NO. 19-35394

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

STATE OF WASHINGTON,

Plaintiff-Appellee,

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-Appellants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs-Appellees,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services. et al.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

STATE OF WASHINGTON'S RESPONSE TO MOTION FOR STAY PENDING APPEAL

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I. INTRODUCTION

To obtain the extraordinary remedy of a stay pending appeal, Defendants must show that they will suffer irreparable injury from leaving in place rules that have existed for nearly 50 years. Defendants come nowhere close to meeting this burden, and the Court could deny their motion on that basis alone.

Defendants also fail to meet any of the other elements they must prove to obtain a stay. They are unlikely to prevail on the merits, as three district courts have held, because the rules Defendants promulgated violate federal law. Moreover, the stay they seek will substantially injure other parties by destroying an existing network of family planning providers for low-income people in Washington and throughout the country, harming the health of patients who rely on those providers. For the same reason, the public interest strongly favors leaving in place the status quo that has existed for five decades, rather than imperiling the health of countless Americans based on an unlawful agency rule.

The Court should deny Defendants' meritless motion to stay.

II. BACKGROUND

A. Statutory and Regulatory Background

Since 1970, Title X[1] has been a critical part of the nation's public health safety net, providing grants to fund high-quality family planning services for low-income individuals. As the sole grantee of Title X funds in Washington, the Washington State Department of Health (DOH) oversees a network of 16 subrecipient organizations operating 85 clinic sites statewide, which served over 91,000 patients in 2017 alone. WA.Supp.Add.018, 022, 025, 113 ¶ 3t (WA cmt.) at 4–5.

Title X's purpose is to ensure access to modern, effective contraception and family planning services, regardless of economic condition. 42 U.S.C. § 300; S. Rep. No. 91-1004, at 9 (1970); ECF No. 1 (Compl.) ¶ 38.[2] Such services help low-income patients avoid unintended pregnancy; prevent pregnancy-related health risks; reduce infant mortality; and enhance education, economic stability, and equality. Title X programs also offer pregnancy testing and counseling; testing and treatment for sexually transmitted infections; cancer screenings; screening for high blood pressure, diabetes, depression, and other

[1] 42 U.S.C. § 300 *et seq*.
[2] "ECF" citations refer to the Eastern District of Washington docket.

health issues; and referrals for out-of-program care. 42 U.S.C. § 300(a); 42 C.F.R. § 59.5(a).

Section 1008 (42 U.S.C. § 300a-6) provides that no Title X funds may be used in "programs where abortion is a method of family planning," but does not restrict grantees from providing abortion care using *non*-Title X funds. For decades, Title X clinics have been able to refer patients for any out-of-program care, and to use the same facilities for Title X programs and abortion services while maintaining financial separation.

Section 1008 does not prohibit providers from communicating with patients about abortion. To the contrary, every year since 1996, Republican and Democratic Congresses have passed appropriations acts requiring that "all pregnancy counseling" in Title X programs "shall be nondirective"—the "Nondirective Mandate." *See, e.g.*, Pub. L. No. 115-245, Div. B, Tit. II, 132 Stat 2981, 3070–71 (2018); Add.55, 117.

Accordingly, and consistent with longstanding practice, the current regulations require grantees to "[p]rovide a broad range of acceptable and effective medically approved family planning methods" and offer nondirective pregnancy counseling, including requested referrals. 42 C.F.R. § 59.5(a)(1), (5). *See* 65 Fed. Reg. 41270, 41278 (July 3, 2000). The HHS Secretary in 2000

described nondirective counseling as "a necessary and basic health service of Title X projects" that is "consistent with the "prevailing medical standards." 65 Fed. Reg. 41273. HHS's Program Requirements for Title X likewise incorporate national, evidence-based standards established in a publication called "Providing Quality Family Planning Services," or "the QFP,"[3] which directs that "[o]ptions counseling should be provided" to pregnant patients as recommended by leading medical associations, including the American College of Obstetricians and Gynecologists (ACOG).[4]

In 2010, Congress enacted Section 1554 of the Patient Protection and Affordable Care Act (PPACA), which provides that HHS "shall not promulgate any regulation that . . . creates unreasonable barriers" for individuals seeking care, "impedes timely access to health care services," "interferes with [patient-provider] communications," "restricts [a provider's] ability . . . to provide full disclosure of all relevant information to patients making health care decisions," or "violates the principles of informed consent and the ethical standards of health care professionals[.]" 42 U.S.C. § 18114.

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[3] *See* WA.Supp.Add.113–14 ¶ 4 (Program Requirements), ¶ 5 (QFP).

[4] WA.Supp.Add.113 ¶ 5 (QFP) at 14, ¶ 3c (ACOG cmt.) at 6; WA.Supp.Add.080–82; NFPRHA.Supp.Add.008–09, 205; ECF No. 1 ¶ 46.

B. The New Rule

On March 4, 2019, HHS published the Final Rule at issue. The Final Rule includes gag requirements that restrict Title X providers from offering abortion information and referrals, while requiring them to provide information and referrals for prenatal care, regardless of the patient's wishes. 84 Fed. Reg. 7747, 7788– 7789 (March 4, 2019). Even if a patient seeks a referral for abortion, providers must deny that request and refer her for unwanted care, and may decline to speak about abortion at all.

The Final Rule also requires physical separation of Title X-funded care from all activities prohibited by the Final Rule—including abortion services and referrals for abortion, as well as expressive or associational activities such as supporting access to safe and legal abortion. *Id*. at 7789. This would mandate, for example, entirely separate facilities, separate personnel, and even separate websites and health care records if Title X providers engage in abortion-related activities.

The Final Rule makes other unprecedented changes, including removing the requirement that Title X services be "medically approved"; requiring that Title X clinics be in close proximity to "comprehensive primary health care services"; vesting HHS with broad discretion to arbitrarily determine grant

eligibility; and limiting the uses of Title X funds (even uses expressly contemplated by the statute). ECF No. 9 at 12. The Final Rule was to go into effect on May 3, 2019.

Washington sued immediately. Both Washington and the NFPRHA Plaintiffs, after consolidation for pretrial purposes, moved to enjoin the rule. On April 25, 2019, the district court held a lengthy hearing and issued a preliminary injunction. Add.96–104 (Oral Ruling), 106–24 (Order). Defendants (collectively, HHS) appealed, then moved for a stay in the district court. ECF No. 58. Without waiting for the district court's decision—which is still pending—HHS also moved for a stay in this Court. A motion to stay an injunction pending appeal must show that moving first in the district court would be "impracticable" or that the district court denied a stay. FRAP 8(a)(2). HHS's instant motion does neither.

C. Other Proceedings

Two other district courts preliminarily enjoined the Final Rule. *California v. Azar*, No. 19-cv-01184-EMC, 2019 WL 1877392, at *44 (N.D. Cal. Apr. 26, 2019); *Oregon v. Azar*, No. 6:19-cv-00317-MC, 2019 WL 1897475 (D. Or. Apr. 29, 2019). HHS appealed and moved to stay both injunctions. *California v. Azar*,

Case Nos. 19-15974, 19-15979 (9th Cir.); *Oregon v. Azar*, Case No. 19-35385 (9th Cir.).

III. ARGUMENT

A. Defendants Cannot Meet the High Standard for a Stay Pending Appeal of a Preliminary Injunction

A stay is an "intrusion into the ordinary processes of administration and judicial review . . . and accordingly is not a matter of right, even if irreparable injury might otherwise result." *Nken v. Holder*, 556 U.S. 418, 427 (2009) (internal citations omitted). The party requesting a stay "bears the burden of showing that the circumstances justify an exercise of [the Court's] discretion." *Id.* at 433–34.

The Court considers (1) whether the applicant has made a "strong showing" of likely success on the merits, (2) "whether the applicant will be irreparably injured absent a stay," (3) whether a stay "will substantially injure" the other parties, and (4) "where the public interest lies." *Id.* at 434; *Lopez v. Heckler*, 713 F.2d 1432, 1436 (9th Cir. 1983) (applicant must make strong showing of likelihood that preliminary injunction will be overturned). A preliminary injunction is subject to limited review, and is reversed only where the district court abused its discretion (e.g., basing its decision on an erroneous

legal standard or clearly erroneous findings of fact). *Adidas Am., Inc. v. Skechers USA, Inc.*, 890 F.3d 747, 753, 757 (9th Cir. 2018).

HHS cannot meet this heavy burden. The district court properly granted the preliminary injunction after considering the (1) likelihood of success on the merits, (2) likelihood of irreparable harm, (3) balance of equities, and (4) public interest in an injunction. Add.109 (quoting *Disney Enters., Inc. v. VidAngel, Inc.*, 869 F.3d 848, 856 (9th Cir. 2017)).

B. HHS Fails to Show It Is Likely to Succeed on the Merits

HHS cannot make the necessary strong showing that it is likely to succeed on the merits. Its argument hinges on the assumption that *Rust v. Sullivan*, 500 U.S. 173 (1991), precludes Washington's claims. HHS misreads *Rust*, fails to account for the conflicts between the Final Rule and post-*Rust* statutes, and ignores the distinct legal and factual issues in the present case, on the present record.

1. *Rust* does not control

In *Rust*, the Supreme Court held that HHS's aberrant and never-fully-implemented 1988 regulations, which included a gag rule and physical

separation requirements,[5] reflected one "permissible construction" of Section 1008. Add.115 n.4; *Rust*, 500 U.S. at 187. *Rust* did not hold that this was the only permissible interpretation, nor that it was "better" than the longstanding policy of offering abortion referrals as part of nondirective pregnancy counseling, while keeping abortion services financially separate. Motion at 8. To the contrary, the Court concluded that "[a]t no time did Congress directly address the issues of abortion counseling, referral, or advocacy"; accordingly, it was "unable to say" the 1988 rule was "impermissible." 500 U.S. at 184–85.

After *Rust* was decided, Congress clarified (and continually reiterated from 1996–present) that "all pregnancy counseling" within Title X "shall be nondirective." 132 Stat. at 3070–71. Additionally, in passing the PPACA, Congress advanced its objective of "Patient Protection" by firmly prohibiting HHS from issuing "any" regulations that impede access to care or interfere with patient–provider communications.[6] 42 U.S.C. § 18114. As detailed below, the Final Rule violates these laws, which were not at issue in *Rust*.

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[5] HHS's characterization of the rules as "materially indistinguishable" glosses over their differences, including multiple challenged provisions with no 1988 analogue. *See* ECF No. 52 at 6.

[6] In light of these statutory prescriptions (and HHS's own summary of Title X's scope, Add.114), *Rust*'s statement that Title X care could exclude pregnancy counseling based on a "preconception" limitation is outdated. *Cf.* Motion at 8, 10, 14.

Neither of these post-*Rust* laws conflicts with Section 1008, as HHS suggests. Motion at 9–10. The Nondirective Mandate clarifies that nondirective pregnancy counseling is not only consistent with Section 1008[7]—a permissible interpretation HHS has implemented for most of the past 50 years—but is *required*. *See Strawser v. Atkins*, 290 F.3d 720, 734 (4th Cir. 2002) (courts must "follow Congress's last word on the matter even in an appropriations law").[8] Likewise, the PPACA limits HHS's authority to regulate patient care, without "repealing" Section 1008. *See Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644 (2007) ("presumption against implied repeals" applies only where statutes irreconcilably conflict); *Morton v. Mancari*, 417 U.S. 535, 551 (1974) (courts may not "pick and choose among congressional enactments," but must "give effect to both"). Here, it is the *Final Rule* that conflicts with controlling law, as the district court properly found. Add.120.

[7] *See California*, 2019 WL 1877392, at *15 ("at oral argument, Defendants' counsel agreed with Plaintiffs that Section 1008 and the Nondirective Counseling Provision can be read in harmony").

[8] HHS previously conceded (contrary to its current argument) that the Nondirective Mandate "imposed additional requirements on [the Title X program]." 84 Fed. Reg. at 7720.

2. The Final Rule violates the Nondirective Mandate, the PPACA, and Title X

The Nondirective Mandate precludes the Final Rule's counseling distortions, which put a "thumb on the scale" for continued pregnancy and steer patients away from abortion. *See* Add.63, 84–85, 120. First, the Final Rule disregards the mandate that pregnancy counseling "shall" be nondirective by permitting *directive* counseling. 84 Fed. Reg. 7789 (§ 59.14(b)(1)) (permitting four types of "counseling and/or information," only one of which is "nondirective"); ECF No. 52 at 6–7. Second, the Final Rule requires coercive referrals, based solely on HHS's unsupported and medically incorrect assertion that prenatal care is "medically necessary," even for patients who choose abortion. Motion at 11; *see* WA.Supp.Add.080–81, 102–03 (prenatal care not medically indicated when pregnancy will be terminated). HHS argues that pregnancy counseling "does not clearly apply to referrals" (Motion at 11), but both Congress and HHS both understand "nondirective counseling" to *include* referrals. ECF No. 52 at 8–9 (citing 42 U.S.C. § 254c–6 ("information and referrals" are "included in nondirective counseling"); 84 Fed. Reg. 7730, 7733–34, 7744 n.72, 7747. The notion that counseling and referral can be *inconsistent* defies medical standards of care and HHS's own Program Requirements. ECF No. 52 at 8 (citing QFP and comments); WA.Supp.App.111–14 (hyperlinks to

same). The district court properly rejected HHS's reliance on different language in a never-enacted bill (Motion at 12–13), which cannot overcome standard medical and legal usage.

Section 1554 of the PPACA,[9] which forbids regulatory interference in the patient–provider relationship, also precludes the Final Rule. Add.120. As the district court correctly recognized, the Final Rule's cost-prohibitive separation requirements and new counseling requirements that violate clinical standards will force out the vast majority of providers in Washington's network, severely restricting rural and uninsured patients' access to care. Add.121–22. This "impedes timely access" and "creates . . . unreasonable barriers to care." 42 U.S.C. § 18114(1), (2); *see* ECF No. 9 at 23–24. The Final Rule also "violates the principles of informed consent and the ethical standards of health care professionals," "interferes with communications," and impedes "full disclosure of all relevant information to patients making health care decisions," 42 U.S.C. § 18114(3), (4), (5), by distorting pregnancy counseling in violation of the Nondirective Mandate. As the district court found, these distortions are likely "inconsistent with ethical, comprehensive, and evidence-based care." Add.120;

[9] HHS calls this provision "obscure" (Motion at 9) but was well aware of it during this rulemaking. *See* 83 Fed. Reg. 57552 (Nov. 15, 2018).

ECF No. 9 at 24 n.77 ("HHS ignored numerous comments detailing the ethical standards for health care providers," citing comments and declarations); WA.Supp.Add.1–3 (comments); NFPRHA.Supp.Add.106–08, 112, 115, 125–26, 130, 170–78 (declarations).

Try as it might, HHS cannot escape Section 1554. The waiver doctrine (Motion at 9–10) is inapplicable to statutory limitations on the agency's authority. *Sierra Club v. Pruitt*, 293 F. Supp. 3d 1050, 1061 (N.D. Cal. 2018); *Nat. Res. Def. Council v. EPA*, 755 F.3d 1010, 1023 (D.C. Cir. 2014) (agency must justify exercise of authority "even if no one objects to it during the comment period"). In any event, commenters "need not raise an issue using precise legal formulations," *Lands Council v. McNair*, 629 F.3d 1070, 1076 (9th Cir. 2010), and here they warned HHS of substantive violations of Section 1554. *See* ECF No. 9 at 23–25 (citing public comments); *Oregon*, 2019 WL 1897475 (citing American Medical Association brief "meticulously matching specific comments to each prong of 42 U.S.C. § 18114"). HHS had ample "opportunity to consider the issue[s]" (Motion at 9), but failed to do so. Nor does the fact that Title X is a grant program somehow exempt the Final Rule from Section 1554, which protects patients against "any" forbidden HHS regulation. 42 U.S.C. § 18114. HHS's attempt to distinguish "funding" programs from others relies on

Rust's inapposite discussion of the constitutional right to choose abortion. *See* 500 U.S. at 202. Government funding discretion does not aid HHS in evading Section 1554.

