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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO. 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiffs,

vs.

JASON WEIDA, et al.,

Defendants

_____ /

Volume 1, Pgs. 1 - 124

VIDEOTAPED DEPOSITION OF: MATTHEW BRACKETT

AT THE INSTANCE OF: THE PLAINTIFFS

DATE: FEBRUARY 8, 2023

TIME: COMMENCED: 10:00 A.M.

LOCATION: AGENCY FOR HEALTH CARE
ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FLORIDA 32308

REPORTED BY: DANA W. REEVES
Court Reporter and
Notary Public in and for
State of Florida at Large

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ALSO PRESENT:

RL Minnich, Videographer

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*Uh-uh is a negative response
*Uh-huh is a positive response

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D E P O S I T I O N

VIDEOGRAPHER: This is the video-recorded deposition of corporate representative for Agency for Healthcare Administration, in the matter of August Decker, et al. vs. Jason Weida, et al. Case No. 4:22-cv-00325, RH-MAF. This deposition is being held at 2727 Mahan Drive in Tallahassee, Florida. Today's date is February 8th, 2023 and the time is 10:08 a.m. The court reporter is Dana Reeves. My name is RL Minnich. I'm the videographer. Would counsel please introduce themselves and the court reporter please swear in the witness?

MS. DEBRIERE: Yes, Katy DeBriere and I represent the plaintiffs.

MS. CHRISS: Simone Chriss and I also represent the plaintiffs.

MS. DUNN: Chelsea Dunn. I also represent the plaintiffs.

MR. JAZIL: Mohammad Jazil for the defense.

MS. DEBRIERE: And we have a few people on the Zoom link from the plaintiff's side. That would be Catherine McKee and Omar Gonzalez-Pagan.

MR. PERKO: And Gary Perko on behalf of the defendants on the Zoom link.

1 MS. DEBRIERE: And Shani Rivaux has joined us
2 from the plaintiff's side as well.

3 COURT REPORTER: All right, sir, if you would
4 raise your right hand, please.

5 Whereupon,

6 MATTHEW BRACKETT
7 was called as a witness, having been first duly sworn to
8 speak the truth, the whole truth, and nothing but the
9 truth, was examined and testified as follows:

10 THE WITNESS: I do.

11 COURT REPORTER: Thank you.

12 EXAMINATION

13 BY MS. DEBRIERE::

14 Q All right. So we're just going to mark
15 exhibits as they're discussed, if that's okay with you,
16 Matt.

17 A That's fine.

18 Q As we walk through those exhibits, I'm going
19 to read off the Bates numbers on the bottom of each
20 page. So those are just the -- that line of numbers I'm
21 reading out loud as we discuss exhibits, and that should
22 help you track what page I'm on as we're discussing
23 them. So we're going to go ahead and mark the notice of
24 deposition as Exhibit 1. I saw that you brought the
25 copy with you, as well, Mr. Brackett.

1 (Whereupon, Exhibit No. 1 was marked for
2 identification.)

3 MR. JAZIL: Is this the court reporter's copy?

4 MS. CHRISS: The witness' copy that can become
5 the court reporter's copy.

6 BY MS. DEBRIERE::

7 Q Okay. So just some preliminary stuff before
8 we go over this notice. I'm going to be using the
9 acronym GAPMS quite a bit. That stands for Generally
10 Accepted Professional Medical Standards, and is the
11 acronym that refers to the process described at Florida
12 Administrative Code Rule 59-G-1.035. When I refer to
13 the GAPMS or GAPMS process, do you understand what I
14 mean?

15 A Yes.

16 Q I will also use the term gender dysphoria,
17 which is defined as discomfort or distress that is
18 caused by a discrepancy between a person's gender
19 identity and that person's sex assigned at birth and the
20 associated gender role and/or primary and secondary sex
21 characteristics. Can we agree that when I say gender
22 dysphoria, that's the definition I'm using?

23 A Yes.

24 Q I will also be using a phrase categorical
25 exclusion of treatment for gender dysphoria, which

1 refers to the exclusion in Florida Administrative Code
2 Rule 59-G-1.050(7). Do you understand that that phrase
3 refers to all the services in that particular portion of
4 the rule when I say categorical exclusion?

5 A I do.

6 Q And then I will also be using the term EPSDT
7 services, which stands for Early Periodic -- Early and
8 Periodic Screening Diagnostic and Treatment Services.
9 When I say EPSDT, do you know what I mean?

10 A Yes.

11 Q Have you ever been deposed before?

12 A Yes, I have.

13 Q Okay. So if there's at any point that you
14 don't understand my question, what I want you to do is I
15 want you to stop and ask me to rephrase it. I don't
16 want you to try to attempt to ask -- answer the question
17 if you don't understand it. Okay?

18 A Okay.

19 Q I have a problem sometimes of speaking over
20 someone else, I don't know if you have the same problem,
21 but what we need to try to do is just give each other
22 space to pause in between the questions so we're not
23 speaking over each other. Okay?

24 A I'm fine with that.

25 Q Okay. Verbal answers. Sounds like, you know,

1 you speak very clearly, so we shouldn't have a problem,
2 but obviously -- although we do have a videographer
3 here, it's better to speak your answer out loud.

4 A I do understand. Articulating hand gestures,
5 the court reporter cannot get those into the
6 transcripts.

7 Q Exactly. All right, if you need to take a
8 break for any reason, totally fine, just let me know. I
9 do ask that you answer my question before we take a
10 break.

11 A Okay.

12 Q And then are you on any medications or other
13 substances that could impact your memory today?

14 A No.

15 Q And state your name for the record.

16 A So my full name is John Matthew Brackett.

17 Q Okay. And it's your understanding that you're
18 representing the Florida Agency for Health Care
19 Administration in a 30(b)(6) deposition?

20 A That's correct.

21 Q Okay. What topics, looking at the notice,
22 which is Exhibit 1, notice of 30(b)(6) deposition, what
23 topics were you designated for? Were they all of them
24 here?

25 A Yes.

1 Q And you're prepared to testify on behalf of
2 the Agency on each of these topics?

3 A Yes.

4 Q Have you seen the 30(b)(6) deposition topics?

5 A You mean as those listed in the -- yes, I have
6 seen them.

7 Q And who provided them to you?

8 A Those were provided to me by our outside
9 counsel.

10 Q Okay. And did you consent to acting as the
11 agency representative?

12 A Yes, I did.

13 Q What did you do to -- excuse me. What did you
14 do to prepare for today?

15 A Mostly just familiarize myself with areas and
16 topics that are on the list that are not familiar to my
17 current job role, and that's pretty much it. So pretty
18 much standard operating procedures here at the Agency
19 that are -- that might fall under different divisions or
20 different teams, et cetera. And just kind of, like,
21 reviewed some of our coverage policies, some of our
22 rules and some of our own materials.

