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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

ALEX AZAR, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,

Defendants.

DECLARATION OF MELISSA MARSHALL, MD IN SUPPORT OF A MOTION FOR A PRELIMINARY INJUNCTION

Date:	April 18, 2019
Time:	12:30 p.m.
Dept:	Courtroom 5, 17th Floor
Judge:	The Honorable Edward M. Chen
Trial Date:	Not set
Action Filed:	March 4, 2019

I, Melissa Marshall, declare and state as follows:

1. I am the Chief Executive Officer ("CEO") of CommuniCare Health Centers ("CommuniCare") in Yolo County, California. I have worked at CommuniCare for almost four years. I make this declaration in support of Plaintiffs' Motion for a Preliminary Injunction in the above-captioned matter. I have personal knowledge of the facts stated herein and, if called as a witness, I would testify competently thereto.

2. In addition to serving as CommuniCare's CEO, I am a practicing physician. I earned my medical degree from the Washington University School of Medicine in Saint Louis and completed a residency at the University of California at Davis Medical School. I am board-certified in family medicine and have been practicing medicine for over 17 years. I provide patients with comprehensive family planning services and refer patients for additional specialty services, such urology, cardiology, radiology, optometry, and podiatry. I typically treat between 300 and 500 patients per year, including patients from the Title-X-funded clinic described below.

3. CommuniCare is a nonprofit corporation licensed as a community clinic and has been a Federally Qualified Health Center since 2007. CommuniCare is a NCQA-recognized[1] Level 3 Patient-Centered Medical Home that provides quality medical, dental, mental health, and substance use services at our clinic sites, which are geographically distributed throughout Yolo County. In fact, we provide health care services to almost one in every eight residents of Yolo County. Since 1972, CommuniCare has continuously provided high quality health care for the culturally diverse, low income, uninsured and underinsured residents of our service area.

4. In 2017, CommuniCare served over 26,000 patients—nearly 80 percent of whom live on income below the federal poverty level. The population we serve includes many people in rural areas and is racially, ethnically, and culturally diverse. Nearly 60% of the population we serve identifies as non-white and over 35% speak a language other than English at home.

[1] The National Committee for Quality Assurance (NCQA) is an independent non-profit that measures and accredits health plans and centers. *See* NCQA, "About NCQA," https://www.ncqa.org/about-ncqa/.

5. CommuniCare receives Title X funding through Plaintiff Essential Access Health. CommuniCare has been part of Essential Access's Title X network since 1993.[2] CommuniCare meets the sexual and reproductive health care needs of all patients through education, prevention (routine physical exams, screening for preventable diseases, immunizations, and health counseling), early detection (routine cancer, screening, STI testing and treatment), contraceptive management, pregnancy testing and neutral, non-directive pregnancy options counseling, emergency contraception, and obstetric/gynecological services.

6. CommuniCare provides clinical sexual and reproductive health services at three health centers, two satellite clinics operating at high schools, a student health services site at a community college, and two perinatal satellite clinics.

7. CommuniCare also provides many other (non-clinical) sexual and reproductive health services in the community, including sexual and reproductive health education and outreach in residential drug treatment facilities, migrant camps, juvenile detention centers, health fairs and community events. CommuniCare also teaches comprehensive sexual and reproductive health education, in compliance with the California Healthy Youth Act, to Yolo County middle and high schools. (This law requires school districts to provide students with integrated, comprehensive, accurate, and unbiased comprehensive sexual health and HIV prevention education at least once in middle school and once in high school.) CommuniCare's certified health educators also offer office hours at area high schools, support community events, and do outreach on social media.

8. CommuniCare served 4,081 Title X patients in 2017, primarily through the drop-in healthcare clinic for teens. In 2018, CommuniCare served 3,622 Title X patients. The majority of CommuniCare's Title X patients are low-income. Over 80% of CommuniCare's Title X patients in 2018 had income under the federal poverty level. Nearly one third were 19 years old or younger. CommuniCare's Title X patients included homeless individuals, individuals with substance abuse issues, individuals with disabilities, and limited English proficiency speakers.