Title X: HHS barely mentions its authorizing statute, which further grounds the district court's ruling. Add.112–13, 120; *see* Motion at 13. Neither Title X's central purpose nor its requirement that services be "voluntary" was at issue in *Rust*. ECF No. 52 at 14–15.

3. The Final Rule is arbitrary and capricious

The district court also properly determined that the Final Rule likely violates the APA because it is arbitrary and capricious. Add.120.

HHS received overwhelming evidence that the Final Rule will force a Hobson's Choice on Title X providers: violate their ethical obligations or leave the program. Leading medical organizations and other commenters—including the American Medical Association, which "literally wrote the book on medical ethics," *Oregon*, 2019 WL 1897475, at *13—informed HHS that the Final Rule would require ethical and fiduciary violations. ECF No. 9 at 24 n.77; WA.Supp.Add.1–3; NFPRHA.Supp.Add.106–08, 112, 115, 125–26, 130, 170–78. HHS responded to these extensive and unanimous comments by citing its unsupported, unexplained "belie[f]" that the Final Rule "adequately

accommodates" ethical requirements. 84 Fed. Reg. 7724; *see* Motion at 13. This bald assertion has no apparent "basis in the record," *Choice Care Health Plan, Inc. v. Azar*, 315 F. Supp. 3d 440, 443 (D.D.C. 2018), and articulates no "rational connection between the facts found and the choice made," *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Lip service is not enough; the agency must "adequately analyze" important factors raised in public comments. *Am. Wild Horse Preservation Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017); *McDonnell Douglass Corp. v. U.S. Dep't of Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004) ("conclusory or unsupported suppositions" do not suffice).

The refusal-of-care "conscience statutes" on which HHS relies (Motion at 14) do not support its rejection of commenters' serious ethical concerns. Indeed, HHS's reliance on such statutes to rationalize the Final Rule, *see, e.g.*, 84 Fed. Reg. at 7716-7717, independently renders it arbitrary and capricious. These statutes apply, if at all, to an unknown minority of Title X providers, exempting them from providing certain care in certain circumstances. *See* Add.118–19. It is arbitrary and capricious to use them as a sword to *prohibit* Title X providers from offering ethical care—but consistent with HHS's goal of remaking Title X as a funding source for providers who oppose access to comprehensive family

planning services, contrary to Congress's intent. *See* ECF No. 9 at 30–31. Likewise, HHS again misplaces its reliance on *Rust*'s First Amendment analysis. *See* Motion at 14; *Rust*, 500 U.S. at 192–200. A determination that the First Amendment might permit a forced choice between accepting funding and violating ethics does not make it rational to force that choice on all providers in a government health care program, especially where it will severely harm the program's purpose and effectiveness.

Its dismissal of ethical issues is not HHS's only failing. As the district court found, the Final Rule is also "arbitrary and capricious because it reverses long-standing positions of the Department without proper consideration of sound medical opinions and the economic and non-economic consequences." Add.120. When an agency reverses position, it must "supply a reasoned analysis for the change," *State Farm*, 463 U.S. at 42, and may not "depart from a prior policy *sub silentio* or simply disregard rules that are still on the books," *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). HHS's Motion fails to mention its *sub silentio* reversal of the QFP's evidence-backed standards, or the Final Rule's numerous regulatory reversals with no 1988 analogue. *See* ECF No. 9 at 31–34.

Further, HHS baselessly claimed patients would be unaffected by the Final Rule, completely disregarding Washington's comments that it would leave over half the State's counties without a Title X provider, imposing extensive economic and human costs. ECF No. 9 at 34–38. HHS merely points back to *Rust*, ignoring the *current* facts on the *current* rulemaking record. Motion at 14–15. HHS's predictions about the costs of compliance and the existence of providers capable of filling huge gaps in the network appear purely speculative—a far cry from *Trout Unlimited*'s "thoughtful, comprehensive" rulemaking based on "substantial" scientific data. 559 F.3d 946, 959 (9th Cir. 2009). Labeling such unreasoned and unsupported conclusions an agency "judgment" (Motion at 15) does not make them any less arbitrary and capricious. *See AT&T v. F.C.C.*, 974 F.2d 1351, 1355 (D.C. Cir. 1992). Washington's harms, on the other hand, are far from "speculative" (Motion at 15) and are supported by overwhelming, unrefuted evidence.

4. Defendants' passing attack on the standard applied by the district court is misguided and inaccurate

Defendants devote one paragraph to claiming the district court erred by applying this Circuit's "sliding scale" analysis of the preliminary injunction factors. Motion at 8–9. But this is the controlling standard; applying any other would have been improper. In any event, the district court concluded that

Plaintiffs had presented "claim[s] that ha[ve] merit and a likely chance of success," and "all four factors tip in their favor," which suffices under any standard. Add.119; *see Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

C. HHS Will Suffer No Imminent, Irreparable Harm Pending Appeal, but Staying the Injunction Would Substantially Harm Plaintiffs and the Public

HHS offered no evidence whatsoever in opposing preliminary injunctive relief: it failed to rebut Washington's evidence of the devastating and immediate harm it will suffer if the Final Rule goes into effect, and it submitted nothing suggesting the Government would be harmed by delayed implementation pending merits adjudication.

HHS still does not seriously contest Washington's evidence of irreparable harm. Motion at 18. That evidence is substantial and the demonstrated injury is real. *See* Add.122–23 (despite "substantial evidence" of harm in the form of numerous declarations[10] and exhibits thereto, "the Government's response in this case is dismissive, speculative, and not based on any evidence presented in the record before this Court"). Plaintiffs demonstrated to the district court that

[10] These declarations are submitted in Washington and NFPRHA's Supplemental Addendums.

the Final Rule—and thus a stay of the preliminary injunction—would harm the State and its residents in multiple ways because it would:

> (1) seriously disrupt or destroy the existing network of Title X providers in both the State of Washington and throughout the entire nation—this network has been carefully knit together over the past 45 years and there is no evidence presented by the Department that Title X is being violated or ignored by this network of providers; (2) impose additional and unnecessary costs on the State of Washington and other states; (3) harm the health of the patients who rely on the existing Title X providers; and (4) drive many Title X providers from the system either because of the increased costs imposed by the new separation requirements or because they cannot or will not comply with the allegedly unprofessional gag rule requirements.

Id. at 16; *see* ECF No. 9 at 13–19, 39–44. Washington showed that over half of its counties would be unserved by any Title X-funded family planning provider if the Final Rule is implemented, and that residents in rural areas, uninsured patients, and students at Washington colleges and universities would be especially hurt. *Id.* There is nothing "speculative" (Motion at 18) about the already-announced provider departures or the resulting statewide network destruction, which are serious and amply substantiated. By contrast, in *United States v. City of Los Angeles* (Motion at 18), affidavits showing that the "primary effect" of funding loss would be "reassignment" of some police officers did not make a "convincing showing" of irreparable harm. 595 F.2d 1386, 1391 (9th Cir. 1979). There is no comparison between employee reassignment and the sudden

destruction of a statewide family planning network delivering needed services to the State's most vulnerable residents.

These harms to public health and unrecoverable financial and other losses to the State are clear, irreparable harms under this Court's precedent. *See, e.g.*, *California v. Azar*, 911 F.3d 558, 571, 581 (9th Cir. 2018) (irreparable harm based on "women losing employer-sponsored contraceptive coverage, which will then result in economic harm to the states"); *Regents of Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 279 F. Supp. 3d 1011, 1033, 1046 (N.D. Cal.), *aff'd*, 908 F.3d 476 (9th Cir. 2018) (irreparable harm based on "loss of specific tax revenues" and "detrimental impact on . . . public health . . . and safety"); *County of Santa Clara v. Trump*, 250 F. Supp. 3d 497, 537 (N.D. Cal. 2017) (irreparable harm where rule would require "steps to mitigate the risk of losing millions of dollars in federal funding"); *Texas v. United States*, 86 F. Supp. 3d 591, 673 (N.D. Tex. 2015), *aff'd*, 809 F.3d 134 (5th Cir. 2015), *as revised* (Nov. 25, 2015) (irreparable harm where "there are millions of dollars at stake in the form of unrecoverable costs to the States"). HHS offers no evidence to refute the harms the Final Rule will impose on real people in Washington and on the State itself. ECF No. 9 at 13–18, 41–44. Granting a stay would inflict irreparable harm, not prevent it.

HHS asserts it will suffer two injuries if a stay is not granted pending appeal. Neither claim withstands scrutiny. First, HHS makes a general argument that it suffers irreparable harm when enjoined from "effectuating statutes enacted by representatives of its people." Motion at 16–17 (quoting *Maryland v. King*, 567 U.S. 1301 (2012)). But *Maryland v. King* is not implicated here. The injunction does not enjoin an enacted statute; it enjoins a *regulation* that *violates* enacted federal statutes, as Plaintiffs demonstrated in a showing sufficient for a preliminary injunction. Add.120. The injunction thus supports the public's interest in "ensuring that 'statutes enacted by [their] representatives' are not imperiled by executive fiat." *E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1255 (9th Cir. 2018).

More specifically, HHS argues that a stay will force it to disburse taxpayer dollars in furtherance of a policy that it has concluded violates Section 1008. Motion at 17. But HHS itself recently awarded grants subject to that same policy as reflected in the current regulations, which belies any claim of irreparable harm. HHS's argument also assumes its success on the merits, contrary to the findings of three district courts that the Final Rule is likely illegal. Add.119–21. As the district court here correctly noted, there is no public interest in perpetuating unlawful agency action. Add.123.

Second, HHS claims it will be delayed in providing guidance to grantees about the Final Rule as it begins the process for next year's continuation awards, leading to disruptions in the Title X program. Motion at 17–18. The preliminary injunction merely preserves the decades-long status quo; staying it would be hugely disruptive. Any disruption caused by maintaining the Final Rule's current compliance deadlines is of HHS's own making, and "self-inflicted wounds are not irreparable injury." *Stuller, Inc. v. Steak N Shake Enters., Inc.*, 695 F.3d 676, 679 (7th Cir. 2012). Moreover, nothing stops grantees from preparing for the possibility that the Final Rule may go into effect at some point; but in the meantime, the injunction enables them to continue serving the public by providing care and services pursuant to Title X, consistent with longstanding regulations and standards of care. *See* Add.123 ("[T]here is substantial equity and public interest in continuing the existing structure and network of health care providers . . . while the legality of the new Final Rule is reviewed and decided by the Court.").

D. The Injunction's Scope Is Proper

"The basic function of a preliminary injunction is to preserve the status quo pending a determination of the action on the merits." *Chalk v. U.S. Dist.*

Court Cent. Dist. of Cal., 840 F.2d 701, 704 (9th Cir. 1988). A nationwide injunction serves that function here.

This case concerns a competitive federal grant program with limited funds, which makes it particularly suitable for "programmatic" relief to ensure consistent, fair standards. *City of Los Angeles v. Sessions*, 293 F. Supp. 3d 1087 (C.D. Cal. 2018). Here, as in *Sessions*, all applicants for Title X funds should be on an "even playing field." *Id.* at 1101. *See also Washington v. Reno*, 35 F.3d 1093, 1104 (6th Cir. 1994) (injunction limited to plaintiffs would not prevent disputed pool of federal funds from being disbursed to third parties on contested legal terms). Subjecting Washington and other grantees to different rules would alter HHS's distribution of Title X appropriations, and HHS offers no proposal for fairly allocating funding in such a scenario. *See E. Bay Sanctuary*, 909 F.3d at 1256 (upholding nationwide injunction where Administration "fail[ed] to explain" how "a narrower [remedy]" would provide complete relief).

Nationwide relief is also needed to provide complete relief to NFPRHA's members throughout the United States, which have a variety of funding relationships within Title X. Moreover, nationwide injunctions are "commonplace in APA cases" and supported by an "uncontroverted line of precedent." *Id.* Both the Supreme Court and the Ninth Circuit have been

"unpersuaded" by the Justice Department's new policy[11] of opposing *all* requests for nationwide relief, which HHS follows here. *City & County of San Francisco v. Trump*, 897 F.3d 1225, 1244–45 (9th Cir. 2018); *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080 (2017) (staying executive order as to parties *and* "similarly situated" persons); *accord E. Bay Sanctuary*, 909 F.3d at 1256; *Hawaii v. Trump*, 878 F.3d 662, 701 (9th Cir. 2017) (per curiam), *rev'd on other grounds*, 138 S. Ct. 2392 (2018); *Washington v. Trump*, 847 F.3d 1151, 1166–67 (9th Cir. 2018).

HHS also inaccurately characterizes the scope of the injunctive relief granted in the lead-up to *Rust* (Motion at 17), which was not limited to the parties appearing before the district courts. *See Massachusetts v. Bowen*, 679 F. Supp. 137, 148 (D. Mass. 1988) (granting injunction to NFPRHA and other plaintiffs, as to all "entities they represent, in any manner either directly or indirectly, anywhere within the United States"); *Planned Parenthood Fed'n of Am. v. Bowen*, 687 F. Supp. 540, 544 (D. Colo. 1988) (granting injunction to plaintiffs "as well as all other parties named in the Preliminary Injunction," a reference to all Planned Parenthood clinics nationwide).

[11] *See* https://www.justice.gov/opa/pr/attorney-general-sessions-releases-memorandum-litigation-guidelines-nationwide-injunctions.

HHS closes with a short request for a partial stay on the grounds that (unspecified) provisions of the Final Rule are "severable," effectively asking this Court to recraft the injunction under the guise of a motion to stay. Any question about severability is premature pending a decision on the merits; the injunction's purpose is to preserve the status quo in the meantime. *See Chalk*, 840 F.2d at 704. In any case, Washington challenged the *entire* Final Rule, which is comprised of interrelated provisions HHS describes as serving one overarching purpose: "to ensure compliance" with its new interpretation of section 1008. ECF No. 44 at 36. Severance is unworkable. *See MD/DC/DE Broad. Ass'n v. F.C.C.*, 236 F.3d 13, 22–23 (D.C. Cir. 2001) (regardless of agency intent, unlawful provisions are not severable where they would "undercut the whole structure of the rule").

IV. CONCLUSION

This Court should deny the government's motion to stay the preliminary injunction pending appeal. Should any stay be granted, Washington requests that it be delayed pending appellate review.

RESPECTFULLY SUBMITTED this 23rd day of May, 2019.

ROBERT W. FERGUSON
Attorney General

/*s/ Kristin Beneski*
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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Motion Response complies with the type-volume limitation of Ninth Circuit Rules 27-1 and 32-3 because it contains 5,200 words. This Motion Response complies with the typeface and the type style requirements of Federal Rule of Appellate Procedure 27 because it has been prepared in a proportionally spaced typeface using 14-point font.

/*s/ Jeffrey T. Sprung*
JEFFREY T. SPRUNG, WSBA #23607

WASHINGTON SUPPLEMENTAL ADDENDUM

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-3040-SAB

DECLARATION OF KARL EASTLUND IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Karl Eastlund, 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 personal knowledge.

2. I currently serve as President and Chief Executive Officer (CEO) of Planned Parenthood of Greater Washington and North Idaho (PPGWNI). I joined PPGWNI in 2003 as Chief Financial Officer before quickly becoming the organization's Chief Operating Officer. In 2011, I became CEO. Prior to working for Planned Parenthood, I was a Principal with Mercer Consulting in Dallas, where I worked with Fortune 500 companies on performance management and incentive compensation strategies. I have an MBA from the University of Texas and am a Certified Public Accountant (CPA). I am currently the Board Chair of the Laboratory Services Cooperative, and a member of several Planned Parenthood Federation of America (PPFA) national work groups.

3. Part of my duties as CEO of PPGWNI include working with PPGWNI's board members, donors, staff, and community members to create a long-term strategic plan for the organization.