23 Q Okay. Who did you speak to?

24 A Principally, consulted with Andrew Sheeran and
25 for any questions that involved managed care, I

1 consulted my supervisor Devona Pickle.

2 Q Did you gather information from anyone, anyone
3 besides counsel?

4 A I gathered a little bit of information from
5 Devona Pickle, since one of the questions directly
6 involved her role in the process.

7 Q Okay. I saw that you brought a document with
8 you today, it looks like maybe you reviewed that to
9 prepare. What is that?

10 A So that is pertinent to the question. I can
11 provide you the exact one. Yeah, I think -- yeah,
12 question three. It was -- since that asked about the
13 process of how we looked at other states' Medicaid
14 programs, which that spreadsheet was -- Devona Pickle
15 administered that role of the GAPMS process. And since
16 that question was on there, I did ask her to provide me
17 with what she used to -- and the research methods used
18 to go through each state Medicaid program to find out
19 what their coverage criteria is, or if they have a
20 statement prohibiting coverage, or if they just don't
21 have any statement whatsoever.

22 MS. DEBRIERE: Okay. And, Mo, do you know if
23 that was produced to us in discovery?

24 MR. JAZIL: I don't believe it was. So we'll
25 make copies and get it to you.

1 BY MS. DEBRIERE::

2 Q How long did it take you to prepare for the
3 deposition today?

4 A Well, given that we received these questions
5 about a week ago, I'd probably say I spent probably off
6 and on -- I mean, in between other projects, probably
7 I'd say three, maybe four working days.

8 Q Okay. A little bit about you. Describe your
9 educational background.

10 A So I received a -- my -- started off, I got my
11 AA at Tallahassee Community College. I received my
12 Bachelor of Arts in history at Florida University, 2003.
13 I graduated magna cum laude. Received my Master of Arts
14 in History from Florida University in 2005. During my
15 time in graduate school, I did spend a few extra years
16 working on a PhD, which I decided not to finish, but
17 during my grad school years, I presented research papers
18 on numerous topics at numerous conferences. And I also
19 published scholarly articles in the Florida Historical
20 Quarterly and Southern Studies and Interdisciplinary
21 Journal of the South.

22 Q The conferences, what were those about?

23 A The conferences ranged. They could -- they
24 were, I think, either conference on Florida history,
25 conferences on environmental history. I think there

1 were, like, graduate symposiums. So often they're also,
2 like, regional conferences. The topics I represented on
3 ranged from anything from environmental history to
4 public health history.

5 Q And your PhD, what -- what were you attempting
6 to get it in?

7 A So I was actually looking at getting my PhD in
8 the history of medicine and public health. And
9 actually, I was -- my dissertation topic was on
10 tuberculosis, on how during the late 19th century, how
11 kind of the infancy of public health agencies and how
12 public health was actually becoming a common concept and
13 how -- and, of course, with the emerging sciences --
14 well, pretty much with the discovery of microbiology and
15 discovery of the tuberculosis bacteria, how all that was
16 coming together to affect changes in the south in public
17 health, and looking at also how, since tuberculosis was
18 very common, on how that shapes southern identity.

19 Q Okay. And what's your current position at the
20 Agency for Health Care Administration?

21 A So my current position is Program Consultant.
22 I work on the Canadian Drug Importation Program
23 primarily.

24 MS. DEBRIERE: And, Court Reporter, just to
25 note, we're going to refer to the Agency for Health

1 Care Administration's throughout as either AHCA or
2 the Agency.

3 BY MS. DEBRIERE::

4 Q Prior to your role with the Canadian Drug
5 Importation Program -- did I get that right?

6 A Yeah, close enough.

7 Q What was your role at the Agency?

8 A My role at the Agency, I was the Program
9 Administrator over the Specialized Services and
10 Behavioral Health teams. Of course, we oversaw the
11 development and, of course, updating of policies, such
12 as durable medical equipment, community behavioral
13 health, non-emergency transportation, school-based
14 services, hospice. There's actually quite a lengthy
15 list.

16 Q And how long did you do that for?

17 A I was in that position for three and a half
18 years.

19 Q Okay. And prior to that, were you at the
20 Agency?

21 A Yes, I was.

22 Q And what was your role then?

23 A I was a Government Analyst II. And during
24 that time period, that was from January 2017 to November
25 2017, I was -- my role specifically tasked with

1 completing the Generally Accepted Professional Medical
2 Standards reports.

3 Q And prior to that time, were you at the
4 Agency?

5 A Yes.

6 Q And what did you do then?

7 A I would -- I worked in the Office of the
8 Deputy Secretary for Health Quality Assurance.

9 Q So your time in the Bureau of Medicaid policy
10 was from December 2017 to --

11 A January 2017 to November 2017. But my job --
12 but becoming a program administrator, I was still in the
13 same bureau.

14 Q So GAPMS -- working on GAPMS was January 2017
15 to November 2017, and then you shifted to another role
16 in Bureau and Medicaid Policy?

17 A Yes.

18 Q And that was in December of 2017 through --

19 A November 2017 through April of 2021.

20 Q And so since May of 2021 or April 2021 you've
21 been with the Canadian Drug --

22 A April 2021.

23 Q Okay. Let's look at the Florida definition of
24 medical necessity. And that is in the Florida Medicaid
25 Definitions Policy, which I'm sure you're intimately

1 familiar, at Section 2.83, and it's incorporated by
2 reference into rule by Florida Administrative Code Rule
3 59-G-1.010.

4 MR. JAZIL: Simone, would you happen to have an
5 extra copy?

6 MS. CHRISS: Yes.

7 MR. JAZIL: I'd rather just not lean over his
8 shoulder.

9 MS. DEBRIERE: You know what, Mo, you can use
10 mine. I basically have it committed to memory.

11 MR. JAZIL: Thank you.

12 MS. DEBRIERE: So we'll go ahead and mark this
13 policy as Exhibit 2.

14 (Whereupon, Exhibit No. 2 was marked for
15 identification.)

16 BY MS. DEBRIERE::

17 Q And, Mr. Brackett, if you want to turn to it,
18 it's 2.83.

19 A Okay.

20 Q What's the purpose of the Medical Necessity
21 standard listed here?

22 A So is -- kind of clarify -- can you clarify
23 what's meant by purpose?

24 Q What does AHCA use that medical necessity
25 standard for?

1 A So these prongs for medical necessity, as
2 defined, these are our guidelines for determining
3 whether or not Florida Medicaid should cover a service.

4 Q Okay. Is it correct to say that the standard
5 is used to determine whether Medicaid service should be
6 prior authorized?