[2] At that time, the organization was called Community Clinic Davis.

9. In 2018, the Title X population received 1,000 Pap tests for cervical cancer screening, nearly 1,000 clinical breast exams, and more than 8,300 tests for sexually-transmitted infections. CommuniCare strives to meet patient needs immediately. For example, if a patient wants an intrauterine device ("IUD") and it is clinically appropriate, CommuniCare may provide it at that same visit. (This is consistent with the Center for Disease Control's Quality Family Planning recommendations.)

10. Each year, Title X funds allow CommuniCare to run its teen health clinic, provide education and outreach in Yolo County communities, and deliver sexual and reproductive health services to patients of reproductive age. Title X funds support treatment for approximately 3,000 patients a year. Of those, approximately 2,000 (1,882 in 2018) were young people seen through the teen clinic. Many of these teen clinic patients subsequently visit CommuniCare for general healthcare. In 2018, Title X funds also made it possible to teach 4,382 public school students comprehensive sexual health education.

11. In 2018, CommuniCare received approximately $177,580 in Title X funding.[3] As a sub-recipient of Essential Access, CommuniCare has been audited by Essential Access staff. Essential Access staff perform site visits every three years to ensure that Title X funds are correctly managed and disbursed. CommuniCare uses Title X funds to support its clinical staff, family planning services, and public education and outreach projects.

12. As mentioned above, I see patients regularly, including through our Title-X-funded services. I have an obligation to provide unbiased options counseling to all my patients. Unbiased options counseling is also known as nondirective counseling. "Unbiased options counseling" or "nondirective counseling" means that when I counsel a patient, I set aside any of my own biases and do not push the patient in a particular direction. Rather, I encourage the patient to talk freely. This counseling requires that I provide my patients with all the relevant information that I can, that I answer questions, and that I provide medical information and

[3] This figure reflects funding from April 2018 to March 2019.

guidance. I must present my patients with a full range of treatment options. But I do not steer the patient down a specific path nor interfere with the patient's autonomy.

13. When I see a pregnant patient who chooses to continue the pregnancy, I coordinate with CommuniCare's award-winning, nationally recognized Perinatal Program.[4] If a pregnant patient wants or needs to terminate the pregnancy, I provide a referral for the patient. In some cases, I may determine that it is medically advisable to terminate the pregnancy, particularly when the life of the mother is at risk. Potentially life-threatening conditions include decompensated cardiac conditions, renal failure, and some untreated cancers. In other instances, pregnancy may be especially risky because of the ways in which it can exacerbate existing medical conditions such as heart disease, hypertension, diabetes, sickle cell anemia, cancer, or AIDS, and I must advise patients accordingly. In these circumstances especially, nondirective options counseling is an essential part of my practice and ensures my patients' health and well-being.

14. Furthermore, I must provide enough information for my patients to exercise informed consent. I am also a provider under California's family planning services program Family PACT and Medi-Cal – so I am also subject to an agreement to abide by California law and adhere to Family PACT's minimum clinical standards. I also have professional and ethical obligations to provide transparent and comprehensive medical information and guidance. I honor and support my patients' autonomy. Patients are entitled to ask questions about recommended treatments so that they can carefully consider decisions about their care. I provide accurate and complete factual information, including information about referrals, and as a doctor I have a legal, ethical, and moral obligation to do so.

15. There are many ethical recommendations that govern my provision of family planning services. For example, in 2014, the Center for Disease Control (CDC) published *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of*

[4] CommuniCare's Perinatal Program includes comprehensive services for prenatal and postpartum care. Our program is run by Certified Nurse Midwives who collaborate with physicians and others to provide holistic maternity care. Our Midwives have a collaborative practice with a nearby hospital. In 2017, 619 patients gave birth through the Perinatal Program.