4. PPGWNI provides health care at eleven health centers across eastern Washington, located in: Ellensburg, Yakima, Sunnyside, Kennewick, Pasco, Walla Walla, Pullman, Spokane Valley, Spokane, Moses Lake, and Wenatchee. In 2017, our health centers provided care to more than 30,000 individuals.

5. With assistance from the Title X program, PPGWNI provides family planning, STI testing and treatment, cancer screenings, and pregnancy option

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counseling at all of these health centers. As required by federal law, PPGWNI does not use Title X funds for abortion.

6. Our health centers in Ellensburg, Pullman, Walla Walla, and Spokane, in particular, serve a student population that relies on PPGWNI's participation in the Title X program to obtain family planning and STI testing and treatment services. University health centers often lack the capacity to meet the reproductive health care needs of students, whether due to limited resources, concerns about confidentiality, and/or not offering a broad range of birth control options, among others.

7. In Spokane, Gonzaga University does not offer any reproductive health services to its students, making our Spokane health center near the Gonzaga campus a critical resource for students. Many students lack adequate insurance, and many do not have a steady source of income. Our ability to provide Title X services on a sliding fee scale is extremely important in serving these patients and ensuring students remain healthy and are able to complete their education.

8. Should HHS's Final Rule become effective, it will have a devastating effect on PPGWNI, but more importantly on the thousands of patients who rely on us for care. That is because due to the unethical requirements to withhold vital health information from our patients, PPGWNI will be forced to leave the Title X program. The proposed physical separation requirements would also, at a minimum, require substantial investment in needless facility changes. Even if we had facilities available in which we could logistically make such changes, the

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process would be prohibitively expensive, and are not efficient uses of this non-profit organization's resources.

9. Without our Title X funding, PPGWNI would potentially have to close several of its health centers. Furthermore, PPGWNI's ability to continue providing services in its remaining health centers would depend on patients' ability to pay, or whether they have insurance coverage. Currently, the Title X program helps PPGWNI provide family planning services to all patients, regardless of their ability to pay. Removing financial assistance for those most in need would severely impact access to contraception and STI screening and treatment in the communities we serve. Currently, community clinics' schedules are often booked for several months at a time, and our patients continually complain about how difficult it already is to access a health care provider or a community clinic because of provider shortages in eastern Washington.

10. If PPGWNI were not in the Title X program, this would likely contribute to a rise in unintended pregnancies, abortions, and untreated STIs and undetected cancers in our communities. The public health crisis this could create would be profound. Many of our communities are already dealing with high unintended pregnancy rates and high STI rates – some of the highest in this country. Adding to this problem is unconscionable, but that is the effect the Final Rule will have.

11. Absent Title X funding, our clinics most at risk of closing are those in communities with the most underserved populations as it is more difficult to create,

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fund, and staff medical clinics in rural areas. Given that, and the lack of alternative resources, these areas are likely to have some of the worst public health outcomes if no family planning clinics are available. In particular, those clinics are located in the cities of Sunnyside, Pasco, Moses Lake, and Wenatchee. There are already provider shortages in those areas, and having to close our clinics or reduce the services provided there would reduce access to needed services and further increase the poor public health outcomes in those communities.

12. Seven of our clinics provide abortion services independent of any Title X program. These clinics have been designed to maximize efficiency to serve the most patients with the staff resources while providing the broad range of services that our patients need. These clinics currently have one reception area and one check-in station each, meaning that they would not satisfy the Final Rule's separation requirements. These clinics would have to undergo massive remodeling in order to comply with the new requirements, but that is not financially or logistically feasible. Health care construction costs are very high, and contractors are difficult to schedule due to current demand for construction workers. At a minimum, meeting the physical separation requirement would take significant resources and time, including time when the clinics would have to be closed. Clinic closure further reduces access, thus exacerbating poor public health outcomes.

13. The Title X regulatory changes require that various aspects of administrative support would need to be separated for different types of services as well. This will be costly, if it is even logistically possible. It would be incredibly

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inefficient to maintain separate but equivalent systems for medical records, finance records, human resources, and staff training, among other functions. Hiring separate staff and establishing systems to perform the same functions is a waste of vital health care resources. That money can and should be spent on improving public health.

14. I have analyzed the costs in order for PPGWNI to comply with the Final Rule's separation requirements. Given the breadth and vagueness of the separation requirement, we assume that PPGWNI's family-planning health centers and Title X-funded education programming would need to become wholly operationally distinct from the rest of PPGWNI. This would entail dedicated buildings for each, dedicated health care, education, and administrative staff, and separate, dedicated office systems and electronic medical records systems.

15. To comply with the separation requirement, we assume we would create 11 parallel sites that would offer Title X services under the new rules (while keeping the 11 current sites and run them outside the Title X program). Based on the current costs of our facilities, I estimate that it would cost $657,000 per year in office rentals, utilities, and maintenance costs to acquire new facilities for the Title X health centers.

16. I estimate we would need to hire additional staff, for a cost of $5,101,875 per year. This estimate contemplates 49 direct service and educational staff and between 19 and 20 administrative staff members. I estimate it would cost

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an additional $204,000 to maintain a separate telephone, data, credit card processing, and call center systems and separate websites and email addresses.

17. PPGWNI would be required to create and maintain a separate electronic health records system for its Title X patients. I estimate that it would cost approximately $150,000 to start up the records system and cost an additional $350,000 annually to maintain.

18. PPGWNI would also incur significant accounting and legal costs from creating its distinct Title X organization, as well as costs arising from the disruption in services as the new systems are created. I estimate that there would be administrative and legal costs totaling $150,000 to form the new entity.

19. Additionally, I understand that PPGWNI would be required to comply with the "physical separation" requirements within a year—by March 4, 2020. Even if compliance with these requirements were financially feasible. PPGWNI would be unable to comply with these onerous requirements in such a short time frame, given the complete overhaul of the organization that the Final Rule requires.

20. In short, I estimate that the cost of compliance with the separation requirement would total more than $6.5 million in the first year, which far exceeds the money in Title X funding PPGWNI receives.

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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 21 day of March, 2019, at Spokane, Washington.

KARL EASTLUND
President and Chief Executive Officer
Planned Parenthood
Greater Washington and North Idaho

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 22nd day of March, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
JEFFREY T. SPRUNG, WSBA #23607
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, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-3040-SAB

DECLARATION OF CYNTHIA HARRIS IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

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I, Cynthia Harris, 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 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 16 subrecipients offering Title X services at

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85 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

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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 six 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.

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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 13 years of monitoring Washington's subgrantees for Title X compliance. As a special assignment during 12 of those 13 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

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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.

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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 16 current subrecipients operating 85 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

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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 39 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 29 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.

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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 13 and 44 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).

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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 15-24. While the age distributions of Title X clients are shifting, most clients are under the age of 25, 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.

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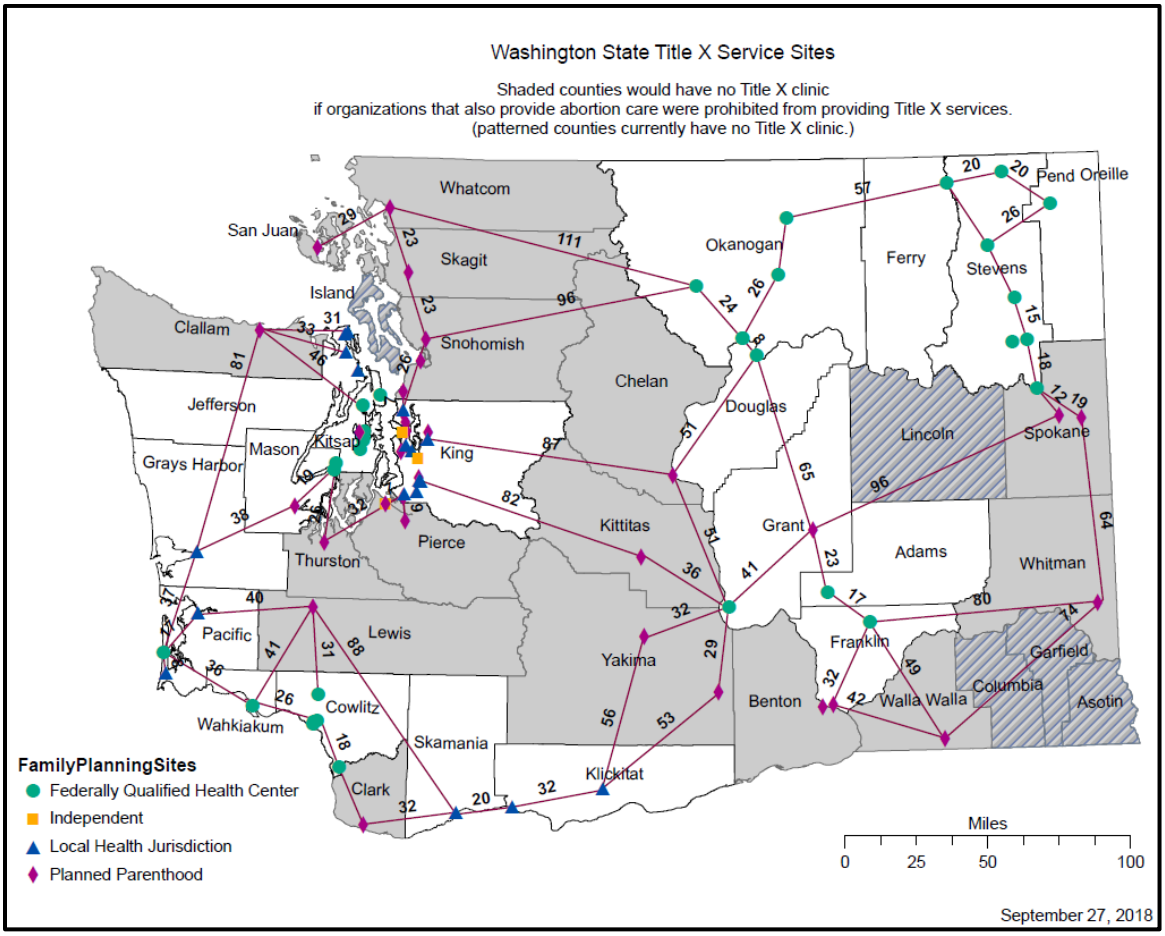
5. DOH's Title X grant subrecipients

27. As of September 1, 2018, there were 16 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:



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

29. 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,

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Pend Orielle, Whitman, and Walla Walla. The following five counties (of 39 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.

30. All but five of our subrecipients have more than 30 years' experience providing family planning services to their communities—four have provided these services for more than 50 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 (LARCs) 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.

31. 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

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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.

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

6. Washington's Title X patients

33. 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.

34. 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

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significantly smaller and less dense populations and fewer available health services.

7. Selection of Subrecipients

35. 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.

36. Abortion care is not provided as part of Washington State's Title X Project.[1] Subrecipients' written policies must state clearly and unequivocally that no Title X funds will be used for abortion services. This is a core element of our competitive selection process.

37. 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

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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.

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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.

38. 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.

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39. 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

40. 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

41. 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.

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42. 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.

43. 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.

44. 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

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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.

45. 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.

46. 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.

47. DOH's On-Site Monitoring Tool, a checklist created by DOH based on the tool that the federal Office of Population Affairs (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

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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.

48. 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.

49. 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.

D. The Final Rule Will Undermine Washington's Title X Program

50. My staff and I have reviewed 84 Fed. Reg. 7714 (the Final Rule). The Final Rule will effectively dismantle Washington's Title X program and cause extensive damage under any possible scenario.

51. The Final Rule makes several important and concerning changes to the Title X regulations. I want to address several changes that particularly adversely impact Washington medical care providers and patients.

52. The Final Rule imposes a gag rule on providers, precluding them from discussing or mentioning abortion as a pregnancy option. Patients will therefore receive substandard care following positive pregnancy tests, in that they will receive falsely limited pregnancy options counseling, misleading responses to requests for referrals if they desire an abortion, and compelled prenatal counseling and assistance in making prenatal care appointments, regardless of the patient's wishes. The patient will have no say about any of this.

53. These requirements end the previously existing guarantee that all pregnant patients will be offered unbiased, factual, and comprehensive counseling necessary to make sure that they are equipped to make fully informed and voluntary decisions about their own health care.

54. The Final Rule prohibits providers from giving patients direct referrals for abortions. The providers must provide pregnant patients referrals for prenatal care, and at best must provide misleading information to patients who request abortion referrals. In addition to providing the mandatory prenatal care referral, providers may choose to provide pregnant patients with the following "counseling and/or information": (1) Nondirective pregnancy counseling, if provided by a physician or "advanced practice provider"; (2) a list of "comprehensive primary health care providers (including providers of prenatal

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care)"; (3) referral to "social services or adoption agencies"; and/or (4) information about "maintaining the health of the mother and unborn child during pregnancy." The list of "comprehensive primary health care providers" "may" (but need not) include some providers who "also provide abortion as part of their comprehensive health care services." Such providers must not be identified as such and must not comprise a majority of the list. But in Washington a Title X provider's theoretical ability to include providers of abortion on this list is illusory: in Washington, there are *no* publicly known primary health care providers that offer abortion care. Denying desired and medically appropriate referrals and coercing patients into unwanted medical treatment frustrates and/or delays their ability to receive wanted and needed medical care. The referral prohibition makes no exception for medically indicated abortion (except in an "emergency"), which is extremely troubling.

55. The practical results would pose serious health and financial risks to patients. For example, if a patient has been diagnosed with a form of cancer that would make carrying a pregnancy to term dangerous, the Final Rule requires the provider to refer the patient for prenatal care and forbids the provider from "presenting abortion as an option."

56. Another example is a patient who is a victim of rape and becomes pregnant as a result. Even if she desires an abortion and the provider's medical opinion is that "assisting" the patient to make an appointment with a prenatal care provider is likely to damage her mental health, the Final Rule affords no

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discretion to the provider. As long as the patient does not urgently require "emergency care," the provider must provide "assistance" in setting up the government-mandated appointment for her. It is for these reasons and many more that many Washington providers consider the requirements unethical.

57. Further, the Final Rule imposes burdensome physical and financial separation requirements for clinics that also provide abortions outside their Title X project or that want to continue providing nondirective pregnancy counseling. The result is that the Final Rule prohibits individual doctors or other medical care providers, as well as clinics and even entire grantee organizations, from providing comprehensive reproductive health care in one location. These strict separation requirements are also costly for clinics, as they would have to construct separate facilities, hire separate staff to perform equivalent functions, and build separate websites and health care records systems if they wish to continue providing comprehensive care. These costs will be prohibitive for many clinics, which already operate on tight budgets.

58. The end result of the Final Rule is to incentivize non-abortion providers to enter or remain in the Title X program, and push abortion providers out (regardless of their compliance with section 1008). Title X providers who also independently provide abortions will face hugely increased costs and difficulties in administering their family planning programs.

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1. The Final Rule will destroy Washington's Title X network

a. The Final Rule will expel clinics that provide approximately 89% of Washington's Title X patient visits

59. The Final Rule will destroy Washington's Family Planning Network and leave many Washington counties, and tens of thousands of family planning patients, without any Title X provider at all. Because the Final Rule will undermine the quality of health care provided through Title X programs and impose burdensome and counterproductive separation and reporting requirements, the majority of providers who are currently in the network will be unable to comply with the new requirements. The Final Rule will inhibit Washington from continuing to operate its Family Planning Program, which up to now has been successful in improving health outcomes in the state. The Final Rule's negative effects will fall particularly hard on uninsured patients and those in rural areas, who in some cases will have no other feasible option for obtaining family planning services. As a result, thousands of people in Washington who rely on Title X providers for contraception and other family planning services will lose access to those services, which will cause long-term harm to the public health and increase health care costs in Washington.

60. Five subrecipients of Title X funds in Washington—four Planned Parenthood affiliates, and the subrecipient managing the Cedar River Clinics— have informed DOH that they will be unable to continue in the Title X program if the Final Rule goes into effect because they cannot meet its new

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requirements. These five subrecipient organizations operate a total of 35 clinics, 24 in western Washington and 11 in eastern Washington. In 2017, these clinics provided Title X family planning services to 89% of all Title X patients served in Washington—a total of 81,114 Washingtonians. Thus, as soon as the Final Rule goes into effect, the clinics serving 89% of Washington's Title X patients will disappear from our program.