7 A I don't -- I don't -- I don't think so.

8 Q Okay. Tell me why.

9 A Because for medical necessity, being medically
10 necessary, this is generally -- this is a criteria for
11 whether or not Medicaid should cover a service. The
12 prior authorization process is just mostly more clinical
13 review to determine whether or not delivery of that
14 service, coverage of that service corresponds to the
15 definition of medical necessity.

16 Q Okay. So when you're doing a prior
17 authorization review, you do determine whether or not
18 the service corresponds to the definition of medical
19 necessity?

20 A So since our subcontractors and our managed
21 care plans do our prior authorizations, they do have to
22 make sure that the -- that with the service they're
23 prior authorizing would, if subjected to the medical
24 necessity guidelines and definition, yeah, they have to
25 make sure it corresponds.

1 Q Okay. And that's part of the prior
2 authorization process?

3 A That's part of the prior authorization
4 process, yes.

5 Q If a Medicaid service is found to be
6 experimental by AHCA, would AHCA or its contractors,
7 subcontractors like a managed care plan, still review
8 whether the service meets any other portion of AHCA's
9 medical necessity rule?

10 A No.

11 Q Okay. Why not?

12 A Because it does have to meet the five prongs
13 of medical necessity, and one of those prongs is it has
14 to be in alignment with GAPMS.

15 Q Okay. So if it's not in alignment with GAPMS,
16 would you analyze it under any other portion of that
17 definition?

18 A No, we wouldn't.

19 Q If a Medicaid service has not been determined
20 experimental, using like GAPMS process, can a Medicaid
21 managed care plan use the portion of the medical
22 necessity standard that reads, be consistent with
23 Generally Accepted Professional Medical Standards?

24 A Once the Agency deemed that it's not
25 consistent, and often these requests usually come to us

1 from the plans, the plan is not going to cover it.

2 Q Okay. Is the plan able to make an independent
3 determination of whether those services are experimental
4 in nature, or must that come from -- decision come from
5 AHCA?

6 A It does not necessarily have to come from
7 AHCA. We do grant our managed care plans a great deal
8 of flexibility when it comes down to the services they
9 wish to cover, but sometimes when they get a service
10 that they're not sure about, they do often -- sometimes
11 will ask us to do a GAPMS review of it to determine
12 whether or not that -- if they should cover it. So
13 sometimes we're kind of more of a reference point, but
14 the plans function pretty independently in these areas.

15 Q Okay. So the plan can make an independent
16 determination as to whether or not a service is
17 experimental or investigational?

18 A No. Whether or not to cover -- we don't allow
19 them to do -- we don't allow them to do independent
20 GAPMS reviews, if that's what you're asking.

21 Q What I'm asking is looking at the prong about
22 whether this service is consistent with GAPMS, whether
23 the plan can deny coverage of a service on that basis
24 without AHCA's initial determination?

25 A No, they need to consult with us before

1 they -- they need to consult with us before they use
2 experimental and investigational as a basis for denial,
3 which they will -- we do get requests from the health
4 plans.

5 Q Okay. All right. So moving on to what's
6 Bates-stamped as defendant DEF_000126105. This is the
7 GAPMS report on cross-sex hormone therapy, which is
8 dated --

9 MS. CHRISS: May '22.

10 BY MS. DEBRIERE::

11 Q May 20th, 2022.

12 VIDEOGRAPHER: Counsel, can you put that mic
13 on, please? They placed it right beside you.

14 MS. DEBRIERE: Yes. Yes.

15 VIDEOGRAPHER: The one to your right. Thank
16 you.

17 MS. DEBRIERE: I should have worn my suit
18 jacket tonight.

19 THE WITNESS: It might get hot here shortly, so
20 I may be taking mine off.

21 MS. DEBRIERE: Should I mark this as 3?

22 MS. CHRISS: Yes, the one for him.

23 MS. DEBRIERE: I think we got it split up. I'm
24 sorry. Mo, do you want to copy?

25 MR. JAZIL: Sure. Do you really have all these

1 committed to memory?

2 MS. DEBRIERE: Well, not this one, no, no, but
3 somewhat.

4 MR. JAZIL: Here's the last one, Katy.

5 MS. DEBRIERE: Thanks.

6 MR. JAZIL: That's pretty impressive if you do.

7 MS. DEBRIERE: Well, not these, but definitely,
8 you know, you practice Medicaid in Florida for
9 seven years, you know what the medical necessity
10 definition is.

11 (Whereupon, Exhibit No. 3 was marked for
12 identification.)

13 MS. DEBRIERE: All right. Not a day past seven
14 years, either.

15 BY MS. DEBRIERE::

16 Q Okay. So looking at -- do you have a copy,
17 Mr. Brackett?

18 A Yes.

19 Q Okay. Looking at -- if you'll flip to what's
20 marked as DEF_000126112, it's page eight.

21 A Okay.

22 Q Starting under coverage policy, there's some
23 discussion about federal regulations, and then moving
24 through to the Florida Medicaid section that ends on the
25 top of page 10, if you could just review that for me.

1 A Okay.

2 Q So is this an accurate portrayal of the
3 standard to determine Florida Medicaid coverage for
4 prescription drugs?

5 A Yes, this is.

6 Q Do all prescription drugs require prior
7 authorization to be reimbursed by Florida Medicaid?

8 A I can't speak fully to that one. I don't -- I
9 don't believe so, but often our managed care plans, we
10 grant them a lot more flexibility when it comes down to
11 prior authorizations, so they may require prior
12 authorization for every drug. But as far as, like,
13 every single drug, as far as the fee for service system
14 goes, I'm not a hundred percent certain, but I believe
15 that we do not require prior authorization for every
16 single drug.

17 Q Okay. Do you know if anybody at the Agency
18 would have a hard answer to that question?

19 A One of our staff pharmacists probably would.

20 Q So can you briefly describe the process a
21 Medicaid recipient undertakes in seeking prior
22 authorization for a drug?

23 A Usually, that's taken by the provider usually,
24 or in the case of pharmacy, I'm not sure who would
25 submit the prior authorization. I don't think that

1 that's -- process is not initiated by the recipient
2 themselves, it's usually initiated by the provider. Of
3 course, it goes through, like, a one-two level review
4 process. That first level is usually done by, like, a
5 nurse or an RN. They just determine whether or not it's
6 medically necessary. If it is, then that one level
7 stops. If it's a denial, it has to go -- I think it
8 goes to a second-level review.

