UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAI'I, STATE OF ILLINOIS, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, STATE OF WISCONSIN, CITY OF CHICAGO, and COOK COUNTY, ILLINOIS, Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA, Defendants.	CIVIL ACTION NO. 1:19-cv-04676-PAE

DECLARATION OF JANET BRANCIFORT

1. I, Janet Brancifort, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

2. I submit this Declaration in support of the State of Connecticut's litigation against the United States Department of Health and Human Services ("HHS"), Alex M. Azar II, in his official capacity as Secretary of the United States Department of Health and Human Services, and United States of America regarding the recently issued rule entitled Protecting Statutory Conscience Rights in Health Care; Delegations of Authority ("Final Rule" or "Rule"). I have compiled the information in the statements set forth below either through personal knowledge, through the Connecticut Department of Public Health ("DPH") personnel who have assisted me in gathering this information from our agency, or on the basis of documents that I have reviewed. I have also familiarized myself with the Final Rule in order to understand its immediate impact upon DPH.

3. I serve as a Deputy Commissioner for DPH, the State of Connecticut's lead agency for public health policy and oversight. DPH provides coordination and access to federal initiatives, training and certification, technical assistance and oversight and specialty public health services that are not available at the local level.

4. I am a Registered Respiratory Therapist and have a Master of Public Health degree. I have 41 years of experience in health and human services, including clinical, research and management experience. I have 13 years of experience in public health administration at DPH. I served as a manager in the Maternal Child Health Section at DPH for seven years prior to being appointed as a Deputy Commissioner in 2014.

I. The Role of Connecticut DPH in Serving the Health and Wellness of Connecticut's Residents

5. DPH is a lead state agency in a comprehensive network of public health services in Connecticut. DPH works in partnership with local health departments to coordinate and access federal initiatives, training and certification, technical assistance and oversight, and specialty public health services. It maintains up-to-date Connecticut health information and analytics which are

used by the Governor of Connecticut, the Connecticut General Assembly, the federal government and local communities to monitor the health of Connecticut's residents, to set health policy priorities and evaluate the effectiveness of health policy. DPH focuses on assuring quality and safety in health care to achieve positive health outcomes. It also seeks to streamline the administrative burden on regulated personnel, facilities, and programs.

6. DPH's mission is to ensure equitable access to resources and high quality health services for all of Connecticut's residents, to address the unique health needs of vulnerable populations living in our State, and to do no harm. Connecticut General Statutes § 19a-4j establishes an Office of Health Equity within DPH to improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among people of different races, ethnicities, ages, genders, socioeconomic position, immigration status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence. DPH's health equity policy is focused on achieving improved health outcomes for these groups across the State.

7. The majority of Connecticut's public health programs and services are supported by federal funds. For fiscal year 2019, DPH administered a budget of approximately $306 million. Forty-three percent of DPH's 2019 budget, or $132 million, was federal grant funding from various agencies including: HHS, the U.S. Department of Agriculture (USDA), the U.S. Environmental Protection Agency (EPA), the Food and Drug Administration (FDA), the Department of Homeland Security (DHS), and the Social Security Administration (SSA). The remainder of DPH's budget is comprised of state allocations (39%) and private or other sources including state approved bonding (18%).

8. DPH received approximately $52,632,185 in funds from HHS in Fiscal Year 2018.

II. Connecticut's Department of Health Passes Through HHS Funds to Sub-Recipients to Support Programs that are Critical to Maintaining and Improving the Health and Wellness of Connecticut's Residents

9. DPH passes through substantial amounts of the HHS funds to third parties, such as private healthcare providers. In total, DPH has 135 contractual and inter-agency relationships with sub-recipients that DPH uses to deliver health services. A few of the critical programs DPH administers with HHS funds are described below.

10. DPH passes HHS funds to Planned Parenthood for the DPH Family Planning program that prevents unintended pregnancy and decreases the birth rate among girls age 15-17 and provides them with primary reproductive health care. This program provides preventive reproductive health care, pregnancy prevention and testing/treatment of sexually transmitted disease and Human Immunodeficiency Virus (HIV) testing at 12 Planned Parenthood centers across Connecticut, and at four subcontracting sites, primarily to low income men and women of reproductive age. The program also provides training and educational programs for professionals serving this group.