Population Affairs ("QFP"), which "describes the scope of services that should be offered in a family planning visit, and how to provide those services . . . ."[5] These *QFP* recommendations explain throughout that providers such as myself should follow the "recommendations of major professional medical organizations, such as the American College of Obstetricians and Gynecologists (ACOG)."[6] With respect to pregnancy tests, the *QFP* recommendations provide that I should present results to my patient and then "discuss[] . . . options and appropriate referrals."[7] The recommendations also explain that this "[o]ptions counseling should be provided in accordance with recommendations from professional medical associations, such as ACOG . . . ." ACOG, in turn, explains that "[h]ealth care providers *must* impart accurate and unbiased information so that patients can make informed decisions about their health care. They *must* disclose scientifically accurate and professionally accepted characterizations of health care services."[8] ACOG further explains that physicians such as myself "have the duty to refer patients in a timely manner to other providers" if we feel that we cannot provide the reproductive services our patients request.[9] As a physician, family medicine doctor, and CEO of an FQHC, I remain current on all of these guidelines to the best of my ability. Especially given the above recommendations and standards, among others, I understand that it is my legal, medical, and ethical obligation to provide an accurate, complete, and timely referral to a patient who requests one when it is medically warranted.

16. In many cases, my patients have had negative interactions with the healthcare system in the past. Most of my patients also face one or more challenges—low income levels, linguistic barriers, behavioral health issues, substance use—and many have experienced trauma. My patients are often afraid to speak openly. To care effectively for them, I must build trust and

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[5] CDC, "Update: Providing Quality Family Planning Services — Recommendations from CDC and the U.S. Office of Population Affairs, 2015," https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm (describing 2014 publication).

[6] CDC, Providing Quality Family Planning Services 13 (2014), *available at* https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

[7] *Id.* at 14.

[8] ACOG Committee Opinion No. 385 at 5 (Nov. 2007), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co385.pdf (emphasis added).

[9] *Id.*

ensure that they are comfortable sharing their concerns with me. If a patient were to detect any hint of being judged, maligned, or misled, it would unravel my relationship with that patient, undermining my effectiveness as a healthcare provider.

17. I am familiar with the final rule "Compliance with Statutory Program Integrity Requirements" (the "New Rule"), published in the Federal Register on March 4, 2019. If the Department of Health and Human Services ("HHS") implements the New Rule on Title X, I will be faced with a Hobson's choice: continue to provide services at a Title X-funded health care center and violate my medical and ethical duties, or no longer accept Title X funding. Specifically, if HHS implemented the New Rule and CommuniCare continued to receive Title X funding, I could not provide family planning services in an ethical manner. As a clinician, I am obligated to provide unbiased options counseling – and the New Rule would prevent me from doing so at a Title-X-funded healthcare center. The New Rule would interfere with my communications with patients, preventing me from presenting a full range of treatment options. It would also restrict my ability to provide full disclosures to my patients regarding *all* relevant information on their health care decisions. In this regard, the New Rule violates the principles of informed consent and the ethical standards to which I am bound as a health care professional. Ultimately, the New Rule would erect unreasonable barriers to my patients' ability to obtain appropriate medical care, impede my patients' timely access to health care services, and limit the availability of health care treatment for the duration of my patients' medical needs.

18. Under the New Rule, I would be *required* to refer *all* pregnant patients to "a health care provider for medically necessary prenatal health care," 42 CFR § 59.14(b), regardless of their circumstances.[10] As an initial matter, prenatal health care is not medically necessary when a patient is terminating her pregnancy. (Moreover, requiring a patient who wishes to terminate her pregnancy to seek prenatal care *delays* the treatment she seeks.) If a pregnant patient that I see does not want to, or medically should not continue a pregnancy, I would be violating my ethical,

[10] Ambiguous exceptions to the general prohibition on referral are discussed in paragraphs 19 and 21, below.

legal, and moral obligations if I referred her to prenatal care. This mandatory referral to prenatal care strips my patients of their autonomy – and it strips me of my professional judgment.

