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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

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

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

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

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

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

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

I, Stirling Price, declare:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

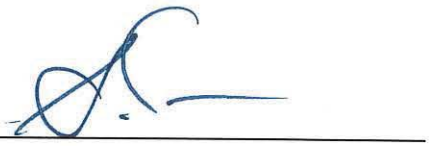
15. On the contrary, DSH already operates under a constrained budget and continues to seek solutions to address the significant growth in its patient population. As of December 31, 2018, DSH had a total of 1,101 patients pending placement, of which 815 were Incompetent to Stand Trial (IST). DSH continues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

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

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

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

Executed on September 9, 2019 in Sacramento, California.



Stirling Price
Chief Deputy Director
California Department of State Hospitals