11. DPH passes HHS funds through to the Personal Responsibility Education Program (PREP). PREP is an evidence-based, teen pregnancy, HIV, STD prevention program for at-risk youth ages 13-19 and pregnant or parenting youth up to age 21 delivered in school and/or community-based settings. PREP's prevention strategies are tailored to youth with histories of abuse, neglect, and trauma. In particular, PREP serves youth in the child welfare or juvenile justice systems who are at a greater risk for unplanned pregnancies and Sexually Transmitted Infections (STIs).

12. DPH passes HHS funds through to the School Based Health Centers (SBHC) program. SBHC provides health services to students at or near schools. SBHC services are

focused on, but not limited to, students who do not have access to a family doctor, or whose families have little or no health insurance. The comprehensive health care provided by SBHC helps Connecticut's students remain in school, stay healthy and be ready to learn.

13. DPH passes HHS funds through to the Children & Youth with Special Health Care Needs (CYSHCN) program. CYSHCN provides services for children who have, or are at increased risk for, a chronic physical, developmental, behavioral or emotional condition. CYSHCN provides medical home care coordination networks, coordination of services, information and referrals, provider and family outreach and parent-to-parent support, and access to respite and extended services. All of these services are tailored to children who require more health and social services than the general population.

14. DPH passes HHS funds through to the Office of Injury Prevention Intentional Injury Prevention Program. This program is a collaborative effort between DPH and the Connecticut Suicide Advisory Board (CTSAB) and the Child Maltreatment Domestic Violence Collaborative. The program seeks to reduce violence-related deaths and injuries caused by homicides, assault, suicide and suicide attempts, domestic violence, child abuse, and sexual violence. DPH's partners in this program have developed specific initiatives related to suicide prevention, fall prevention, concussion and traumatic brain injury prevention, sexual violence prevention, and opioids and prescription drug overdose prevention.

15. DPH passes HHS funds through to the Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP). CBCCEDP is a comprehensive screening program available throughout Connecticut for women who are medically underserved. The program seeks to significantly increase the number of women who receive breast and cervical cancer screening, diagnostic and treatment referral services. The program services, which are provided

free of charge through DPH's statewide health care provider network, include: office visits, screening and diagnostic mammograms, breast biopsies, breast ultrasounds, fine needle aspirations, pap tests, colposcopies and colposcopy-directed biopsies, loop electrosurgical excision procedure (LEEP), surgical consultations, and clinical breast exams.

16. DPH passes HHS funds through to the Newborn Hearing Screening Program. This program seeks to reduce the loss to follow-up/loss to documentation about infants who have not passed a physiologic newborn hearing screening examination prior to discharge from the newborn nursery by utilizing specific, targeted and measurable interventions. Infants who do not pass newborn hearing screening and do not consistently receive follow-up testing are at risk for speech, language, social, and other delays.

17. DPH passes HHS funds through to Family Wellness Healthy Start (FWHS). FWHS provides care coordination, health education, referral and follow-up services and support during pregnancy and for up to two years postpartum to low income women and their babies in Hartford and New Britain, Connecticut. FWHS seeks to improve access to women's wellness visits; promote quality services; strengthen family resilience; achieve collective impact; and increase accountability through quality improvement, performance monitoring and evaluation.

18. DPH passes HHS funds through to Perinatal Case Management (PCM). PCM serves very high risk pregnant and parenting teens, including those with a history of substance abuse, mental illness, child welfare involvement, low income, unstable housing/homeless, and those at-risk for school drop-out and domestic violence. PCM provides intensive case management, home visits, parenting support and education, referrals and follow-up to mental health providers, health care, shelters, and substance abuse treatment to this group.