61. In 17 of Washington's 39 counties, the only Title X provider is a clinic operated by one of the above five subrecipients. In all of eastern Washington, which has 20 counties, only nine counties would have any Title X provider at all. In western Washington, ten other counties would have no Title X providers—including six of the ten most populous counties.

62. If the Final Rule goes into effect, Title X patients in these counties would either need to travel hundreds of miles to Title X clinics in distant counties or forego the benefits of the Title X program altogether. As a result of the Final Rule, over half of Washington counties would be unserved by a Title X-funded family planning provider.

63. The Public Health Service of King County—a subrecipient that does not provide abortion services but does provide nondirective pregnancy counseling—has expressed that it cannot comply with the Final Rule and maintain its current level of family planning service. In 2017, King County served 5,489 Title X clients.

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64. The Final Rule will not just force out subrecipients that offer abortion services independent of the Title X Project. Its "gag" provisions and other needlessly costly requirements will likely force an exodus of other providers as well.

65. The harmful consequences of the Final Rule will uniquely impact rural and uninsured patients. In four largely rural Washington counties, one quarter or more of Title X patients are uninsured, and the only Title X clinics have announced that the Final Rule would preclude them from continuing in the Title X Project. These counties are San Juan (30% of Title X patients were uninsured in 2017), Skagit (29%), Douglas (28%), and Whitman (27%). These counties do not have local health jurisdictions providing family planning services. They would lose their federally funded providers entirely.

66. In five other counties in rural Washington, Title X patients are served by small Title X clinics that have announced they cannot comply with the Final Rule. These clinics are in Ellensburg (in Kittitas County), Walla Walla (in Walla Walla County), Wenatchee (in Chelan County), Pullman (in Whitman County), and Moses Lake (in Grant County). Because they are so small and a significant amount of their work involves Title X-funded services, some of these clinics may not survive the loss of federal funds. Once these current Title X clinics are driven from Washington's Title X network, many of their patients will not be able to shift to another provider. Even if some current Title X providers

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remain in the program, the distance patients would have to travel to reach them is impracticable.

67. Students will also be especially hurt by the Final Rule. As a result of the above five subrecipients' departure from Washington's network, there will no longer be any federally funded providers near Washington State University, Western Washington University, Central Washington University, Eastern Washington University, Big Bend Community College, Columbia Basin College, and Yakima Valley Community College. Students at these campuses will lose access to federally subsidized services unless they are able to travel elsewhere, which may prove difficult or impossible for many.

68. Further, the remaining subrecipients cannot fill the gap created by the five subrecipients' departure even in the unlikely event they all remain in the program. Federally Qualified Health Centers in Washington do not have the infrastructure nor the financial means to provide services to the 81,000 patients formerly served by the departing subrecipients. Even if there were remaining subrecipients, they are already at capacity and do not have the resources, especially providers, to handle an influx of clients. DOH is aware of no other nonprofit family planning services providers in Washington that can step in to fill this gap.

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b. HHS would not fund the remaining skeletal Title X network at anywhere near the existing level

69. Title X grants are awarded on a competitive basis, and Washington competes against other states and against non-profit organizations nationwide for family planning funds. The applications are assessed by reviewers who suggest to HHS which applications scored the highest in meeting the criteria set out in HHS's announcement of funding availability.

70. The current level of Title X funding Washington receives is based on historical funding and the current scope of our network. The scope of our network is how well we cover the state (number of agencies) and how many clients we can serve. As shown above, under the Final Rule, at the very least Washington will lose its Title X providers that served 89% of individual clients in 2017. There are no other providers in most of these areas that could absorb that many low-income clients. The number of clients we serve would go down. Given this, Washington would not continue to receive the roughly $4 million current award from HHS to administer its Title X program. Based on my experience, with a network that omits the number of counties—particularly rural, underserved counties—described above, Washington's Title X grant would be a fraction of its current grant. With the reduced area covered and the reduced number of clients, there is no assurance that HHS would award Title X grant funds to the State at all.

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71. Our current grant proposal includes as subrecipients the five entities that have announced they could not continue in the Title X program if the Final Rule is effective. Assuming Washington continues as a Title X grantee, this means that as soon as the Final Rule becomes effective, Washington would lose the network described in its application. As a result, its current level of funding would be in jeopardy.

2. Washington's options for responding to the Final Rule are severely limited

72. I have considered options for responding to the Final Rule's disqualification of the vast majority of providers in Washington's Family Planning Network. This has included the possibility of creating a parallel program providing for family planning services (including non-coercive, non-directive options counseling and, where appropriate, abortion referrals) funded exclusively with state dollars, while continuing to apply for and use federal funds to provide limited family planning services. This is impossible, for several reasons.

a. DOH does not have the funding that would be required to comply with the Final Rule

73. It would require a different administrative infrastructure than DOH currently has, and one that satisfies the physical separation requirement, for DOH to administer a limited Title X Project alongside a state-funded Family Planning

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Program that offers non-coercive, non-directive options counseling and referrals. DOH does not have funding for this.

74. The physical separation requirements of the Final Rule appear to require that grantees maintain offices, staff, administration, and record-keeping for a Title X Project entirely separate from those involved in administering family planning services prohibited by the new regulatory requirements.

75. For DOH to continue to offer options counseling and, where appropriate, abortion referrals, it would need to build a new program separate from its Title X Project. It would need to start by unwinding its current, integrated program and the infrastructure and contractual relationships that accompany it. DOH would have to expend considerable resources just for the administrative process of shutting down the current jointly funded program and building a new, state-funded program from the ground up.

76. Even assuming that all current participants in the integrated Family Planning Program would participate in an exclusively state-funded program despite receiving less funds than they currently do, there would be administrative costs associated with the changes needed to implement the new program. The funding mechanism with the clinics would change to solely state funds, and clinics may need to be billed differently to manage costs. The integrated billing system currently used may no longer work; for example, we may need to create a per-patient reimbursement or a fee-for-service reimbursement rather than a

grant-based reimbursement. As a result, a new billing system would need to be established and implemented, further increasing administrative costs.

77. Assuming the Final Rule becomes effective after the new grant period begins (*i.e.*, after April 1, 2019), Washington would be required to revise contracts with subrecipients of Title X funds; create and administer a system to determine payments owed to former Title X subrecipients for their work performed prior to the termination date; create and administer a system to return any unspent grant funds back to HHS pursuant to the terms of the grant; and create and administer an entirely new program for providing family planning services that does not utilize any Title X funds.

78. DOH would incur significantly increased costs to administer two separate programs, with separate staff, administration, and record-keeping systems. Further, DOH would have to expend resources upfront to get the separate programs running.

79. DOH does not have the funds to terminate the existing infrastructure and implement such a duplicative infrastructure. No legislative appropriation exists that would allow DOH to incur these costs and develop an exclusively state-funded program from the ground up. Indeed, the 2019 regular legislative session in Washington is underway and concludes on April 28, 2019, and deadlines to pass bills out of committees expire by March 1, 2019. It is unrealistic to suggest that DOH could even obtain a new appropriation in the 2019 legislative session, even if it sought one.

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b. Even ignoring the absence of funding, Washington could not create parallel programs within the 60-day window before the Final Rule becomes effective

80. Even if parallel federally and state-funded programs were not foreclosed by the absence of funding, nothing could be built in the 60-day window prior to effective date of Final Rule, resulting in an immediate and damaging gap in services. Under the Final Rule, the prohibition on referrals for abortion care becomes effective 60 days after the publication date, or May 3, 2109. Whether the Washington legislature would appropriate funding for a parallel family planning program is entirely speculative, and in any event, as stated above, it would take longer than 60 days to occur. Further, it would take far longer than 60 days to take the other steps outlined above for terminating the existing program and creating a new one.

81. In the interim, there would be no added state funding, and Washington and its residents would be harmed in numerous ways: almost all of Washington's current network of family planning providers would be unavailable to Title X-funded patients; many uninsured and underinsured patients would lose access to family planning services entirely; those patients who were able to continue to see Title X providers would receive misleading information, resulting in lower-quality family planning services; and the incidence of unintended pregnancies, undiagnosed cancer, and untreated STIs would increase, driving up the State's health care costs.

82. Furthermore, DOH cannot comply with the Final Rule's new

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separation requirements. DOH administers the State's Title X program primarily from its headquarters at a government building in Olympia, Washington. DOH also administers a host of other programs and exercises its other state governmental functions from the same location, some of which may relate to abortion. Some DOH personnel, particularly those at higher levels, are involved in the administration of both the Title X program and other programs and activities. DOH's activities include seeking appropriations for and administering state-funded health care programs that include abortion; supporting, providing information, and testifying to the legislature on legislation such as the Reproductive Parity Act; supporting reproductive health education and outreach; developing public-facing content/materials that may include information about abortion; paying dues to organizations that provide public health support such as the National Family Planning and Reproductive Health Association; and other activities consistent with Washington's public policy and commitment to protecting the health and welfare of its residents. By requiring that these activities having nothing to do with Title X be physically separated from the Title X program itself, even at the highest administrative level, the Final Rule would severely disrupt State business and place enormous burdens on the State.

c. A DOH program that complied with the restrictions of the Final Rule would be contrary to Washington law

83. It is not at all clear that DOH could continue to operate a Title X program subject to the Final Rule, even if it also operated a separate state-funded

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program that would include the departing subrecipients. Initiative 120, approved by Washington voters in 1991, states:

> If the state provides, directly or by contract, maternity care benefits, services, or information to women through any program administered … in whole or in part by the state, the state shall also provide women otherwise eligible for any such program with substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies.

RCW 9.02.160. Further, the state cannot "discriminate against the exercise of" an individual's right to choose or refuse birth control or to have an abortion "in the regulation or provision of benefits, facilities, services, or information." RCW 9.02.100(4).

84. It is doubtful that Washington could provide "substantially equivalent benefits, services, or information" to the patients in a Title X Project operated under the Final Rule and in a separate state-funded family planning program. Pregnancy testing is a core service provided by any family planning program, and patients who visit a family planning clinic to obtain contraception are typically tested for pregnancy. Patients at a Title X Project who received confirmation of a pregnancy would not receive information to enable them to terminate their pregnancies if they wished, contrary to the language of RCW 9.02.160. Further, the provider would be unable even to refer the patient to the separate state-funded program, since such a referral is prohibited by the Final Rule.

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85. It also is unlikely that the State would have funding available to provide in the hypothetical state-funds-only program care equivalent to what the Final Rule requires for Title X patients. This is because without federal Title X monies, DOH does not have enough funding to provide family planning services to all low-income patients who would be eligible for Title X services.

3. The loss of Title X funds would irreparably harm Washington and its most vulnerable residents

86. As discussed above, it is not legally or logistically feasible for Washington to continue accepting any Title X funding subject to the Final Rule. If federal Title X funds disappeared, Washington's Family Planning Program would lose one third of its funding, which will make it impossible to maintain the program at its current level. DOH would have less funding to allocate to subrecipients, which would result in fewer patients receiving services, causing negative health consequences for patients and the State. If services are reduced, the incidence of unintended pregnancies and reproductive health-related illnesses and disease within Washington will increase, leading to worse long-term health and economic outcomes, as well as more abortions.

87. At the subrecipient level, reduced funding would result in decreased services in several respects, which may include shorter business hours, reduced staffing available to treat patients, and even closing of those clinics that cannot withstand the reduction in revenue and increase in costs.

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88. It is difficult to quantify exactly how many patients would lose access in this scenario, though a reduction is guaranteed because subrecipients would have less funding to serve eligible clients. DOH projects that, if it lost approximately one third of the current funding for its family planning program, at very least it would not have the funds to continue to serve patients above the federal poverty level; it would not be able to continue to serve underinsured (as opposed to entirely uninsured) patients; and it may otherwise have to restrict the population of patients eligible for subsidized family planning services.

89. In 2017, Title X served 40,041 people with incomes above 100% of the federal poverty level, and 72,989 people with some public or private insurance. Based on DOH's projections, the loss of Title X funds would mean that all people in these categories would lose access to subsidized family planning services. If they could not afford to pay on their own—or could not afford to travel to a clinic that offers these services at a level that is affordable—they would lose access to family planning services entirely.

90. Counties with high numbers of low income, underinsured people who want and need family planning services will be the most adversely impacted by the disappearance of federal funds. DOH's funding on its own will no longer be enough to help pay for services for people who have insurance but cannot afford their co-payments or deductibles. These people will risk losing access to family planning services entirely.

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91. At colleges and universities, some students who currently receive family planning services will lose access to them. Underinsured and insured students (as opposed to wholly uninsured students) would likely not have subsidized access to these services in an exclusively state-funded program. This means that if a patient is on her parents' insurance plan, she will have to obtain care through that insurance plan if she cannot afford to pay the higher non-contracted rate out of pocket. Such patients, even as adults, might not be able to keep their family planning care confidential from their parents or family members—which in some cases will discourage them from seeking needed and wanted care.

92. There is no guarantee that the 16 currently contracted providers operating 85 clinics statewide—assuming they all stay in an exclusively state-funded network—will able to continue operating in light of the reduced funding they would receive. Some clinics might be unable to operate on a tighter budget even if they do reduce their services. Patients who would have been served by those clinics may need to travel a longer distance to access the services they need from clinics within the network. Long-distance travel is often more difficult for low-income patients due to lack of access to transportation (particularly in rural areas), inability to take time off work, lack of access to affordable childcare, and other factors. Clinics operated by currently contracted providers in Eastern Washington are up to 96 miles apart.

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93. With reduced funding, it is questionable whether DOH could adequately address the needs of patients who need a higher level of confidential billing or confidential Explanation of Benefits documents (EOB). Confidentiality is needed to protect current and potential victims of domestic violence by partners who might disagree with their decisions related to family planning and any pregnancy. The Family Planning Program funded only with state dollars may not be able to serve patients who need confidential services but are insured or above income eligibility. Patients requiring confidential services will face a difficult choice: receive services knowing their confidentiality will be compromised, forego services, or write their insurance company and ask them to suppress the EOB (hoping the insurance company will receive the information and not send an EOB that could be read by any family member picking up the mail). This latter process takes time, and some patients likely will not trust that it will preserve their confidentiality.

94. The services provided through an exclusively state-funded program will also need to decrease in scope. DOH projects that it would be unable to provide continuing education for clinicians and staff at current levels, and may not be able to provide it at all. DOH will also likely have to limit educational and outreach activities due to reduced funding, decreasing awareness that subsidized family planning services are available and exacerbating poor health outcomes associated with lack of access. Other ancillary services like STI testing and treatment not directly related to family planning will likely be eliminated, putting

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Seattle, WA 98104-3188
(206) 464-7744

patients at risk of poor reproductive health outcomes associated with untreated STIs.

95. The costs imposed by the Final Rule on the State of Washington 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. *See* 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, Vo. 92, No. 4, p. 668 (2014) (*available at* https://www.gutmacher.org/sites/default/files/pdfs/pubs/journals/MQ-Frost_1468-0009.12080.pdf). 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 account for the additional costs administrative associated with changing the State's system for the provision of family planning services as discussed above.

96. As a result of the Final Rule, more unplanned pregnancies and unwanted childbearing will occur, cervical cancers will not be diagnosed in early stages when they are treatable, and poor health outcomes will result from undiagnosed and 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

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unhappiness. The failure to diagnose cancers and STIs early can lead to further complications, and even death.

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 21 day of March, 2019, at Sea Tac, Washington.

Cynthia Harris

CYNTHIA HARRIS
Program Manager
Family Planning Program
Washington State Department of Health

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 22nd day of March, 2019, at Seattle, Washington.