19. The New Rule claims that I may "discuss abortion" in providing "[n]ondirective pregnancy counseling." *Id.* § 59.14(b)(1). But it does not explain how I can do so without running afoul of the broader prohibition on "promot[ing]" or "encourag[ing]" abortion. *Id.* § 59.14(a). In that respect, the Rule's allowance for "[n]ondirective pregnancy counseling" is illusory—the only "discussion" of abortion the Rule clearly allows is telling a patient that abortion is not a "method of family planning." *Id.* § 59.14(d)(5). Additionally, given these contradictory provisions, I do not understand exactly *what* the New Rule requires, and I do not understand how to implement it. For example, a patient may ask me about the recovery time for a medical abortion. If I answer that question, the Secretary may find my practice to be out of compliance with the New Rule's ban on encouraging and promoting abortion. In short, I do not understand what I can and cannot do or say under the New Rule.

20. The New Rule also provides that I could not provide a referral to a clinic where my patient could receive comprehensive information about abortion or schedule that service. Instead, even if one of my patients requests a referral to an abortion provider, I would only be able to provide "a list of . . . primary health care providers (including providers of prenatal care)." *Id.* But that list need not include ***any*** abortion providers, and if it did, those providers would also have to be "comprehensive primary health care providers," and could not make up more than half the list. *Id.* § 59.14(d)(4). Crucially, "[n]either the list nor project staff may identify which providers on the list perform abortion." *Id.* In Yolo County, there are currently no providers of abortion services who also provide comprehensive primary health care. This would dramatically delay – if not altogether block – my patients' access to information about their desired care.

21. Furthermore, the New Rule does not include a clear exception to its prohibition on abortion referral – even for instances where my patient would suffer health consequences if she continues her pregnancy. Instead, the New Rule states that "[i]n cases in which emergency care is required, the Title X project shall only be required to refer the client immediately to an appropriate provider of medical services needed to address the emergency." *Id.* § 59.14(b)(4).

But, the New Rule provides only *one* example of an emergency warranting such a referral: an ectopic pregnancy. *Id.* § 59.14(e)(2). In all other circumstances, the Final Rule would only allow me to offer the list of primary care providers. In my view, there are many other types of medical emergencies that would warrant referral to an abortion provider or other medical provider. But frankly, I do not understand the contours of this "emergency care" exception, and I would not understand when I was, or was not, permitted to refer patients under this exception. This New Rule would therefore put my patients in a dangerous situation and/or put me in an untenable situation –if a pregnant patient presented with any emergency other than an ectopic pregnancy, I would be discouraged from providing her with an abortion referral for fear of violating a rule that I do not understand.

22. It may be useful to consider one detailed hypothetical on how this New Rule would affect me and my patients. I will assume for this hypothetical that CommuniCare continues to receive Title X funding. Let's say a young woman comes into our clinic. Perhaps she has been raped and is pregnant, or has a medical condition that increases the risk of pregnancy, feels she is too young to start a family, or simply does not wish to be pregnant. She wants to terminate the pregnancy immediately and discreetly. She speaks limited English, has no internet access in her home, and only has access to public transportation. She has an income under the federal poverty level and taking time off work puts her at risk of losing her job. Under the New Rule, I could not provide her with a referral to an abortion provider. The most I could do is give her a "a list of . . . primary health care providers (including providers of prenatal care)," only half of which provided abortions. In other words, I could not give her complete and accurate information. When she asks for a referral to an abortion provider, I would instead have to give her a list that was at least half *non*-abortion providers. She would have no easy or effective way of researching the providers on this list, nor determining which might actually provide abortions. As there are no primary care providers that also provide abortions in Yolo County, my patient would have to travel to Sacramento. Even if my patient could determine which primary care provider also provided abortions, she would still have to get an appointment and make it to Sacramento, 27 miles from one of our health center locations. It would likely be difficult for her to get an