19. DPH passes HHS funds through to providers for HIV testing in clinical and non-clinical health settings. These HHS funds enable effective behavioral interventions, syringe services, condom distribution, social marketing, pre-exposure prophylaxis (PrEP) navigation services, health insurance premium assistance, CT AIDS Drug Assistance Program, treatment adherence, medical case management, early intervention services, outpatient ambulatory services, substance abuse treatment, mental health treatment, nutritional therapy, medical transportation, housing, oral health services and emergency financial assistance.

20. DPH passes HHS funds through to hospitals and local health departments to provide comprehensive testing and treatment for infected clients and those exposed to any Sexually Transmitted Disease (STD). These STD program funds pay for referrals for other services that clinicians determine to be needed.

21. The programs described in these preceding paragraphs—which are just a sampling—are absolutely essential to maintaining and improving public health in Connecticut. The loss of funding for any of these programs would be extremely detrimental to the health and well-being of Connecticut's residents.

III. The Final Rule Poses a Very Real Financial and Programmatic Risk to DPH and Its Sub-Recipient Entities

22. My understanding of the Final Rule is that the risk of loss of funds for DPH is both real and very hard for DPH to predict or prevent. DPH is at risk of losing all HHS funds if one of the 135 sub-recipients fails to comply with the Rule; but DPH's ability to control the actions of a sub-recipient is limited.

23. Even if DPH expends the substantial resources that would be needed to educate sub-recipients about the Final Rule, DPH may not be able to ensure that steps have been taken by

the sub-recipients to comply with the Final Rule. I am not sure how DPH will be able to adequately monitor sub-recipients on an ongoing basis for compliance.

24. Moreover, if one or more employees of a sub-recipient declines to perform a job, without notice, DPH will not be able to adequately assess whether any potential sub-recipient can actually provide the services contemplated by an award of funds. If the Final Rule prevents DPH from even screening sub-recipients for their ability to perform the procedures contemplated by an award of funds, then residents of Connecticut may not receive necessary care. The risk posed by an employee's refusal to provide care is especially acute for small-scale providers who will find it more difficult to double-staff to provide required care. In the long term, this may result in fewer awards to small-scale providers by DPH and a decrease in the number of services available to Connecticut's residents.

25. If HHS strips Connecticut's DPH of all of its funding because of an action of a sub-recipient, I am reasonably certain DPH will not be able to fill the gap to continue many, or maybe any, of these critical programs.

IV. Existing State Regulations and Policies Protect Connecticut Employees' Rights to Refuse to Provide Non-Emergency Care Based Upon Religious, Moral or Ethical Objections

26. My understanding is that Connecticut health care providers are already given protection to refuse to provide care to which they have an ethical, moral or religious objection. In Connecticut, existing regulations permit a healthcare provider who has an ethical, philosophical, or religious objection to certain procedures to decline to treat a patient, but require that the provider must turn over care of the patient without delay to another provider.

27. For example, a healthcare provider is not required to implement a "do not resuscitate order," but must turn over care to another provider who will implement the order and,

pending the assumption of care by another provider, must honor the order. *See* Regs. Conn. State Agencies § 19a-580d-9(a).

28. Connecticut law also allows an individual to refuse to assist in a non-emergency abortion if doing so would violate his or her judgment, philosophical, moral, or religious beliefs. *See* Regs. Conn. State Agencies § 19-13-D54.

29. I am also aware that some healthcare providers that receive HHS funds through Connecticut also have internal policies that address religious objections. For example, the University of Connecticut Health Center has an existing policy that permits an individual to raise a religious objection to participating in a procedure. The individual must do so in writing, and there is a procedure for evaluation of the request in light of the needs of the patient.

V. If Healthcare Providers in DPH Funded Programs Are Empowered to Refuse Care Without Prior Notice, Connecticut Residents Will Be Harmed

30. My understanding of the Final Rule is that it expands definitions of terms in ways that affect how DPH will function in the future. In particular, the Final Rule's definition of "assist in the performance" increases the number of individuals who may raise religious objections to go beyond covering healthcare providers who directly participate in a medical procedure. Under the Rule, as I understand it, now clerical staff and others who only indirectly aid a patient by scheduling a procedure or referring a patient to a specific healthcare provider can refuse to perform those functions. I am also concerned about the expanded or uncertain scope of the terms "discrimination" and "health care entity."