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

ATTORNEY GENERAL OF WASHINGTON
800 Fifth Avenue. Suite 2000
Seattle, WA 98104-3188
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Exhibit 1

1. DATE ISSUED MM/DD/YYYY	2. CFDA NO.	3. ASSISTANCE TYPE
08/27/2018	93.217	Project Grant

1a. SUPERSEDES AWARD NOTICE dated
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.	5. ACTION TYPE
1 FPHPA006359-01-00 Formerly	New

6. PROJECT PERIOD	MM/DD/YYYY		MM/DD/YYYY
From	09/01/2018	Through	03/31/2019
7. BUDGET PERIOD	**MM/DD/YYYY**		**MM/DD/YYYY**
From	09/01/2018	Through	03/31/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
OASH Office of Grants Management

1101 Wootton Parkway
Suite 550
Rockville, MD 20852

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
P.L. 91-572 PHS Act Sec. 1001 as Amended, 42 CFR 59

8. TITLE OF PROJECT (OR PROGRAM)

Washington State Department of Health application for Title X family planning services grant as umbrella agency for 12 subrecipient organizations (The Washington State Title X Network)

9a. GRANTEE NAME AND ADDRESS

HEALTH, WASHINGTON STATE DEPARTMENT OF
PO BOX 47855
Washington State Department of Health
Olympia, WA 98504-7855

9b. GRANTEE PROJECT DIRECTOR

Ms. Cynthia Nettie Harris
310 ISRAEL RD SE
MS 47880
PCH/Family Planning Program
OLYMPIA, WA 98501-7880
Phone: 360-236-3401

10a. GRANTEE AUTHORIZING OFFICIAL

Ms. Janna Bardi
101 Israel Rd SE
Tumwater, WA 98501-5570
Phone: 360-236-3723

10b. FEDERAL PROJECT OFFICER

Reyna Jesus
Room 716G
200 Independence Avenue, SW
Washington, DC 20201
Phone: 206-615-3678

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — II

a.	Salaries and Wages	278,885.00
b.	Fringe Benefits	97,609.00
c.	Total Personnel Costs	376,494.00
d.	Equipment	0.00
e.	Supplies	1,611.00
f.	Travel	55,975.00
g.	Construction	0.00
h.	Other	35,667.00
i.	Contractual	7,298,627.00
j.	TOTAL DIRECT COSTS	7,768,374.00
k.	INDIRECT COSTS	123,209.00
l.	**TOTAL APPROVED BUDGET**	7,891,583.00
m.	Federal Share	2,783,000.00
n.	Non-Federal Share	5,108,583.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	2,783,000.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	0.00
d. **AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION**	2,783,000.00
13. Total Federal Funds Awarded to Date for Project Period	2,783,000.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. **6**	
c. 4		f. **7**	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:

a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)

GRANTS MANAGEMENT OFFICIAL: **Alice M Bettencourt, Grants Management Officer**

17. OBJ CLASS 41.45	18a. VENDOR CODE 1916001067A1	18b. EIN 911444603	19. DUNS 808883128	20. CONG. DIST. 10
FY-ACCOUNT NO.	**DOCUMENT NO.**	**ADMINISTRATIVE CODE**	**AMT ACTION FIN ASST**	**APPROPRIATION**
21. a. 8-3984521	b. FPHPA6359A	c. FPH70	d. $2,783,000.00	e. 75-18-0359
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

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Federal Financial Report Cycle			
Reporting Period Start Date	Reporting Period End Date	Reporting Type	Reporting Period Due Date
09/01/2018	09/30/2018	Quarterly	10/30/2018
10/01/2018	12/31/2018	Quarterly	01/30/2019
01/01/2019	03/31/2019	Final	06/29/2019

SPECIAL TERMS AND REQUIREMENTS

1. This award consists of:

   Program income (fees, premiums, third-party reimbursements which the project may reasonably expect to receive), as well as State, local and other operational funding, will be used to finance the non-federal share of the scope of project as defined in the approved grant application and reflected in the approved budget. Program income and the level projected in the approved budget will be used to further program objectives. Box 15 on this Notice of Award (NoA) indicates **E – Other**: Program Income may be used to meet the cost sharing or matching requirement of the Federal award. The amount of the Federal award stays the same. Program Income in excess of any amounts specified must be added to the Federal funds awarded. They must be used for the purposes and conditions of this award for the duration of the Project period. 45 CFR 75.307 (e).

Title X Funds	$2,783,000
Cost Sharing Funds (10%)	$278,300
Program Income	$4,830,283
Other Funds	$0
Total Project Budget	$7,891,583

2. In accepting this award, the grantee stipulates that the award and any activities thereunder are subject to all provisions of 42 CFR part 59 subpart A currently in effect or implemented during the period of the grant.

3. Notwithstanding any other provision of law, no provider under Title X of the Public Health Service Act shall be exempt from any State law requiring notification for the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

4. In accepting this award, the grantee certifies that it will encourage family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

5. In order to maintain an accurate record of current Title X service sites, grantees are expected to provide timely notice to the Office of Population Affairs (OPA), as well as to the appropriate HHS regional office, of any deletions, additions, or changes to the name, location, street address and email, and contact information for Title X grantees and service sites. This database will also be used to verify eligibility for 340b program registration and recertification. You must enter your changes to the Title X database within 30 days of the change at https://www.opa-fpclinicdb.com/. All changes will be reviewed and approved by the relevant HHS regional office prior to being posted on the OPA

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website. This does not replace the prior approval requirement under HHS grants policy for changes in project scope, including clinic closures.

6. In accepting this award, the grantee stipulates that the award and any activities thereunder are subject to all provisions of 42 CFR part 59 subpart A currently in effect or implemented during the period of the grant.

   Notwithstanding any other provision of law, no provider under Title X of the Public Health Service Act shall be exempt from any State law requiring notification for the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

   In accepting this award, the grantee certifies that it will encourage family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

   In order to maintain an accurate record of current Title X service sites, grantees are expected to provide timely notice to the Office of Population Affairs (OPA), as well as to the appropriate HHS regional office, of any deletions, additions, or changes to the name, location, street address and email, and contact information for Title X grantees and service sites. This database will also be used to verify eligibility for 340b program registration and recertification. You must enter your changes to the Title X database within 30 days of the change at https://www.opa-fpclinicdb.com/. All changes will be reviewed and approved by the relevant HHS regional office prior to being posted on the OPA website. This does not replace the prior approval requirement under HHS grants policy for changes in project scope, including clinic closures.

   If you or your sub-recipient(s) enrolls in the 340B Program, you must comply with all 340B Program requirements. You may be subject to audit at any time regarding 340B Program compliance. 340B Program requirements are available at http://www.hrsa.gov/opa/programrequirements/

7. ***Program Priorities:*** Each year the OPA establishes program priorities that represent overarching goals for the Title X program. Program priorities derive from the Department of Health and Human Services (HHS) priorities. Applicants should provide evidence of their capacity to address program priorities. The FY 2018 program priorities are as follows:

   1. Assuring innovative high quality family planning and related health services that will improve the overall health of individuals, couples and families, with priority for services to those of low-income families, offering, at a minimum, core family planning services enumerated earlier in this Funding Announcement. Assuring that projects offer a broad range of family planning and related health services that are tailored to the unique needs of the individual, that include natural family planning methods (also known as fertility awareness based methods) which ensure breadth and variety among family planning methods offered, infertility services, and services for adolescents; breast and cervical cancer screening and prevention of STDs as well as HIV prevention education, counseling, testing, and referrals.
   2. Assuring activities that promote positive family relationships for the purpose of increasing family participation in family planning and healthy decision-making; education and counseling that prioritize optimal health and life outcomes for every individual and couple; and other related health services, contextualizing Title X services within a model that promotes optimal health outcomes for the client.
   3. Ensuring that all clients are provided services in a voluntary, client-centered and non-coercive manner in accordance with Title X regulations.
   4. Promoting provision of comprehensive primary health care services to make it easier for individuals to receive both primary health care and family planning services preferably in the same location, or through nearby referral providers, and increase incentive for those

individuals in need of care choosing a Title X provider.

5. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, and human trafficking.
6. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities; and
7. Demonstrating that Title X activities are separate and clearly distinct from non-Title X activities, ensuring that abortion is not a method of family planning for this grant.
8. Use of OPA performance metrics to regularly perform quality assurance and quality improvement activities.

8. ***Key Issues:*** In addition to program priorities, the following key issues should be considered in developing the project plan:

    1. Efficiency and effectiveness in program management and operations;
    2. Management and decision-making and accountability for outcomes;
    3. Cooperation with community-based and faith-based organizations;
    4. Meaningful collaboration with subrecipients and documented partners in order to demonstrate a seamless continuum of care for clients;
    5. A meaningful emphasis on education and counseling that communicates the social science research and practical application of topics related to healthy relationships, to committed, safe, stable, healthy marriages, and the benefits of avoiding sexual risk or returning to a sexually risk-free status, especially (but not only) when communicating with adolescents;
    6. Activities for adolescents that do not normalize sexual risk behaviors, but instead clearly communicate the research informed benefits of delaying sex or returning to a sexually risk-free status.
    7. Emphasis on the voluntary nature of family planning services;
    8. Data collection (such as the Family Planning Annual Report (FPAR) for use in monitoring performance and improving family planning services.

STANDARD TERMS

1. You must comply with all terms and conditions outlined in the grant award, including grant policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements (GPS), (note any references in the GPS to 45 CFR Part 74 or 92 are now replaced by 45 CFR Part 75, and the SF-269 is now the SF-425), and requirements imposed by program statutes and regulations, Executive Orders, and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts. By drawing or otherwise obtaining funds for the award from the grant payment system or office, you accept the terms and conditions of the award and agree to perform in accordance with the requirements of the award.

    The HHS Grants Policy Statement is available at:
    http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf

    Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards are

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at 45 CFR Part 75 effective December 26, 2014.

2. Certain changes to your project or personnel require prior approval from the Grants Management Officer (GMO). (See Part II, HHS Grants Policy Statement (GPS), any references in the GPS to 45 CFR Part 74 or 92 are now replaced by 45 CFR Part 75). All amendment requests requiring prior approval must be signed by the grantee authorizing official and or PI/PD and submitted through the GrantSolutions Amendment Module. Only responses signed by the GMO are considered valid. If you take action on the basis of responses from other officials or individuals, you do so at your own risk. Such responses will not be considered binding by or upon any OASH Office.

   Any other correspondence not relating to a prior approval item should be uploaded to Grant Notes within the GrantSolutions system. Include the Federal grant number and signature of the authorized business official and the project director on all such correspondence.

3. The *Consolidated Appropriations Act, 2018*, limits the use of federal funds from the HHS Office of the Assistant Secretary for Health (OASH) on all grant or cooperative agreements henceforth including the current budget period.

   (1) Salary Limitation

   "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II."

   Effective January 7, 2018, the Salary Limitation is based upon the Executive Level II of the Federal Executive Pay Scale. That amount is **$189,600**. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. An individual's direct salary is not constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to the grant. A recipient may pay an individual's salary amount in excess of the salary cap with non-federal funds.

   (2) Acknowledge of Federal Grant Support (Section 505)

   When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state—

   (1) the percentage of the total costs of the program or project which will be financed with Federal money;

   (2) the dollar amount of Federal funds for the project or program; and

   (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

4. Reporting Subawards and Executive Compensation

   a. Reporting of first-tier subawards.

   1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery Act funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009,

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Pub. L. 111–5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to the Federal Funding Accountability and Transparency Act Subaward Reporting System (FFRS).

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action as specified in the submission instructions posted at http://www.fsrs.gov specify.

b. Reporting Total Compensation of Recipient Executives.

1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if—

i. the total Federal funding authorized to date under this award is $25,000 or more;

ii. in the preceding fiscal year, you received—

A. 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

B. $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at the Executive Compensation page of the SEC website.)

2. Where and when to report. You must report executive total compensation described in paragraph b.1. of this award term:

i. As part of your registration profile in the System for Award Management (SAM).

ii. By the end of the month following the month in which this award is made, and annually thereafter.

c. Reporting of Total Compensation of Subrecipient Executives.

1. Applicability and what to report. Unless you are exempt as provided in paragraph d. of this award term, for each first-tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly compensated executives for the subrecipient's preceding completed fiscal year, if—

i. in the subrecipient's preceding fiscal year, the subrecipient received—

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A. 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

B. $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at the Executive Compensation page of the SEC website.)

2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c.1. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

d. Exemptions

If, in the previous tax year, you had gross income, from all sources, under $300,000, you are exempt from the requirements to report:

i. Subawards,and

ii. The total compensation of the five most highly compensated executives of any subrecipient.

e. Definitions.

For purposes of this award term:

1. “Entity” means all of the following, as defined in 2 CFR part 25:

i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;

iii. A domestic or foreign nonprofit organization;

iv. A domestic or foreign for-profit organization;

v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.

2. “Executive” means officers, managing partners, or any other employees in management positions.

3. “Subaward”:

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i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. ll .210 of the attachment to OMB Circular A–133, ‘‘Audits of States, Local Governments, and Non-Profit Organizations’’).

iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.

4. “Subrecipient” means an entity that:

i. Receives a subaward from you (the recipient) under this award; and

ii. Is accountable to you for the use of the Federal funds provided by the subaward

5. “Total compensation” means the cash and noncash dollar value earned by the executive during the recipient’s or subrecipient’s preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax-qualified.

vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

5. **Trafficking in Persons**

This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104)

a. Provisions applicable to a recipient that is a private entity.

1. You as the recipient, your employees, subrecipients under this award, and subrecipients' employees may not-

i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;

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ii. Procure a commercial sex act during the period of time that the award is in effect; or

iii. Use forced labor in the performance of the award or subawards under the award.

2. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity –

i. Is determined to have violated a prohibition in paragraph a.1 of this award term; or

ii. Has an employee who is determined by the agency official authorized to terminate the award to have violated a prohibition in paragraph a.1 of this award term through conduct that is either-

A. Associated with performance under this award; or

B. Imputed to you or the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376.

b. Provision applicable to a recipient other than a private entity.

We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a subrecipient that is a private entity-

1. Is determined to have violated an applicable prohibition in paragraph a.1 of this award term; or

2. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph a.1 of this award term through conduct that is either-

i. Associated with performance under this award; or

ii. Imputed to the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376

c. Provisions applicable to any recipient.

1. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph a.1 of this award term

2. Our right to terminate unilaterally that is described in paragraph a.2 or b of this section:

i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. 7104(g)), and

ii. Is in addition to all other remedies for noncompliance that are available to us under this award.

3. You must include the requirements of paragraph a.1 of this award term in any subaward you make to a private entity.

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d. Definitions. For purposes of this award term:

1. "Employee" means either:

i. An individual employed by you or a subrecipient who is engaged in the performance of the project or program under this award; or

ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.

2. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

3. "Private entity":

i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR 175.25.

ii. Includes:

A. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b).

B A for-profit organization.

4. “Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C. 7102)

6. You are hereby given notice that the 48 CFR section 3.908, implementing section 828, entitled “Pilot Program for Enhancement of Contractor Employee Whistleblower protections,” of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013) applies to this award.

7. In any grant-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By “same-sex spouses,” HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By “same-sex marriages,” HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By “marriage,” HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage.

8. Reporting of Matters Related to Recipient Integrity and Performance

NOTICE OF AWARD (Continuation Sheet)

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1. General Reporting Requirement

If the total value of your currently active grants, cooperative agreements, and procurement contracts from all Federal awarding agencies exceeds $10,000,000 for any period of time during the period of performance of this Federal award, then you as the recipient during that period of time must maintain the currency of information reported to the System for Award Management (SAM) that is made available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)) about civil, criminal, or administrative proceedings described in paragraph 2 of this award term and condition. This is a statutory requirement under section 872 of Public Law 110-417, as amended (41 U.S.C. 2313). As required by section 3010 of Public Law 111-212, all information posted in the designated integrity and performance system on or after April 15, 2011, except past performance reviews required for Federal procurement contracts, will be publicly available.

