting a claim of discrimination.
32	18-297866	2/18/2018	000544087		Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
33	18-297792	2/27/2018	000544035	000544043	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
34	18-298353	3/4/2018	000544170	000544178	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
35	18-298614	3/6/2018	000544188	000544196 000544198 000544207	Complaint is not against entity regulated under the Refusal Statutes. *See also* State Pls.' MSJ Br. Section II(C)(1) (discussing this complaint).
36	18-298868	3/8/2018	000545406	000545141 000545415	Not a complaint
37	18-298848	3/8/2018	000544236	000544235	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
38	18-301470	3/22/2018	000544443		Not a complaint.
39	18-304776	3/23/2018	000544516		Complaint is against entity not regulated under the Refusal Statutes. *See also* State Pls.' MSJ Br. Section II(C)(1) (discussing this complaint).
40	18-300986	3/28/2018	000544399	000544407	Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes
41	18-302042	4/9/2018	000544465	000544473	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
42	18-306185	4/12/2018	000544599		Complaint is not against entity regulated under the Refusal Statutes. *See also* State Pls.' MSJ Br. Section II(C)(1) (discussing complaint at 000544188, which is irrelevant for the same reasons as this complaint).

43	18-306408	5/2/2018	000544606		Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes. Complainant is not protected entity under the Refusal Statutes.
44	18-304862	5/3/2018	000544590	000544598	Complaint is against Title X Funding Opportunity Announcement issued by HHS; HHS claims that it did not enforce pre-existing Title X referral and nondirective options counselin requirements against those with religious objections, *see* 84 Fed. Reg. 23,191 n.64.
45	18-316745	9/12/2018	000544736	000544744	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes.
46	18-316861	9/13/2018	000544753	000544761 000544762	Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes/conduct prohibited under the Refusal Statutes alleges discrimation based on conduct that is not protected under refusal statutes.
47	18-317335	9/18/2018	000544976	000544984	Complainant is not a protected entity under the Refusal Statutes Complaint does not allege discrimination/conduct prohibited by the Refusal Statutes Complaint is against entity not regulated under the Refusal Statutes.
48	18-293704	1/19/2018	000542414	000542422	Complaint expressed opposition to Proposed Rule.
49	18-293773	1/20/2018	000542449	000542457	Complaint expressed opposition to Proposed Rule.

Exhibit H

Record Evidence of Complaint Investigation and Closure			
Count	**Complaint No.**	**Description**	**Bates No.**
1	10–109676	Closure Letter	000541798
2	11–122388	Closure Letter	000541805
3	11–122387	Closure Letter	000541807
4	14–193604	Closure Letter	000541809
5	14–193604	Closure Letter	000541996
6	15–193782	Closure Letter	000541809
7	15–195665	Closure Letter	000541809
8	15–193782	Closure Letter	000541996
9	15–195665	Closure Letter	000541996
10	16–224756	Closure Letter	000542001
11	16–238113	Closure Letter - Withdrawl	000541892
12	17–259696	Closure Letter	000541967
13	17-252154	Closure Letter - Withdrawl	000541966
14	18–292848	Closure Letter	000542001