9 Q Okay. And what is -- what is involved in that
10 review? What is being reviewed?

11 A Well, I'm not intimately familiar with it
12 because we used it a long, long time ago, prior to SM's.
13 We did that stuff in-house. That was before my time
14 with the Agency, but now that's outsourced to EQ Health
15 Solutions in the fee-for-service system. But they do
16 review the medical records, et cetera, and then, I
17 think, any other materials that are submitted by the
18 doctor, so --

19 Q Do they compare it to coverage policies or
20 guidelines?

21 A Well, for children, I don't -- it wouldn't be
22 necessary to because of EPSDT, but for adults, I don't
23 know. That's information that we would have to ask our
24 vendors. I assume they would, but that's an assumption.

25 Q Okay. Tell me a bit more about what you mean

1 by coverage guidelines when it needs to be reviewed for
2 children because of EPSDT.

3 A Well, because of EPSDT, in which, since you're
4 familiar with all this, of course, even regardless of
5 what something says on the coverage policies -- because
6 our coverage policies and our fee schedules are very
7 prescriptive, they list out what services can be
8 covered, what services can't be covered. Our fee
9 schedules, of course, outline the amount of money that
10 we pay for each service and our perimeter service gaps,
11 most importantly, the service gaps. So for children, if
12 it's deemed medically necessary, and usually it does
13 have to go through the prior authorization process for
14 an EPSDT consideration, if it's determined medically
15 necessary, regardless of whether it's on a fee schedule
16 or not, or in excess of our fee schedule, or if it's not
17 listed in that coverage policies, because of EPSDT
18 requirements from the feds, we do have to cover it.

19 Q Okay. Okay. And how do you define medical
20 necessity for EPSDT?

21 A It's the same as listed in definitions policy.

22 Q Okay. What would be the process for obtaining
23 Medicaid coverage for a drug where prior authorization
24 is not required?

25 A Well, so the thing about Medicaid coverage for

1 drugs is that we do cover all drugs that are FDA
2 approved. So if -- unless it has a prior authorization
3 requirement and if that FDA approved covered drug can be
4 covered by Medicaid.

5 Q Okay. What if it's not FDA approved?

6 A If it's not FDA approved or if it's -- so are
7 we talking about, like, complete non-FDA approval or are
8 we talking about like our off-label usage?

9 Q Actually, let's back up. So if it's FDA
10 approved, does that mean it does not need to go through
11 the prior authorization process for Medicaid to
12 authorize it?

13 A If it's not FDA approved, we -- I mean, we're
14 not going to cover it if it's not FDA approved.

15 Q Okay. If it is FDA approved, does the
16 Medicaid recipients still have to undertake the prior
17 authorization process to --

18 A If it's FDA approved, and it's a drug that
19 we've required prior authorization, then, yes.

20 Q Okay. If it's a drug that does not require
21 prior authorization, what does that process look like
22 for coverage?

23 A I generally -- I think it just -- the pharmacy
24 fills the prescription, they file a claim, agency pays
25 the claim and the dispensing fee.

1 Q Okay. So there's no review in medical
2 necessity under that --

3 A Providing the drug does not -- does not have
4 prior authorization criteria, yes.

5 Q Okay. So if it's a drug that does not require
6 authorization, AHCA does not determine if it's being
7 prescribed for a medically necessary use; is that
8 correct?

9 A Can you repeat that?

10 Q Yep. If a drug does not require prior
11 authorization, AHCA does not -- AHCA or its contractors
12 does not undertake a determination as to whether it's
13 being prescribed for a medically necessary use?

14 MR. JAZIL: Object to form.

15 THE WITNESS: We covered -- we cover services
16 that are medically necessary. So if it's -- that
17 would be in violation of policy if drugs are being
18 covered -- if drugs are being prescribed and
19 covered, when for -- when medical records and the
20 documentation -- when medical necessity is not
21 being met, that is that -- no, we would not cover
22 in those circumstances.

23 BY MS. DEBRIERE::

24 Q How would you make that determination that you
25 would not cover if you're not doing a prior

1 authorization review?

2 A So generally when issues like that, when
3 providers are billing Medicaid for services that are not
4 medically necessary, that's usually when our Medicaid --
5 Medicaid program Integrity, they start getting involved
6 in looking at -- looking at such claims.

7 Q How would that rise to the surface of
8 triggering an investigation with Medicaid Integrity?

9 A Well, there are lots of tip-offs. I mean, we
10 do have a -- we do have a fraud hotline. So somebody
11 could report a provider for fraud. There -- it could be
12 result from an on-site survey. Our Bureau of Recipient
13 Provider Assistance does -- they often do Medicaid
14 surveys on providers. It could also potentially result
15 from a -- one of our health quality assurance surveys,
16 if they're going in and looking at, like, their
17 compliance with licensure rules. So it really depends
18 on where the fraud's detected. So there are multiple
19 avenues for reporting Medicaid fraud.

20 Q Does AHCA have a pharmacy coverage policy for
21 every prescription drug?

22 A We do have our outpatient prescribed drugs
23 services coverage policy. And that, of course, is for
24 our covered outpatient drug benefit.

25 Q Does that policy list every potential

1 prescription drug prescribed under -- prescribed to a
2 Florida Medicaid recipient?

3 A No. So -- because Florida Medicaid covers any
4 drug that's FDA approved, when these medical necessity
5 guidelines, that's kind of an encompassing umbrella.
6 And then, of course, we do have the preferred drug list
7 which is assembled by the Pharmaceutical and
8 Therapeutics Committee. We always just call P&T, so --
9 but because the list is so vast we don't actually
10 reproduce it in any kind of a form. So the prescribed
11 drug services policy, the way it's worded is supposed to
12 be all-encompassing, but there are exclusions in Section
13 5.2 of non-covered service -- of drugs that we won't
14 cover under certain circumstances.

15 Q Okay. So it lists some drugs you won't cover,
16 but it doesn't list all the drugs you will potentially
17 cover?

18 A Right. But it's also -- but it's not -- it
19 doesn't specifically state drugs, it's just -- it's more
20 specific to conditions. Like we don't say we won't
21 cover -- well, let me use it -- Viagra, but we say that
22 we will not cover drugs for ED.

23 Q Okay. So there's some general descriptions of
24 what you won't -- will and won't cover?

25 A Yes.

1 Q Is there a pharmacy -- is there an AHCA
2 pharmacy coverage policy for estradiol? And I'm happy
3 to spell it for you if you need it.

4 A Oh, are we talking about estradiol.

5 Q Estradiol. Thank you.

6 A No, we don't have specific coverage policies
7 for specific drugs. And by estradiol, I mean, that's
8 an -- that's a kind of name brand estrogen.

9 Q Okay. And how about for medroxyprogesterone
10 acetate, or Provera?

11 A We don't have specific coverage policies for
12 those.

13 Q Okay. How about micronized progesterone?

14 A Those would all be encompassed under the
15 prescribed drug services policy.

16 Q Okay, but not specifically named?

17 A We don't specifically name drugs.

18 Q I'm just going to run down the list. Spiro --
19 and you're going to correct me when I say it wrong --
20 Spironolactone.