appointment in general and it may be especially difficult for her to get an appointment when her work allows her to travel. By public transportation, it would take over two hours one-way on three different buses to get to the Sacramento provider. In other words, the inaccurate and incomplete information the New Rule would force me to provide would work extraordinary hardships on my patient. These hardships would dramatically delay, or even block, her access to care. This type of delay for a woman seeking a time-sensitive service like abortion counseling increases the impact on, and risk to, her health. Furthermore, my provision of false information would hurt our provider-patient relationship.

23. Furthermore, this interference with my patient relationships would have far-reaching and devastating effects. As described above, many of my patients have had negative interactions with the healthcare system in the past. The Final Rule—under which I would have to remain silent or misrepresent options to patients—would erode patient trust. Ultimately, the Final Rule would discourage Title X patients from visiting CommuniCare at all, thereby compounding health disparities.

24. For these reasons, I could not ethically or legally provide family planning services to Title X patients under the new rule. In addition, even if CommuniCare tried to comply with the New Rule, it would be impossible to do so. As set forth above, some aspects of the Final Rule are so ambiguous that I cannot ascertain how to comply with them.

25. The New Rule also requires that "[a] Title X project must be organized so that it is physically and financially separate . . . from activities which are prohibited under section 1008 of the Act and §§ 59.13, 59.14, and 59.16"—i.e., abortion counseling, abortion referral, and any advocacy activities that promote abortion or seek to make it more available. 42 CFR § 59.15. The Secretary must determine whether a Title X program is compliant by considering the following factors:

> (a) The existence of separate, accurate accounting records; (b) The degree of separation from facilities (e.g., treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites) in which prohibited activities occur and the extent of such prohibited activities; (c) The existence of separate personnel, electronic or paper-based health care records, and workstations; and (d) The extent to which signs

> and other forms of identification of the Title X project are present, and signs and material referencing or promoting abortion are absent."

But the Rule gives no direction about what weight each factor carries or how exactly this separation would be judged. I have no way of operationalizing these factors. Without any concrete guidance, this provision effectively requires us at CommuniCare to provide any abortion counseling, referrals, and care in *completely* physically and financially separate facilities, with separate personnel, from the rest of our programs – or risk noncompliance with Title X.

26. It would be fiscally and logistically impossible for CommuniCare to physically and financially separate our Title X programs from our other programs. To implement physical separation, we would have to double, effectively, every clinic site. We estimate that it would cost several million dollars over the next year to separate our Title X program from our other programs. These costs are prohibitively high, especially given that we are a nonprofit, federally qualified health center.

27. Finally, if CommuniCare continued to receive Title X funds, we would have to provide assurance "satisfactory to the Secretary . . . that the project does not provide abortion and does not include abortion as a method of family planning." 42 CFR § 59.13. Again, I do not understand what would constitute a "satisfactory" representation to the Secretary, and of course CommuniCare would never run afoul of any federal (or any other) reporting requirements – this is yet another reason why we do not understand and could not comply with the New Rule.

28. For these reasons, if the New Rule is implemented, it is highly unlikely that CommuniCare will continue to accept Title X funding. Without Title X funding, CommuniCare will not run the outreach services that inform young people of its teen clinic services, nor provide teen clinic services at all. Our patient population will not have access to the same quality and quantity of reproductive and health care services. Some Yolo County residents may lose access to our services altogether.

29. In the absence of Title X funds, CommuniCare will likely have to cut providers and staff. We have had to cut employees in the past due to decreases in federal funding. The elimination of Title X funds would mean further staff reductions, which will reduce the quality

and quantity of health services that are currently provided in Yolo County. Without CommuniCare's family planning services, many of our community's youth will have nowhere else to go for essential sexual and reproductive health care.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on March 21, 2019 in Davis, California.

MELISSA MARSHALL, MD