2. Proceedings About Which You Must Report

Submit the information required about each proceeding that:

a. Is in connection with the award or performance of a grant, cooperative agreement, or procurement contract from the Federal Government;

b. Reached its final disposition during the most recent five year period; and

c. If one of the following:

(1) A criminal proceeding that resulted in a conviction, as defined in paragraph 5 of this award term and condition;

(2) A civil proceeding that resulted in a finding of fault and liability and payment of a monetary fine, penalty, reimbursement, restitution, or damages of $5,000 or more;

(3) An administrative proceeding, as defined in paragraph 5 of this award term and condition, that resulted in a finding of fault and liability and your payment of either a monetary fine or penalty of $5,000 or more or reimbursement, restitution, or damages in excess of $100,000; or

(4) Any other criminal, civil, or administrative proceeding if:

(i) It could have led to an outcome described in paragraph 2.c.(1), (2), or (3) of this award term and condition;

(ii) It had a different disposition arrived at by consent or compromise with an acknowledgement of fault on your part; and

(iii) The requirement in this award term and condition to disclose information about the proceeding does not conflict with applicable laws and regulations.

3. Reporting Procedures

Enter in the SAM Entity Management area the information that SAM requires about each proceeding described in paragraph 2 of this award term and condition. You do not need to submit the information a second time under assistance awards that you received if you already provided the information through SAM because you were required to do so under Federal procurement contracts that you were

NOTICE OF AWARD (Continuation Sheet)

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GRANT NO. 1 FPHPA006359-01-00	

awarded.

4. Reporting Frequency

During any period of time when you are subject to this requirement in paragraph 1 of this award term and condition, you must report proceedings information through SAM for the most recent five year period, either to report new information about any proceeding(s) that you have not reported previously or affirm that there is no new information to report. Recipients that have Federal contract, grant, and cooperative agreement awards with a cumulative total value greater than $10,000,000 must disclose semiannually any information about the criminal, civil, and administrative proceedings.

5. Definitions

For purposes of this award term and condition:

a. Administrative proceeding means a non-judicial process that is adjudicatory in nature in order to make a determination of fault or liability (e.g., Securities and Exchange Commission Administrative proceedings, Civilian Board of Contract Appeals proceedings, and Armed Services Board of Contract Appeals proceedings). This includes proceedings at the Federal and State level but only in connection with performance of a Federal contract or grant. It does not include audits, site visits, corrective plans, or inspection of deliverables.

b. Conviction, for purposes of this award term and condition, means a judgment or conviction of a criminal offense by any court of competent jurisdiction, whether entered upon a verdict or a plea, and includes a conviction entered upon a plea of nolo contendere.

c. Total value of currently active grants, cooperative agreements, and procurement contracts includes —

(1) Only the Federal share of the funding under any Federal award with a recipient cost share or match; and

(2) The value of all expected funding increments under a Federal award and options, even if not yet exercised

9. Consistent with 45 CFR § 75.113, applicants and recipients must disclose, in a timely manner, in writing to the HHS Awarding Agency, with a copy to the HHS Office of the Inspector General, all information related to violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS Office of the Inspector General all information related to violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

HHS OASH Office of Grants Management
1101 Wootton Parkway, Suite 550
Rockville, MD 20852

AND

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US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS—MANDATORY GRANT DISCLOSURES
PO Box 23489
Washington, DC 20026

URL: http://oig.hhs.gov/fraud/report-fraud/index.asp (Include "Mandatory Grant Disclosures" in subject line)

Fax: 1-800-223-8164 (Include "Mandatory Grant Disclosures" in subject line)

Failure to make required disclosures can result in any of the remedies described in 45 CFR §75.371 Remedies for noncompliance, including suspension or debarment (See 2 CFR Parts 180 & 376 and 31 U.S.C. 3321).

The recipient must include this mandatory disclosure requirement in all subawards and contracts under this award.

REPORTING REQUIREMENTS

1. The Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) combined the audit requirements for all entities under one Act. An audit is required for all entities as stipulated in 45 CFR Part 75.500. The audits are due within 30 days of receipt from the auditor or within 9 months of the end of the fiscal year, whichever occurs first. The audit report when completed should be submitted online to the Federal Audit Clearinghouse at http://harvester.census.gov/fac/collect/ddeindex.html.

2. **FINANCIAL REPORTING REQUIREMENT Federal Financial Reporting (FFR) SF 425:**

   You must use the SF-425 Federal Financial Report (FFR) for expenditure reporting. You may find the SF-425 and instructions for completing the form on the Web at: http://apply07.grants.gov/apply/forms/sample/SF425-V1.0.pdf. You must complete **all** sections of the FFR.

   a. Your FFR reporting schedule has been issued as a condition of this grant award, including a Final FFR covering the entire project period due 90 days after the project period end date.You may also view the complete table of the reporting schedule after logging into GrantSolutions from the My Grants List screen, select the **Reports** menu dropdown and then select the **Federal Financial Report** submenu.

   b. GrantSolutions will automatically issue you a reminder seven (7) days prior to each report due date. If you have not submitted by the due date, you will receive a message indicating the report is **Past Due**. Please ensure your GrantSolutions account and contact information are up to date so you receive notifications.

   c. **Electronic Submissions accepted only via GrantSolutions** – Your FFR must only be submitted for review via the GrantSolutions FFR reporting module. No other submission methods will be accepted without prior written approval from the GMO. You must be assigned to the grant with authorized access to the FFR reporting Module as FINANCIAL OFFICER when submitting. If you encounter any difficulties, contact the Grant Solutions Help Desk or your assigned Grants Management Specialist. Please reference the CONTACTS section of NoA Terms and Conditions to locate the name of this individual.

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The Quarterly cash reporting to the HHS Payment Management System on the FFR is also required. Please note at this time,these FFR reports are separate submissions via the Payment Management System; data is not transferable between the two systems and you will report twice on certain data elements.

3. **Closeout Requirements:** This project is in its final budget period. Once the project period has ended you are required to submit a Final Program Progress report, the SF-425 Final Federal Financial report, the Payment Management System FFR – Cash Transaction Report, and the SF-428 Tangible Personal Property report and/or Disposition report within 90 calendar days after the expiration of the project and budget period end date. Failure to submit these required reports when due may result in the imposition of a special award condition or the withholding of support for other active or future projects or activities involving your organization.

   a. The Final Program Progress Report: Your reports must address content required by 45 CFR § 75.342(b)(2). Additional guidance on content of the progress report may be provided by the Program Office. Submit your report via attachment to the Grant Notes section within GrantSolutions.

   b. SF-425 Final Federal Financial Report: Submit your Final FFR via the FFR Reporting Module in Grant Solutions. You may find the instructions for completing the FFR form on the Web at: http://apply07.grants.gov/apply/forms/sample/SF425-V1.0.pdf

   c. Federal Financial Report (FFR) (SF-425) Cash Transactions: Submit your report via the HHS Payment Management System. The instructions for submitting this report are available at https://pms.psc.gov/.

   d. SF-428 and SF-428-B Tangible Personal Property report and/or Disposition reports: Submit reports via attachment to the Grant Notes section within GrantSolutions. You may find the forms SF 428 on the Web at: https://www.grants.gov/web/grants/forms/post-award-reporting-forms.html#sortby=1

   Additional instructions for completing all reports will be provided in the Pre-closeout letter from the Office of Grants Management.

CONTACTS

1. Fraud, Abuse and Waste:

   The HHS Inspector General accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in Department of Health and Human Services' programs. Your information will be reviewed promptly by a professional staff member. Due to the high volume of information that they receive, they are unable to reply to submissions. You may reach the OIG through various channels.

   Internet: https://forms.oig.hhs.gov/hotlineoperations/index.aspx

   Phone: 1-800-HHS-TIPS (1-800-447-8477)

   Mail: US Department of Health and Human Services
   Office of Inspector General
   ATTN: OIG HOTLINE OPERATIONS
   PO Box 23489
   Washington, DC 20026

NOTICE OF AWARD (Continuation Sheet)

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For additional information visit https://oig.hhs.gov/fraud/report-fraud/index.asp

2. PAYMENT PROCEDURES:

   Payments for grants awarded by OASH Program Offices are made through Payment Management Services (previously known as the Division of Payment Management) (https://pms.psc.gov/home.html). PMS is administered by the Program Support Center (PSC), HHS. NOTE: Please contact the Payment Management Services to establish an account if you do not have one.

   Inquiries regarding payments should be directed to https://pms.psc.gov/home.html; Payment Management Services, P.O. Box 6021, Rockville, MD 20852; or 1-877-614-5533.

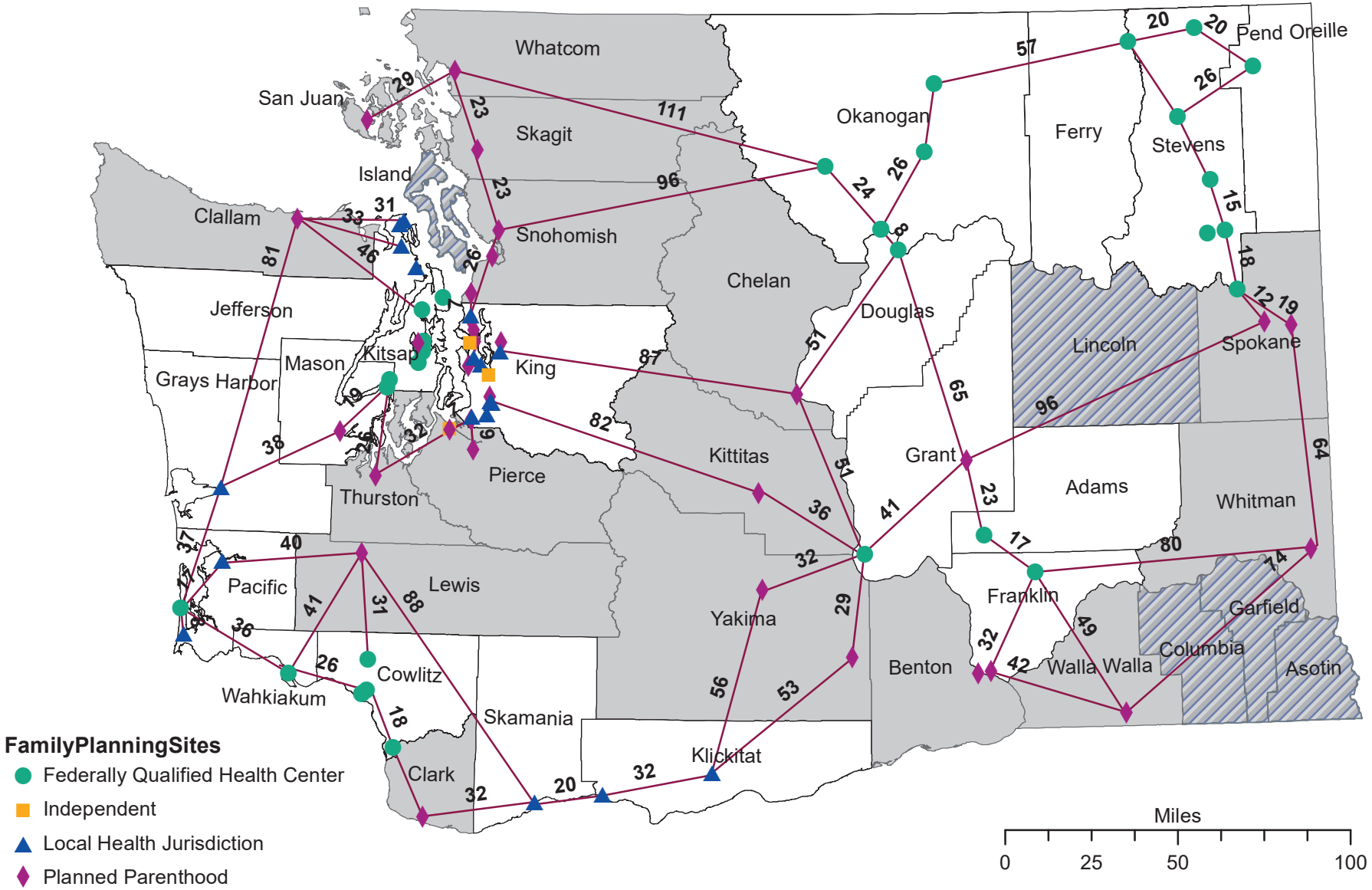
3. GrantSolutions is our web-based system that will be used to manage your grant throughout its life cycle. Please contact GrantSolutions User Support to establish an account if you do not have one. Your Grants Management Specialist has the ability to create a GrantSolutions account for the Grantee Authorized Official and Principle Investigator/Program Director roles. Financial Officer accounts may only be established by GrantSolutions staff. All account requests must be signed by the prospective user and their supervisor or other authorized organization official. For assistance on **GrantSolutions** issues please contact: **GrantSolutions User Support at 202-401-5282 or 866-577-0771**, email help@grantsolutions.gov , Monday – Friday, 8 a.m. – 6 p.m. ET. Frequently Asked Questions and answers are available at https://grantsolutions.secure.force.com/.

4. For assistance on **grants administration** issues please contact: Mr. DeWayne Wynn, Grants Management Specialist, at **(240) 453-8822,** FAX (240) 453-8823, e-mail Dewayne.Wynn@hhs.gov or OPHS Grants Management Office, 1101 Wootton Parkway, Suite 550, Rockville, MD 20852.

Exhibit 2

Washington State Title X Service Sites

Shaded counties would have no Title X clinic
if organizations that also provide abortion care were prohibited from providing Title X services.
(patterned counties currently have no Title X clinic.)



September 27, 2018

Exhibit 2

Jeffrey T. Sprung, WSBA #23607
Kristin Beneski, WSBA #45478
Paul M. Crisalli, WSBA #40681
Assistant Attorneys General
ROBERT W. FERGUSON
ATTORNEY GENERAL
Washington Attorney General's Office
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-3040-SAB

DECLARATION OF ANUJ KHATTAR, M.D., IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Anuj Khattar, M.D., 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 personal knowledge.

2. I am an American Board of Family Medicine certified physician who works in comprehensive reproductive health care centers in Oklahoma and Washington, as well as family medicine clinics and a hospital in Washington State. Many of these clinics receive Title X funding. The proposed changes to the Title X program would steer funding away from these reproductive health care providers toward programs such as limited service pregnancy centers (LSPCs), which do not inform patients about the full-range of evidence-based, reproductive health care services available to pregnant people, much less provide those services.

3. As a primary care physician and reproductive health provider, I see directly how patients benefit from receiving medically-accurate care from Title X providers. I also have seen how limited pregnancy service centers often mislead patients in order to prevent them from making informed decisions about their medical treatment.

4. After caring for multiple patients who first sought pregnancy-related care at LSPCs prior to coming to a Title X clinic or comprehensive pregnancy care center, I have seen first-hand how LSPCs seek to prevent patients who wish to terminate their pregnancies from accessing care. My patients have shared with

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me how they were shown false ultrasounds (that often are not their own) by LSPCs in order to convince them they are further along in their pregnancies than they really are. Almost all LSPCs withhold information from patients that they need in order to make informed decisions, including information about the full range of treatment options available to them.

5. Withholding information from women causes delays in obtaining care. This is harmful to women who ultimately seek to terminate their pregnancies as second-trimester abortions are more expensive and more difficult to access than first trimester abortions. A long enough delay will prevent a woman from being able to obtain care at all.

6. At Title X clinics, patients are offered counseling about, and referrals for the full spectrum of evidence-based, options available to pregnant people. Patients are treated respectfully and given accurate and fact-based medical information.

7. The proposed changes to the Title X program would cease funding to entities that are currently providing life-saving health care, including cancer and sexual health screenings, to over 4 million people in the United States. This would divert patients to clinics that are already struggling to meet patient demands, or to clinics that will not provide comprehensive education about their sexual health and pregnancy options.