21 A Spironolactone. That one, I mean, once again,
22 the previous answer applies. It's enveloped by our
23 prescribed drug services coverage policy. We don't
24 have, like, an individual policy addressing that
25 specific drug.

1 Q Okay. Finasteride.

2 A I think that's close enough. Same as before
3 it's covered -- it's enveloped by the prescribed drug
4 services coverage policy. We do not have an individual
5 coverage policy for that drug.

6 Q Dutasteride.

7 A We do not have an individual coverage policy
8 for that drug, but it is covered. It is -- it is
9 addressed through the prescribed drug services coverage
10 policy.

11 Q Okay. Testosterone.

12 A The same as before, we don't have an
13 individual coverage policy for it, but it is covered
14 through the prescribed drug services coverage policy.

15 Q Testosterone enanthate.

16 A Same as before, as in, we don't have a
17 specific coverage policy, but it is covered through the
18 prescribed drug services coverage policy.

19 Q Okay. Two more. Testosterone undecanoate.

20 A We do not have an individual coverage policy
21 for that, but it is enveloped by our prescribed drug
22 services policy.

23 Q Gonadotropin-releasing hormone antagonists.

24 A Gonadotropin, yeah. So, yeah, we do not have
25 an individual coverage policy for GnRH. And that, of

1 course, would be covered through the prescribed drug
2 services coverage policy, is how it would be addressed.

3 Q Okay. You do not have a policy, a pharmacy
4 policy for GnRH antagonists?

5 A Not promulgated into rule.

6 Q Okay. Do you have any coverage policies -- I
7 didn't realize that when I asked whether there was a
8 coverage policy that you interpreted that to mean that
9 it had to be promulgated into rule. Do you have any
10 coverage policies regarding these drugs that are not
11 promulgated into rule?

12 A As far as the policy goes, we don't really
13 have a policy so for it -- so much. There was a
14 guideline produced, I think, in 2016 that was given to
15 Magellan for guidance on the prior authorization
16 process, but as far as a policy goes, no, we don't
17 have -- we don't have a specific policy for these drugs.

18 Q Okay. So there was some guidance that AHCA
19 provided to Magellan regarding GnRH antagonists.

20 MS. DEBRIERE: Simone, can I have that coverage
21 guidance?

22 MS. CHRISS: This one?

23 MS. DEBRIERE: Yes, please. Thank you. We'll
24 mark that as Exhibit 4. You definitely need a copy
25 of this one.

1 (Whereupon, Exhibit No. 4 was marked for
2 identification.)

3 THE WITNESS: I've seen it enough times.

4 BY MS. DEBRIERE::

5 Q Well, so is that what you're referring to when
6 you said the guidance provided to Magellan?

7 A Yes.

8 Q That's all I needed to know. Okay. So I'm
9 sure we'll come back to that. And so you referenced FDA
10 approval in Medicaid coverage earlier. When making
11 decisions about individual claims for coverage for
12 Medicaid recipients, does AHCA or its contractor
13 determine whether the use the drug is being prescribed
14 for is FDA approved?

15 A Well, absolutely, yes. I mean -- I mean, if
16 it doesn't have FDA approval, I mean, it's still -- I
17 mean, it's either not FDA-approved, it's still going
18 through clinical trials. It's not FDA-approved, then
19 no, it's not eligible for coverage.

20 Q Okay. How does AHCA do that on an
21 individualized basis?

22 A So for an individualized basis, generally this
23 is a prior authorization process, the request is put in.
24 The recipients, or health care plan enrollees, the
25 specific condition is evaluated and determination of

1 medical necessity is made.

2 Q Okay. What if the drug does not require prior
3 authorization, then how does AHCA determine whether the
4 use it's being prescribed for is FDA-approved?

5 A That would normally have to involve a
6 retrospective claims review.

7 Q Okay. So at the time it'd be covered, but
8 then AHCA would go back and look to see if it should
9 have been covered?

10 A That's correct.

11 Q And how do they do that?

12 A How do they do that?

13 Q Yeah.

14 A I don't know the specifics, generally either
15 MPI or another bureau. Often people in the field will
16 often look at review claims, and this has happen
17 frequently, that if claims are found to be paid in error
18 or paid for services that were not necessarily -- not
19 medically necessary, but the Agency does have the
20 ability and frequently does gather recoupments on
21 providers.

22 Q Okay. MPI stands for --

23 A Medicaid Program Integrity.

24 Q So that's like a fraud investigation?

25 A Yes, there are two fraud investigation teams

1 of the state. For MPI, they're specifically here for
2 Medicaid. Every Medicaid program in the country is
3 required to have a program integrity team, but we also
4 have Medicaid Fraud Control Unit over at the Attorney
5 General's Office.

6 Q Okay. Just turning back quickly to Exhibit 4,
7 why is this not considered a coverage policy?

8 A Because coverage policies are generally --
9 well, first of all, it's not promulgated in a rule. So
10 all of our coverage policies go through the rulemaking
11 process, which is, of course, allows for public input
12 and everything like that. This is mostly more -- these
13 are guidelines developed in-house and provided to our
14 PBM subcontractor.

15 Q Okay. For use in determining whether or not
16 to prescribe GN -- strike that.

17 Are there other coverage guidelines like this
18 not promulgated into rule for other drugs?

19 A For other -- I am not aware of whether or not
20 we have any other guidelines like this.

21 Q Okay. What about for cross-sex hormone
22 therapy?

23 A There was -- to my knowledge, there was no
24 guidance or for cross-sex hormones.

25 Q Okay. So going back to the MPI post-claim

1 reviews, how often does that happen? Can you quantify?

2 A I don't have enough numbers of how often it
3 happens, because obviously we have thousands of Medicaid
4 providers. Then we do hear about cases of recoupment,
5 so I couldn't tell you what the percentage of providers
6 that had to pay back to the Agency money, but I can
7 tell -- I can definitely tell -- like, I know -- well,
8 for instance, I know -- like, I think Miami-Dade or
9 Broward County have -- like, their school district
10 actually they had -- after they had received a Federal
11 Audit from HHS, they ended up having to pay back, I
12 think, a million or so dollars in funds because they
13 were delivering services that weren't properly
14 documented and weren't meeting that medical necessity
15 criteria. So as far as the larger numbers go, I don't
16 have those.

17 Q Is there somewhere publicly the public can
18 access that information, or where we can access that
19 information?

20 A So a public records request can always be put
21 in. We don't have that information available on our
22 website, but anyone can put in a public records request
23 and find out, like, how often recoupments do occur.