31. The lack of clarity as to who or what services fall under the Rule's terms creates a situation where the State of Connecticut, through DPH and other state agencies, must prepare for compliance with the Rule without a clear understanding of who the Rule applies to or how tangential their behavior may be and still fall under the Rule.

32. DPH must expend time, resources, and effort to comply with the Rule. DPH may have to modify hiring and contracting practices, as well as double-staff programs and services and other functions where there is a higher likelihood of an objection.

33. If a healthcare provider refuses to provide care, this will result in poorer health outcomes for Connecticut residents. These poor health outcomes are very serious and include increased infant HIV mortality rate, increased neonatal abstinence syndrome, increased HIV, HCV, STD and overdose related morbidity and mortality rates for populations in Connecticut. The risk of poor health outcomes will be exacerbated if a provider does not even need to provide notice of a refusal prior to refusing to provide care.

VI. If Providers Are Empowered to Refuse Care, the Final Rule Could Have An Especially Negative Impact on the Most Vulnerable Residents of Connecticut

34. Many of DPH's programs described above in Section II provide life-saving services to populations most in need, such as infants, youth, LGBT persons, women and families with limited income, and individuals who are at higher risk for HIV, STD, and opioid related overdoses in Connecticut.

35. The STD Control Program is a good example of the serious risk posed by a provider's refusal to provide care, without notice, even once. The STD Control Program receives funding from HHS to prevent, monitor the prevalence of, and control three major STDs: chlamydia, gonorrhea and syphilis. Disease Intervention Specialists (DIS) who work in this program are specially trained epidemiologists who link individuals testing positive for syphilis with treatment and help to locate their partners. Their work prevents further spread of the disease. DPH must be able to ensure that providers in this area are willing to actually fulfill the duties of the program.

36. There has been a significant increase in STDs in recent years across Connecticut, especially in young adults and adolescents, pregnant women and men who have sex with men. These individuals are often co-infected with other STDs, which makes them more susceptible to HIV. The STD Control Program helps to get these individuals into care and treatment as early as possible to protect them and the public at large.

37. Though easily treatable, untreated STDs can have lasting and devastating impacts, such as neurological and ocular syphilis, infertility in women and congenital syphilis which can lead to poor pregnancy outcomes, including miscarriages, premature births, stillbirths, or death in newborns. Babies exposed in utero can have deformities and delays in development. Connecticut had two cases of congenital syphilis in 2018. Just these two cases will have significant effects and indicate that DPH needs to increase testing and treatment of pregnant women.

38. If a patient is denied care or treatment for these, and other diseases, even one time, or if funding for these programs is stripped, the health of Connecticut's residents will be harmed. As a result, the State will almost certainly incur increased health care costs from delayed or denied treatment.

VII. The Final Rule's Threatened Loss of Funds Will Especially Impact Connecticut's Most Vulnerable Residents

39. The loss of HHS funds to the State due to non-compliance by a sub-recipient would result in negative health outcomes to the citizens of Connecticut because it could substantially reduce the ability of the State to provide healthcare to its citizens. Connecticut is facing another budget crisis and it is uncertain whether the Connecticut legislature would be

willing and able to allocate sufficient funds to programs impacted by a loss of HHS funds by DPH.

40. If Connecticut is stripped of HHS funds then it will not be able to provide the same quality healthcare services like HIV-related services to the LGBT population. An adequately funded HIV workforce is necessary to continue to provide critical prevention education to youth, routine HIV testing, linkage to care, and treatment services. If funding for HIV programs is lost, these patients and clients will be further marginalized and have poorer health outcomes. Ultimately, the State of Connecticut will incur some or all of the cost for this failure to provide adequate care.

I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct.

Executed on this 12th day of June, 2019

JANET BRANCIFORT
DEPUTY COMMISSIONER,
CONNECTICUT DEPARTMENT OF PUBLIC HEALTH