8. If Planned Parenthood or the independent clinics I work at withdraw from Title X funding, many patients will no longer have access to breast and

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colon cancer screening, contraception, or fact-based sexual health information. Withdrawal of Title X funding will disproportionately affect low income individuals and people of color who do not have health insurance or who have high deductible health insurance. Our practice would not be able to adequately serve the needs of the population and patients would likely stop seeking preventive services at these clinics due to higher costs. Expecting other providers to be able to absorb patients from Planned Parenthood and other Title X funded clinics is not realistic. Many primary care clinics are already struggling to meet the demands of their current patient panels.

9. Moreover, the proposed gag rule runs contrary to medical ethics. As written, the proposed changes do not allow for abortion referral even in medically urgent situations.

10. When physicians take the Hippocratic Oath we are told to first do no harm to our patients. A gag rule that forces health care providers to withhold information about appropriate and evidence-based treatment options violates this most basic principle, and undermines our role as community healers. This gag rule will not improve the health of our communities. Rather, it will lead to distrust of the medical system because it will deny patients appropriate medical information about services that are within their legal rights to seek.

11. In addition, there are situations in which pregnancy endangers a woman's health, but not life. Barring providers from providing referrals for abortion in these situations would create a significant risk to women's health.

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12. The proposed rule further undermines women's health by diverting funding away from clinics that provide comprehensive reproductive health care toward sites that offer fertility awareness-based methods of family planning only.

13. Women require a variety of choices in contraceptive methods due to side effects, drug interactions, and hormones, among other things. Some women also require methods that they can use confidentially or without their partners' permission. Without a full range of options from which to choose, women may lose access to the method that is most effective for them, which may result in an increased number of unintended pregnancies and other negative health consequences.

14. The termination of Title X funding for the clinics in which I work would leave uninsured and underinsured women, LGBTQ individuals, and patients in other vulnerable communities without access to basic sexual and reproductive health care. This will lead to an increase in sexually transmitted infections and unintended pregnancies, which in turn will increase healthcare costs. We should be focusing on solutions that decrease healthcare costs and improve access to preventative care, not measures like the proposed rule, which will have the opposite effect.

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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 21 day of March, 2019, at 0939 AM, 2019.

ANUJ KHATTAR, M.D.

ATTORNEY GENERAL OF WASHINGTON
800 Fifth Avenue. Suite 2000
Seattle, WA 98104-3188
(206) 464-7744

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 22nd day of March, 2019, at Seattle, Washington.

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

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(206) 464-7744

Jeffrey T. Sprung, WSBA #23607
Kristin Beneski, WSBA #45478
Paul M. Crisalli, WSBA #40681
Assistant Attorneys General
ROBERT W. FERGUSON
ATTORNEY GENERAL
Washington Attorney General's Office
800 Fifth Avenue, Suite 2000
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(206) 464-7744

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-3040-SAB

DECLARATION OF DR. JUDY KIMELMAN IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Judy Kimelman, 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 personal knowledge.

2. I obtained my M.D. degree from Stanford University School of Medicine in 1989 and completed my residency at the University of Washington School of Medicine in Obstetrics and Gynecology in 1993. I obtained my B.A. degree with Honors from University of California, Berkeley.

3. I have been licensed to practice medicine in the State of Washington since 1989. Since medical school, my practice has been located in Seattle, focusing on obstetrics and gynecology. I currently practice at Seattle Obstetrics & Gynecology Group within the Swedish Medical Center, where I have worked since 1998. I treated and provided care for approximately 2200 women in the last year.

4. I am a member of the King County Medical Society, the Seattle GYN Society, the Washington State Medical Association (WSMA), the Washington State Obstetrics Association, and am a fellow with the American College of Obstetricians and Gynecologists (ACOG). I served on the WSMA Board of Trustees from 2007 to 2016. I also was a WSMA PAC member and Chair. I have served in a number of roles with the ACOG Washington Section from 2004 to current, including Secretary, Vice Chair, Chair, and Legislative Chair. I have also served as the ACOG District VIII Secretary and Treasurer.

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5. In 2018, I received the Louis M. Hellman Midwifery Partnership Award (a national award presented jointly from ACOG and the American College of Nurse-Midwives). I received the 2017 ACOG National Award for Legislative Advocacy Work, the 2014 ACOG Mentor of the Year Award, the 2013 Washington State Obstetricians Association Outstanding Leadership Award, and the 2010 ACOG National Award for Legislative Day Conference.

6. I have been published in peer-reviewed journals regarding medical issues in obstetrics and gynecology. A representative publication is *Elevated MSAFP and Midtrimester Placental Abnormalities in Relation to Subsequent Adverse Pregnancy Outcomes*, American Journal of Obstetrics & Gynecology (1992). A true and correct copy of my curriculum vitae is attached to this declaration as Exhibit (Ex.) 1.

7. I do not currently work within a Title X project in my current position. I refer patients to Title X clinics, and well over half of my patients have been to a Title X clinic at some point in their reproductive lives.

8. I submit this declaration to discuss applicable medical guidelines, ethical standards, and standard of care for the medical care and treatment of patients who are determined to be pregnant.

9. According to the medical standards of care, medical ethics, and ACOG clinical guidelines, when a patient is diagnosed with a pregnancy, it is important to provide her with information about her options that is relevant to her circumstances and to answer any questions about what those courses of care might

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entail. A pregnant patient who is ambivalent about her pregnancy should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion.[1] If the woman decides to continue the pregnancy to term or indicates that she is considering doing so, then the medically indicated course of care is to refer her for prenatal care. If the patient believes that adoption might be the best course of care, then the medically indicated course of care would be to refer her for prenatal care and to provide information on counseling and services related to adoption.[2] If the woman decides to terminate the pregnancy or indicates that she is considering doing so, then the medically indicated course of care would be to refer her to a clinic that can review with her the options for terminating her pregnancy and provide her with the appropriate care.

10. Under the medical standards of care and ACOG guidance for appropriate care, it would *not* be considered medically indicated or appropriate to

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[1] *See* American College of Obstetricians & Gynecologists, Abortion Policy Statement (2014) (true and correct copy attached as Ex. 2); *see also* American College of Obstetricians & Gynecologists, Committee Opinion No. 528, Adoption (2012, reaffirmed 2018) (true and correct copy attached as Ex. 3).

[2] *See* American College of Obstetricians & Gynecologists, FAQ 168: Pregnancy Choices: Raising the Baby, Adoption, and Abortion. https://acog.org/Patients/FAQs/Pregnancy-Choices-Raising-the-Baby-Adoption-and-Abortion (last accessed March 21, 2019) (true and correct copy attached as Ex. 4).

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refer a patient for prenatal care, or provide a patient with prenatal care, without regard to her intentions for the pregnancy. Prenatal care is not a medically indicated or appropriate course of care for a patient who intends to terminate her pregnancy. Standards of care and principles of medical ethics preclude doctors from referring patients for a course of treatment without providing the information necessary for the patient to make an informed decision about her care.[3]

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 22nd day of March, 2019, at Kingston, Washington

DR. JUDY KIMELMAN

[3] *See* ACOG Committee Opinion No. 439, Informed Consent (2009) (true and correct copy attached as Ex. 5).

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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 22nd day of March, 2019, at Seattle, Washington.

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

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ROBERT W. FERGUSON
ATTORNEY GENERAL
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800 Fifth Avenue, Suite 2000
Seattle, WA 98104
(206) 464-7744

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-03040-SAB

DECLARATION OF BOB MARSALLI IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Bob Marsalli, 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 personal knowledge.

2. I am the Chief Executive Officer of the Washington Association for Community Health with a master's level professional degree and 14 years of executive management experience working for and with community health centers in the states of Oregon, Montana, and now, Washington.

3. As CEO, I am responsible for the overall leadership and management of the Association, ensuring the implementation of the mission of the organization and the strategic and operational plans approved by the Board of Directors.

4. The Washington Association for Community Health is Washington State's federally-designated primary care association, a nonprofit organization that provides training, technical assistance, and advocacy support to improve the programmatic, clinical, and financial performance of Washington's 27 federally-qualified health centers (FQHCs), which collectively serve over 1,092,000 patients annually. As part of its mission, the Washington Association for Community Health collaborates with federal and state agencies to monitor the policy and regulatory environment and educate policymakers and agency officials about the health center program and its value to patients.

5. Five of Washington's 27 FQHCs are recipients of federal Title X Family Planning Program grants, subject to program rules established by the

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United States Department of Health and Human Services (HHS). Additionally, as an element of their mission to provide comprehensive, patient-centered primary care services to low-income and underserved members of their communities, most FQHCs in Washington State have established formal or informal partnerships and/or referral arrangements with Title X Family Planning Program grantees within their service areas. Generally, these partnerships and/or referral arrangements are established in order to provide patients with the best possible care for their unique health care needs and individual circumstances and to optimize the use of scarce federal health care resources. As part of its work to improve the programmatic, clinical, and financial performance of its members, protect public health, and to improve access to critical health care services in underserved communities, the Washington Association for Community Health encourages and facilitates collaboration between its member FQHCs and Title X Family Planning Program grantees.

6. FQHCs, including the five Washington State FQHCs that are also Title X Family Planning Program grantees, provide "whole person" care, co-locating primary care with mental health, substance use disorder, oral health, nutrition, maternity, and other services according to individualized treatment plans that coordinate a wide variety of health care professionals and disciplines. FQHC providers are trained to address the social and environmental factors – including everything from food insecurity to intimate partner violence – that impacts patients' health and ability to access care. This approach

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to care requires FQHC staff to develop strong and trusting relationships with their patients, many of whose life experiences may lead them to be particularly cautious about whom to trust. HHS's amendments to its Statutory Program Integrity Requirements interfere with the patient-provider relationship of trust by limiting a provider's ability to give their patients comprehensive information according to evidence-based clinical guidelines, even when the patient directly asks for this information.

7. HHS's updated Statutory Program Integrity Requirements revise "bright line" separation standards to require "[t]he existence of separate. . . electronic or paper-based health care records[.]" This provision poses a significant risk to patient health and safety. All FQHCs in Washington State, including the five who are Title X Family Planning Program grantees, have fully integrated their electronic health record management systems across all services, a financially costly effort that was undertaken precisely because it enables all the providers that a patient may visit to understand the full scope of an individual's health challenges and treatment plans. The advent of integrated health records is important not only for cost-effective care, but also is a critical element of planning for patient safety. Under the new rules, a hypothetical patient who is referred to a pregnancy termination provider may not have this fact adequately notated in the health record to which her Title X or primary care provider has access – and if there is a complication arising from her abortion, information concerning the termination may not reach her provider in a timely fashion.

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8. I understand that as a result of these rule changes, several Title X providers in Washington State may halt their operations, compelling more than 81,000 patients to find alternative health care providers. It has been suggested that FQHCs may serve these patients, leaving few or no patients without access to care. While FQHCs are required to serve every individual who seeks care regardless of ability to pay, they face the same financial, workforce, workspace, and capacity restraints as any other safety net health care provider, and would not be able to serve that volume of patients adequately without several years to prepare and significant additional funding, neither of which has been provided.

9. For instance, between 2016 and 2017, the total number of patients served by FQHCs based in Washington State increased by 56,393 individuals, and between 2015 and 2016, the total number of patients served by FQHCs based in Washington State increased by 64,530 individuals. In both cases, individual FQHCs had several years to plan to handle this increased patient volume and were bolstered by millions of dollars in federal, state, and private grants to fund capital infrastructure and technology investments and additional clinical workforce. No such time or funding has been made available in this case.

10. FQHCs in Washington simply do not have adequate capacity to meet the needs of 81,000 more patients. There are several structural elements to providing access to new patients, including facilitating sufficient caregivers, support staff members, dedicated exam rooms, administrative support, and the like. To illustrate this in in numerical terms, an average hard-working provider

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will have a patient panel of 3,000 patients and will require at least two medical assistants and one care coordinator. This provider will require three dedicated exam rooms. To absorb 81,000 patients, Washington FQHCs would immediately need to hire 108 new full-time equivalents, including 28 new treating providers. They would need to make 84 new exam rooms materialize. At this very time, health centers are unable to locate sufficient clinicians for their current caseload, and wait times for new appointments can be as much as 6 weeks. For medical care alone, the idea of adding 81,000 patients is an impossible lift. And this does not even include the additional administrative responsibilities such a volume of new patients would entail, which makes absorbing these patients yet more unrealistic.

11. Additionally, while the total patient increases noted above are spread across all 27 FQHCs in Washington State, Title X Family Planning Program grantee closures will occur only in a few select locations, disproportionately impacting, and perhaps overwhelming, the FQHCs operating in those service areas. While FQHCs strive to provide comprehensive primary care to all underserved communities, they operate in partnership and collaboration – not competition – with other parts of the health care safety net, including Title X Family Planning Program providers. Rule changes causing some elements of the safety net to close their doors could result in a hugely disruptive ripple effect, overwhelming remaining providers and leading to less access for extremely vulnerable patients.

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 March, 2019, at Olympia, Washington.

Bob Marsalli

BOB MARSALLI
Chief Executive Officer
Washington Association for Community Health

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 22nd day of March, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
JEFFREY T. SPRUNG, WSBA #23607
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, et al., Defendants.	NO. 1:19-cv-3040-SAB DECLARATION OF DAVID SCHUMACHER IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, David Schumacher, 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 personal knowledge.

2. I was appointed Director of the Office of Financial Management (OFM) by Governor Jay Inslee in January 2013. I have 26 years of experience in budgeting and policy development. I began my state career in 1990, working as an economic analyst for the state Department of Revenue for three years. I then worked for two years as a revenue analyst in OFM's Forecasting Division. I served as a budget analyst for the Senate Ways & Means Committee for eight years before being named staff director in 2003. In 2008, I worked as northwest government affairs director for The Boeing Company for two years. I returned to the Senate Ways & Means Committee as staff director in late 2010 before my appointment as Director of OFM. I have bachelor's and master's degrees in economics from the University of Washington.

3. As Director, I provide strategic direction and day-to-day management of a multi-faceted state agency. As the Governor's chief budget officer, I am responsible for developing the Governor's budget proposals. I am also a member of the Governor's senior staff and cabinet. As chief budget officer, I provide high-level policy and financial management input and guidance to the Governor's senior staff and state agency leaders throughout the government. I also serve on various committees, advisory groups, and executive steering committees as designated by law or as the Governor's representative.

4. OFM is the central financial management agency for the State of Washington, as well as the budget and policy arm of the Governor. As such, OFM assists the Governor in developing and presenting his or her operating, capital,

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and transportation budget proposals, takes part in negotiating these budgets with the Legislature, and assists agencies in implementation of the enacted budgets. OFM is also responsible for the implementation and oversight of the statewide accounting system, including the design and operation of the State's financial systems. OFM also plays a significant role assisting in revenue and caseload forecasting. Once a budget has been adopted, OFM is responsible for approving agency spending plans consistent with legislative intent.

5. A loss of federal Title X funding in state fiscal year 2019 (through June 30, 2019) would result in a loss of services as there are no state-funded appropriations available in the near term to backfill for the total loss of federal funds. The Legislature has the constitutional duty and obligation to appropriate funding for state spending. There is no legislative authority provided for the state to use state funding to offset a loss of federal Title X funds. The legislative session is scheduled to end April 28, 2019. If the session ends without appropriating state funds to offset the federal Title X funds, the funds could not be appropriated until the Legislature reconvened in January 2020. Alternatively, the Governor or Legislature would need to call a special session. In my experience, it would be highly unusual for a special session to be called to address a programmatic appropriation to backfill a change in federal funding. Further,

6. Similarly, for the upcoming 2019-21 biennium, legislative appropriations will be required to provide authority for state agencies to make expenditures between July 1, 2019 and June 30, 2021. In the regular process, the

Legislature will make appropriations of anticipated federal funding for programs in the biennial state budget. It is more difficult to predict legislative appropriations of state funding in the next biennium, given strong competition for limited state resources. It is not automatic that state funds would be appropriated to backfill a loss of federal funds. OFM currently projects that state revenues authorized under current state revenue laws will not be sufficient to sustain state-funded services at current levels into the 2019-21 biennium. This is because the current state budget relies on the use of reserves and one-time fund transfers in the current biennium in order to balance resources to spending. Those one-time resource changes are unlikely to be sustainable over multiple biennia. Further, growth in state caseloads and costs of current services are projected to grow in the next biennium. Recent state increases in funding for K-12 education have been significant, and K-12 spending now accounts for more than half of the state Near General Fund spending. The phase-in of new K-12 spending is mandated under the state constitution, must be maintained in full in the next biennium, and is also anticipated to grow as the phased-in investments must be sustained over a full biennium in 2019-21. So, while state revenues are also projected to increase next biennium, the total cost of current services to eligible clients and programs is anticipated to grow faster than revenue. Following significant growth in K-12 funding in recent years, there is strong pent-up demand for funding increases in other areas of the state budget, notably in mental health services, health care, long-term care and employee compensation.