24 Q Do you know what a drug compendium is?

25 A Yes. Yeah, I'm aware of three.

1 Q Which three are you aware of?

2 A Drug Index is one. There are two others whose
3 names do not -- whose names I do not recall immediately
4 offhand. I believe they are listed. And, of course,
5 they do usually consist of, like, a very large amount of
6 information on each specific drug, and it talks about,
7 like, appropriate uses and so forth. So, for each of
8 these compendia -- and I -- they are -- we do utilize
9 them when evaluating whether or not we can use an
10 FDA-approved drug for an off-label purpose.

11 Q Okay. Do you know if those three compendia are
12 Drug Text Information System, United States
13 Pharmacopoeia Drug Information and American Hospital
14 Formulate -- Formulary Service Drug --

15 A That sounds correct.

16 Q And those are the three compendia listed in
17 the Federal Medicaid Act?

18 A Yes.

19 Q Okay. So when I'm using compendium, or
20 compendia for next set of questions, I'm referring only
21 to those three listed in the Federal Medicaid Act.

22 A Okay, that's fine.

23 Q For drugs that do not require prior
24 authorization, when making decisions about individual
25 claims for coverage, does AHCA or its contractors

1 determine whether the use that drug is being prescribed
2 for is supported by citation in one of the compendia?

3 A So is this for drugs that do not require prior
4 authorization, or drugs that do require prior
5 authorization?

6 Q Do not require.

7 A We really don't because we don't require prior
8 authorization. We're not able to check.

9 Q So that means where AHCA does not require
10 prior authorization for a Medicaid recipient to obtain
11 coverage of a particular drug, it covers the drug
12 without knowing in advance whether the use it's being
13 prescribed for is supported by citation in one of the
14 compendia?

15 A If we're not requiring prior authorization,
16 there's no way for us to know in advance.

17 Q Okay. So I know you mentioned it earlier.
18 I'm just going to reference it on my computer, and that
19 is the prescription drug list. And the website link --
20 I'll turn it so both you and counsel can see it, without
21 spilling my drinks. That URL is
22 [HTTPS://AHCA.myflorida](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- Florida is spelled out --
23 [.com//Medicaid/prescribed_drug/pharm](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- P-H-A-R-M --
24 [_thera](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- T-H-E-R-A -- /PDF/PDL.pdf. So I'm showing you
25 what is AHCA's preferred drug list. Do you recognize

1 it?

2 A Yes, I recognize that.

3 Q What is the PDL?

4 A So the preferred drug list -- so even though
5 we have everything that's FDA-approved, our
6 Pharmaceutical and Therapeutics Committee, they do place
7 drugs on the preferred drug list. I don't know the --
8 necessarily all the details. I think often it has to do
9 with the ability for the agency to obtain rebates and so
10 forth, so -- but they do put this together. It is
11 publicly available on our website. And, of course, it
12 does -- it does, of course, have age -- it does have
13 age, minimum age, maximum age, clinical care required.

14 I would like to clarify, though. I know for
15 our -- in our Medicaid Management Information System,
16 which we often dub as FMMIS, we do program for procedure
17 codes and so forth, corresponding diagnosis codes. So
18 if a claim does not correspond to a diagnosis code,
19 and -- that claim can be denied automatically in the
20 system.

21 Q Okay. Okay.

22 A Which, I'm sorry, I forgot --

23 Q No, no, no. It's helpful. I just want to
24 make a note of it.

25 A And we do program our system with ICD-10

1 codes, so we do have a build in our system for claims to
2 deny if they don't necessarily correspond to a specific
3 diagnosis code.

4 Q And that's regardless of whether the drug
5 requires prior authorization?

6 A If it's prior authorized, the prior -- there's
7 a different process for entering claims into the system
8 that are prior authorized. So I think if it was prior
9 authorized, that would override the automatic denials,
10 but I would have to confirm that, but I believe that's
11 how the system does work.

12 Q So FMMIS can be programmed to deny a certain
13 service if it's associated with a particular diagnostic
14 code, and that's done automatically?

15 A That's automatic. Yeah. Claims can deny
16 automatically in the system, so we do have a fail-safe
17 there.

18 Q Okay. And that's even if the drug does not
19 require prior authorization?

20 A That's correct.

21 Q Okay.

22 A So I know it's definitely the case for the
23 procedure codes that I administered when I was over --
24 when I was over specialized services. I'm going to
25 assume that we have the same in place for NDC's,

1 National Drug Codes.

2 Q Okay. Because the services you were
3 previously working on were not prescription drugs, is
4 that correct, they were other Medicaid services?

5 A No, they were a little of everything.

6 Q Do you have a diagnostic code for every drug
7 in the system?

8 A I can't speak to that at the moment.

9 Q Okay. Is there some way we can find that
10 information out?

11 A Yeah, we can -- we can find that out for you.

12 MS. DEBRIERE: Okay. Can we flag that as a
13 question, follow-up question?

14 BY MS. DEBRIERE::

15 Q If a drug is on the PDL, does it mean it's on
16 the fee schedule?

17 A So we don't -- so with drugs, and this is one
18 of the things with having worked -- working on the
19 Canadian Drug Importation Program is that drug pricing
20 is not a transparent process, so we don't actually list
21 rates, we just list what we cover, or we list what's on
22 the PDL. We don't actually say what we'll reimburse.

23 Q Okay, but if it's listed on the PDL, even if
24 the rate's not on the fee schedule, AHCA is going to
25 cover it?

1 A Yeah.

2 Q Okay. Does the PDL apply to managed care plan
3 coverage of prescription drugs?

4 A Yes, that's actually -- well, yes, actually.
5 I think -- I think -- I believe it does. That we
6 wouldn't -- I would need to verify, but as far as --
7 like, I know that's the way our pharmacy benefit works.
8 So with pharmacy benefit managers, generally the law
9 ensures subcontract, that's the pharmacy benefit
10 managers, who handle both their prior authorization of
11 drugs and also negotiating rebates with manufacturers to
12 help, of course, lower expenses. And so -- but for
13 Medicaid, the SMC health plans, they have PBM's that
14 they're really only there for the prior authorization
15 process of prescription drugs. So their PBM's do not
16 negotiate rebates. All that's done on the Agency side.
17 So the agencies have contracted PBM, which is another
18 branch of Magellan. They're the ones that negotiate all
19 the rebates.

20 Q Okay. Just for clarity of the record, PBM
21 stands for --

22 A Pharmacy Benefit Manager.

23 Q Okay. And then SMC PBM's, they're using the
24 PDL to determine whether or not to authorize coverage
25 for a prescription drug?

1 A Well, since with Medicaid we'll cover anything
2 that's FDA-approved, they're going to be reviewing
3 primarily medical necessity.

4 Q Okay. Are they going to match up the request
5 for drug coverage to the PDL?

6 A I don't know if they do that or not.

7 Q Okay. So you don't know if Medicaid managed
8 care plans rely on the PDL to authorize coverage?

9 A I don't. I can't speak to that.

10 Q All right. Let's look at a few specific
11 drugs. Say this one for me again.

12 A Estradiol.

13 Q Estradiol. Thank you. Okay. So the PDL
14 indicates that AHCA covers estradiol in each of these
15 formulations, there's many listed here, for at least one
16 indication, but we don't know what the indication is, or
17 at least the PDL doesn't indicate it, correct?

18 A That's correct.

19 Q Okay, but AHCA does not cover estradiol to
20 treat gender dysphoria?

21 A That's correct.

22 Q For what uses or indications does AHCA
23 authorize coverage for estradiol?

24 A So for -- well, when estradiol needs to be
25 covered, generally, as I speak very generally, of

1 course, usually it's used for hormonal imbalances, but I
2 mean, but still we go back -- we defer back to the
3 medical necessity guidelines.

4 Q So what does the no -- let's look at the very
5 first list -- listed formulation of estradiol, which is
6 associated with Climara 0.025-milligrams-per-day patch.
7 And looking over at the clinical PA required, it says
8 no. What does that mean?

9 A That means if the provider wants to prescribe
10 it, that, of course, they can prescribe it without
11 having to have a clinical review process.

12 Q So that means no prior authorization is ever
13 required?

14 A Not under fee-for-service. Managed care
15 plans, however, they have the flexibility to make it go
16 through prior authorization.

17 Q Okay. So in fee-for-service, estradiol will
18 be covered without AHCA or its contractor first
19 determining for what purpose it's being used?

20 A Right, not until the claim comes in.

21 Q Okay. So that would mean that Medicaid could
22 cover this drug if it were prescribed for
23 non-FDA-approved uses?

24 A That's, of course, where our claim system
25 comes in. So our claim -- our claim system was

1 programmed -- and, of course, I'm speaking generally of
2 our CPT codes, et cetera, that if it doesn't -- if the
3 diagnosis code doesn't align with what's in the system,
4 that can come back as a denial.

5 Q Okay. So for estradiol, let's use this as an
6 example, but not a hypothetical, in real life.

7 A Okay.

8 Q If estradiol is prescribed for treatment of
9 gender dysphoria, is FMMIS programmed to automatically
10 deny that claim?

11 A I would have to confirm with our -- with our
12 Medicaid fiscal agent operations to make sure -- to know
13 whether or not that the system has been updated for --
14 to deny that.

15 Q Is it possible to program a system to do that?

16 A To program it to deny it?

17 Q Based on -- based on the diagnostic code --

18 A From my experience, it's pretty -- it's a
19 pretty simple affair to update the system to -- when
20 we -- because we are uploading new and deleting
21 diagnosis codes or uploading new procedure codes, I
22 mean, it's generally a pretty straightforward process.

23 Q Okay. Can you provide us a list of those
24 diagnostic codes at some point?

25 A For estradiol?

1 Q I think -- well the diagnostic codes would
2 be -- are you using CPT codes? What are you using?

3 A So we use ICD-10 for --

4 Q ICD. Okay.

5 A -- because it's going to be primarily -- those
6 are going to be like your -- well, those are your
7 service codes. Those aren't drug codes.

8 Q Okay. So you use -- for your diagnostic
9 codes, it's associated with ICD-10?

10 A That's correct.

11 Q Okay. So, looking at testosterone, this
12 indicates that -- we've got to get there first, don't
13 we? So this indicates that AHCA covers testosterone,
14 and each of these formulations listed on the PDL for at
15 least one indication, although based on the PDL, we
16 don't know which indications for which it covers; is
17 that correct?

18 A Yeah. I mean, there's a very large number of
19 FDA-approved clinical indications for testosterone.

20 Q Okay. Just for clarity, AHCA will never cover
21 testosterone when used to treat gender dysphoria, is
22 that correct?

23 A Yes.

24 Q And it looks like, at least some of these
25 formulations, including, for example, Andrew Durham,

1 four milligrams, 24-hour patch, that there is a clinical
2 prior authorization that's required. Is that correct?

3 A Yes. Yeah. Based on the PDL? Yes, there
4 would be a PA required.

5 Q For what uses or indications does AHCA provide
6 prior authorization or approve coverage?

7 A So that goes back to our definition of medical
8 necessity.

9 Q Okay. Would it also be governed by AHCA's
10 drug criteria? And I'll just -- I'll pull that up. So
11 when I say AHCA's drug criteria, I'm referring to that
12 criteria listed at [https://AHCA --
13 A-H-C-A --.myflorida.com/Medicaid/prescribed_ drug/drug
14 _criteria.shtml](https://AHCA--A-H-C-A--myflorida.com/Medicaid/prescribed_drug/drug_criteria.shtml).

15 And so would the drug criteria -- I'm looking
16 at the screen. It says testosterone criteria updated
17 6-16-2022. Would the indications for which testosterone
18 will be prior authorized -- prior authorized, would it
19 be contained in this criteria?

20 A It would be contained in that criteria.
21 That's correct.

22 Q Okay. Is this list exhaustive of all
23 prescription drugs that AHCA will cover?

24 A I think -- I mean, I haven't seen the entire
25 list, so -- but, I mean, for any drugs that we deem that

1 criteria is necessary, I imagine that would be an
2 exhaustive list.

3 Q Okay. This applies in fee-for-service,
4 correct?

5 A Those would apply for fee-for-service, yes.

6 Q How about for managed care?

7 A Managed care plans would need to be able to --
8 they would -- they would need to mirror their criteria
9 and align it with the agency's.

10 Q So it can't -- my understanding is the managed
11 care plan criteria cannot be more restrictive than what
12 AHCA --

13 A That's correct. So they can be less
14 restrictive, they can't be more restrictive.

15 Q Okay. Would the drug criteria listed here at
16 the link to testosterone provide all the instances in
17 which testosterone would be covered after prior
18 authorization review?

19 A On the criteria?

20 Q Uh-huh?

21 A After --

22 Q Yes.

23 A Well, I would -- I'd have to -- I haven't
24 actually had a chance to physically look at the
25 criteria, so -- but I would assume that what we have the

1 criteria is accurate, especially given that it was
2 updated in June 2022.

3 Q Okay. Turning back to EPSDT briefly. If the
4 drug was being prescribed to a child under age 21, when
5 AHCA or its contractor was undertaking the prior
6 authorization process, could AHCA or that contract --
7 would AHCA or that contractor deviate from this criteria
8 if the drug was otherwise prescribed for a medically
9 necessary use?