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The anticipated timing of legislative appropriations for the 2019-21 biennium is the same as that described in paragraph 5.

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 March, 2019, at Olympia, Washington.

DAVID SCHUMACHER
Director
Office of Financial Management

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 22nd day of March, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-3040-SAB

DECLARATION OF DR. JUDY ZERZAN-THUL IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Judy Zerzan-Thul, 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 personal knowledge.

2. I am the Chief Medical Officer for the Washington State Health Care Authority and have been employed in this position since August 20, 2018. I am responsible for assessing and improving the quality of care for State-purchased health care programs, including Apple Health (which is commonly referred to as Medicaid) and the Employee and Retirees Benefits program.

3. Prior to joining the Washington State Health Care Authority, I was employed as the Chief Medical Officer for the State of Colorado Department of Health Care Policy and Financing for nine years. In that capacity, I was responsible for providing clinical guidance for Colorado Medicaid and the Children's Health Insurance Program, including pharmacy and medical benefits, measuring and improving quality, and data analysis.

4. I obtained my Doctor of Medicine degree from Oregon Health & Science University. I also hold a Master's degree in Public Health from the University of North Carolina. I am Board Certified in Internal Medicine and I have over 20 years of experience as a medical doctor. I have active current licenses to practice medicine in the states of Colorado and Washington.

5. The Health Care Authority provides coverage for reproductive health services, including family planning and pregnancy related services, for

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low-income Washington residents through a variety of programs in Apple Health. Family planning coverage includes all FDA-approved contraceptive methods and the clinical services necessary for clients to safely and effectively use their chosen contraceptive method. Comprehensive reproductive health services are not limited to simply obtaining contraceptives. Family planning visits address an individual's overall health and well-being and include other services, many of which are preventive, such as: screening for sexually transmitted infections (STI), cancer screening, referrals for mammograms, vaccinations, preconception health care and counseling, diagnosis of pregnancy and monitoring, and treatment of common primary care medical conditions (for example high blood pressure, diabetes, and depression).

6. The Health Care Authority also administers "Family Planning Only" programs that provide family planning services to uninsured people who do not meet Apple Health eligibility. While it is a State program separate from the Department of Health's (DOH) Title X program that funds family planning to patients, many of the Family Planning Only patients go to Title X subrecipient clinics to receive their care. Both Apple Health and Family Planning Only cover family planning services for Washington residents, including all FDA-approved contraceptive methods and the clinical services necessary for clients to safely and effectively use their chosen contraceptive method.

7. Eligibility for Apple Health programs is based on several factors, including income level. Factors such as age, household size, tax filing status, and

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pregnancy status determine the applicable income eligibility requirements for applicants. For example, childless adults are generally eligible for Apple Health at up to 133% of the Federal Poverty Level, whereas children up to 18 are eligible up to 210% of the Federal Poverty Level. Pregnant women are eligible for Apple Health up to 193% of the Federal Poverty Level. The Family Planning Only programs provide coverage of family planning specific services for women and men up to 260% of the Federal Poverty Level.

8. Apple Health relies on the existence of clinics receiving Title X funds to provide family planning services. The Title X program is administered by DOH and funded with both federal and state dollars. The program pays for administrative and operational functions at clinics that provide family planning services, including training of staff, education of clients, and delivery of family planning services to self-pay individuals who do not qualify for Apple Health or the Health Care Authority's Family Planning Only programs, or who choose not to participate in these coverages. Washington's Title X program also offers technical assistance, training, and financial support to operations for approved clinics that allows them to focus on providing high-quality, comprehensive family planning services that have demonstrated success in preventing unintended pregnancy.

9. The Health Care Authority itself does not participate in the Title X program or rely on its funding, but Title X-funded services do support the Health Care Authority programs and clients at clinics that provide a broad range of

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health care services. Title X funds do not pay for covered services provided to clients enrolled in programs administered by Health Care Authority; however, Title X funds likely pay for the administrative and operational costs at clinics where those services are provided.

10. Every county in Washington has at least one provider that contracts with the Health Care Authority to provide family planning services. My understanding is that Planned Parenthood intends to withdraw from the Title X program if the U.S. Department of Health and Human Services' (HHS) proposed Final Rule goes into effect. If that occurs, other providers in Washington will not have the capacity to absorb all of the clients previously served by Planned Parenthood who will be displaced by the new rule. The healthcare market will experience a level of destabilization as facilities and clinics attempt to determine how to absorb over 80,000 Title X clients who will flood the marketplace. Those 80,000 individuals will in turn be personally impacted in their attempt to find and establish a trusting relationship with a new provider at new locations where the family planning services are likely to be less comprehensive. Based on income eligibility criteria outlined below, it is certain that some former Title X patients will receive family planning services from Washington's Medicaid or Family Planning Only programs funded by the State.

11. It is my understanding that HHS's Final Rule deems prenatal health care to be "medically necessary" for *all* pregnant patients. This assertion is incorrect. Pre-natal care is not always medically necessary for patients

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determined to be pregnant. In particular, if a patient determined to be pregnant elects to terminate the pregnancy, pre-natal care would not be medically necessary. HHS's assertion appears to be based on the mistaken assumption that if a certain type of care is "medically necessary" for purposes of Medicaid coverage, all patients must receive that type of care. "Medical necessity" in the Medicaid context is one criterion by which an insurance administrator defines coverage and reimbursability. It is not a standard a provider uses to determine whether a patient must as a medical matter receive a particular service.

12. Unintended pregnancy is a drain on multiple aspects of Washington's health and social services systems, as well as being a hardship for Washington families. Unintended pregnancies impact the educational, financial, employment, and health statuses of individuals and families. The Health Care Authority relies on the high-quality services provided at Title X-funded clinics to achieve performance measures related to reductions in unintended pregnancies, improved pregnancy outcomes, cancer and sexually transmitted disease (STD) screenings, and treatment of conditions that maintain healthy reproductive functioning. HHS's new rule prevents those clinics who are providing these high quality services from operating in a sustainable way because they will no longer be able to integrate their services and use resources efficiently.

13. Women and men who lose access to contraception through Title X-funded programs, and who are not covered by their employer's insurance or able to afford an individual plan on the Health Benefit Exchange, may no

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longer be able to afford their current form of contraception or not be able to access contraception at all. The likely result is an increase in the number of unintended pregnancies. The potential for clients to reduce or stop working due to pregnancy could change the families' income, potentially causing these families to become eligible for Apple Health. The change in family size due to pregnancy could also cause these families to become eligible for Apple Health. This would result in an increase in state expenditures related to pregnancy, delivery, newborn, and child health services. Other support services will be impacted as well, as an increase in the number of families eligible for Apple Health will lead to increased costs for transportation, home visiting, and case management.

14. In fiscal year 2016[1], the Health Care Authority and its contracted Managed Care Organizations spent $32,587,728 for coverage of family planning services for Apple Health clients.

15. In fiscal year 2017, the Health Care Authority and its contracted Managed Care Organizations spent on average $10,440 per delivery. Additionally, there are pregnancy services costs for pregnancy losses prior to 20 weeks' gestation. The costs of each new unintended pregnancy will most likely be incurred by Health Care Authority, since the Health Care Authority currently

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[1] It is my understanding from the Health Care Authority staff in our Financial Services Division that accurate data for fiscal year 2017 was not readily available during the preparation of my declaration.

funds nearly 50% of all births in Washington State. Moreover, many individuals who would qualify for Title X-funded contraception but who will have lost access to their Title X clinic due to HHS's new rule are either already enrolled in Apple Health or will qualify for Apple Health due to their unintended pregnancy.

16. In state fiscal year 2017, the Health Care Authority and its contracted Managed Care Organizations spent $18,993,684 for family planning, STI/STD screening and treatment, cancer screening, early pregnancy care, vaccinations, and other preventive and routine medical services provided by Planned Parenthood clinics for 54,436 unique Apple Health clients. If the Planned Parenthood clinics close or no longer have the funding needed to serve all of their patients, these Apple Health clients may need to find new providers—possibly losing their contraceptive coverage and additional medical services during the transition. As noted previously, this disruption has negative health impacts on these individuals and negative financial impacts on the Health Care Authority. Planned Parenthood provides services to 86.5% of Title X clients.

17. In state fiscal year 2017, the Health Care Authority, through its Family Planning Only programs, spent $2,065,921 on family planning and family planning related services for 6,454 unique clients not eligible for Apple Health. These clients are primarily seen in Title X clinics, and if the Planned Parenthood clinics close or no longer have the funding needed to serve all of their patients, these clients may no longer have a provider for comprehensive family planning services. The Family Planning Only programs have a limited number of enrolled

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providers. Losing the Title X providers will have a significant impact on the Health Care Authority's ability to continue these programs as they currently operate.

18. It is my understanding that there are self-pay clients who go to Title X clinics as they are not currently eligible for Apple Health, the Family Planning Only, or even Title X programs. The 16,082 self-pay Title X clients will either need to find a new clinic that can comply with HHS's new rule, or they will suffer financial hardship to maintain their contraception. They may not be able to find a clinic near them that will accept a sliding scale payment. The Health Care Authority will not be able to absorb these clients because they do not qualify for Apple Health or the Family Planning Only programs, or they may decline these coverages. If these clients do not get adequate services, the Health Care Authority will likely see increased costs due to unintended pregnancies.

19. According to DOH, Washington served 91,329 patients through its Title X program in 2017, with 128,409 patient visits. 47% of Washington's Title X-funded patients were enrolled in Apple Health or one of the Family Planning Only programs. 35% are covered by commercial insurance. An additional 18% are self-pay. According to DOH's projections, Title X services prevented 18,150 unintended pregnancies in 2017; the resulting cost savings for Title X services (including STD, HIV, HPV, and Pap tests) was $113,267,480. Since 81% of Title X clients have incomes below 200% of the federal poverty level, most unintended pregnancies resulting from the loss of Title X services

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will most likely be funded through Apple Health, as these clients either already have Apple Health or will become eligible for Apple Health because of the higher eligibility income criteria during pregnancy.

20. If Title X clients move to a Federally Qualified Health Center (FQHC) from a clinic like Planned Parenthood or a public health department due to the clinic's loss of Title X funding, costs will increase for the Health Care Authority. Providers at FQHCs are often entitled to a higher reimbursement per visit than clinics without this designation.

21. Again, it is my understanding that HHS's new rule will force Planned Parenthood out of the Title X program. In Washington, this has the potential of leaving over 80,000 of our State's residents without reasonable options for critical family planning services and other women's health care.

22. The rule also frustrates, rather than promotes, the purposes of Title X—which aims to improve the overall health of individuals, couples, and families through the provision of family planning and related health services. As a direct result of HHS's new rule, millions of dollars will be spent in Washington to pay for unintended pregnancies, unplanned births, abortions, treatment of sexually transmitted infections, cervical and breast cancer treatment, and other public health risks that the Title X program is designed to prevent.

23. The harm caused by this rule will have the heaviest impact on our State's most vulnerable populations—low income individuals and families, people living in rural communities, and our State's minority population.

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Individuals will experience a disruption in their healthcare services while they search for new providers, and many in rural communities may not be able to access a clinic or provider due to increased distances and difficulties with transportation.

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 21 day of March, 2019, at Olympia, Washington.

DR. JUDY ZERZAN-THUL
Chief Medical Officer
Washington State Health Care Authority

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 22nd day of March, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-03040-SAB

DECLARATION OF KRISTIN BENESKI IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

I, Kristin Beneski, pursuant to 28 U.S.C. § 1746, 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 an Assistant Attorney General with the Washington State Attorney General's Office and counsel of record for the State of Washington in this matter.

3. Attached hereto as Exhibits 1a–1t are true and correct copies of public comments on the proposed rule that preceded the Final Rule at issue in this case, downloaded from the "regulations.gov" website from the following URLs:

a. American Academy of Nursing (AAN cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-106624.

b. American College of Nurse-Midwives (ACNM cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-198447.

c. American College of Obstetricians and Gynecologists (ACOG cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-179339.

d. American College of Physicians (ACP cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-184400.

e. American Medical Association (AMA cmt.): https://www.regulations.gov/ document?D=HHS-OS-2018-0008-179739.

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f. American Public Health Association (APHA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-156243.

g. Attorneys General of California, Connecticut, Delaware, Hawai'i, Illinois, Iowa, Maine, Maryland, Minnesota, New Jersey, New Mexico, North Carolina, and the District of Columbia (CA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-161828.

h. Center for Biological Diversity (CBD cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-53602.

i. Jody Steinauer, MD, MAS (Dr. Steinauer cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-162655.

j. Family Planning Councils of America, Inc. (FPCA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-203129.

k. Guttmacher Institute (Guttmacher cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-178129.

l. Faculty and Researchers at the Miliken Institute of Public Health, George Washington University (GW Fac. cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-105581.

m. Jacobs Institute of Women's Health (JIWH cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-155665.

n. Missouri Family Health Council, Inc. (MO FHC cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-179218.

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o. National Family Planning & Reproductive Health Association (NFPRHA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-192227.

p. National Institute for Reproductive Health (NIRH cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-105286.

q. National Women's Law Center (NWLC cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-184044.

r. Planned Parenthood Federation of America (PPFA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-198841.

s. Lori A. Brown, AIA, Professor (Prof. Brown cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-161953.

t. Attorneys General for the States of Washington, Oregon, Vermont, and the Commonwealth of Massachusetts (WA cmt.): https://www.regulations.gov/document?D=HHS-OS-2018-0008-182278.

4. Attached hereto as Exhibit 2 is a true and correct copy of the Office of Population Affairs' Program Requirements for Title X Funded Family Planning Projects (April 2014), obtained from the U.S. Department of Health and Human Services' (HHS) website at: https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf.

5. Attached hereto as Exhibit 3 is a true and correct copy of the QFP (Providing Quality Family Planning Services: Recommendations of the CDC and

the U.S. Office of Population Affairs) (April 25, 2014), obtained from the CDC's website at: https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

6. Attached hereto as Exhibit 4 is a true and correct copy of the 2017 QFP Update (Update: Providing Quality Family Planning Services—Recommendations from CDC and the U.S. Office of Population Affairs, 2017) (Dec. 22, 2017), obtained from the CDC's website at: https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6650a4-H.pdf.

7. Attached hereto as Exhibit 5 is a true and correct copy of a report by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health entitled "The Fight for Women's Reproductive Health in the Rio Grande Valley" (Nov. 2013), obtained from: http://www.nuestrotexas.org/wp-content/uploads/2015/03/NT-executive-summary-EN1.pdf.

8. Attached hereto as Exhibit 6 is a true and correct copy of an article by Marian F. MacDorman, Ph.D, et al., "U.S. Maternal Mortality Trends" (Sept. 1, 2016), obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/.

9. Attached hereto as Exhibit 7 is a true and correct copy of an article by Jennifer J. Frost, et al., "Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program" (2014), obtained from: https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/MQ-Frost_1468-0009.12080.pdf.

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

DATED this 22nd day of March, 2019, at Seattle, Washington.

/s/ Kristin Beneski
KRISTIN BENESKI
Assistant Attorney General

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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 22nd day of March, 2019, at Seattle, Washington.

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

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