10 A I have trouble following that question.

11 MR. JAZIL: Object to form.

12 BY MS. DEBRIERE: :

13 Q So where testosterone was prescribed to a
14 child under 21.

15 A Okay.

16 Q And EPSDT applies, then could AHCA or its
17 contractor in its prior authorization review deviate
18 from the criteria listed here? If medically necessary.

19 A As long as it meets medical necessity
20 criteria, whether or not there's criteria involved and
21 it meets -- if it's for an off-label use and it meets
22 our off-label criteria, I mean, under EPSDT, I mean,
23 yes, Florida Medicaid can cover it, but -- I mean, that
24 would, of course, require significantly in-depth review,
25 et cetera, but, I mean, hypothetically speaking, yes.

1 Q And one of the requirements -- just to circle
2 back -- one of the requirement under that medical
3 necessity review is that the prescribed drug cannot be
4 for an experimental or investigational use, correct?

5 A That's correct.

6 Q All right. Just turning quickly back to FMMIS
7 programming of the ICD-10 codes, what ICD-10 codes are
8 programmed into the system for estradiol?

9 A What ICD-10 codes?

10 Q Yes.

11 A We would have to check the system. I would --
12 because I know pharmacy codes are set up a little
13 differently than our procedure codes. So I'm kind of
14 using the procedure code as analogous to the drug codes,
15 but we would need to speak with one of our pharmacists.

16 MS. DEBRIERE: Can we flag that as a follow-up
17 question, too? I had one more. So if you -- can
18 we take a break for two minutes? I just want to
19 confer -- or we can do longer if you need a second
20 to go to the bathroom.

21 THE WITNESS: If you need a break, you can go
22 ahead and take the break. That's fine.

23 MS. DEBRIERE: Thank you. Okay.

24 VIDEOGRAPHER: This concludes video one. The
25 time is 11:05 a.m.

1 (Brief recess.)

2 VIDEOGRAPHER: This is the beginning of video
3 two. The time is 11:08 a.m.

4 BY MS. DEBRIERE::

5 Q All right. So turning back to the preferred
6 drug list, AHCA's preferred drug list, and looking at
7 the formulation of testosterone cypionate -- did I say
8 that correctly?

9 A I really don't know.

10 Q The PDL indicates that AHCA covers
11 testosterone cypionate for at least one indication,
12 although it doesn't say what indication, correct?

13 A Not on the PDL, no.

14 Q Does it say it anywhere? Is there anywhere we
15 can find that information?

16 A Unless there's that criteria, unless we have a
17 criteria listed on the website, generally, no, that's
18 like one of the things -- I mean, we do have our claim
19 system set up, which -- but like all that information
20 is -- I mean, I suppose it could be obtained through
21 public records request. That's usually the process.

22 Q Okay. So AHCA will never cover testosterone
23 cypionate, or any formulation of testosterone for
24 treatment of gender dysphoria, is that correct?

25 A That's correct.

1 Q So looking at the formulation of testosterone
2 cypionate of testosterone CYP 1000 milligrams per 10
3 milliliters, that indicates there's no clinical prior
4 authorization required, correct?

5 A That's correct.

6 Q So that means that AHCA will cover the drug or
7 reimburse for the drug without determining for what use
8 it's being prescribed?

9 A Well, based on my understanding of how our
10 system works, through my experience is that the claim
11 would deny.

12 Q Because why?

13 A Because the diagnosis code that'd be
14 associated with that drug would trigger the system to do
15 a denial.

16 Q Okay. So you're looking not at the indication
17 of the -- what indication the drug's being prescribed
18 for, but instead you're looking at the diagnostic code?

19 A So -- that's correct. Part of the process
20 requires the procedure code, diagnostic code and place
21 of service. Of course, those are for our health
22 services, but those three all have to be programmed into
23 the system. So say you're delivering a -- doing a
24 checkup in a other setting, or you're doing like a
25 setting that's not approved by us, it's not in our

1 policy, that claim would deny.

2 Q Okay. What if it wasn't for the treatment of
3 gender dysphoria? What if it was for a diagnostic code
4 that was not programmed to automatically deny?

5 A If it was for -- so if it was for a diagnosis
6 code that was not programmed to deny?

7 Q Right.

8 A If it's programmed in the system -- we
9 don't -- so we program the codes that it will approve.
10 So all the other codes, it's not loaded in the system
11 would automatically deny. So each -- so there'll be a
12 set of ICD-10 codes that are -- that would link up with
13 a particular service. As long as the diagnostic code
14 corresponds to that service, the claim will pay.

15 Q Okay. So with the formulation of testosterone
16 cypionate that we've been discussing that no clinical
17 prior authorization is required, if the diagnostic code
18 is programmed into the system, then it's going to
19 automatically approve without looking at the indication
20 for which the drug is prescribed?

21 A Provide that the claim form is -- it's a clean
22 claim and all the pertinent information corresponds with
23 the physician requirements, they will pay.

24 Q What is involved in a clean claim?

25 A No errors.

1 Q Errors of what?

2 A Someone might type in the wrong code by
3 accident. Maybe they -- human error.

4 Q Okay. But you're -- but in that clean claim,
5 there's no requirement to submit the indication for
6 which it's being prescribed or AHCA undertaking a review
7 of that?

8 A I mean, we do do retrospective review of
9 claims.

10 Q At the time the coverage is being requested.

11 A Okay. Can we go back a little bit?

12 Q Yeah, yeah. Yeah. So looking at this
13 formulation of testosterone cypionate, where no clinical
14 prior authorization is required, when the claim is
15 submitted and -- when the claim is submitted, AHCA is
16 not doing a review of whether the indication it's being
17 prescribed for -- sorry. Scratch that.

18 Looking at testosterone cypionate, in the
19 formulation that we've been discussing where no clinical
20 prior authorization was required, when the claim is
21 submitted, AHCA -- neither AHCA nor its contractors does
22 a review to determine for what indication the drug is
23 being prescribed for?

24 A Right, there'd be no manual clinical review
25 process or prior authorization process, if that's what

1 you're asking.

2 Q And when you said AHCA will only cover drugs
3 that are FDA-approved, does that mean that AHCA never
4 covers off-label use of a drug?

5 A We do have a -- no, we definitely would
6 never -- we have a procedure for covering FDA-approved
7 drugs for non-approved clinical indications, AKA
8 off-label use. We do have a procedure for that. So we
9 wouldn't necessarily -- no, we would never say never.
10 That's --

11 Q Okay. I thought you said earlier that AHCA
12 will only cover FDA-approved drugs?

13 A Right. But, I mean, like, let's say there's a
14 drug that -- okay. Let's say it's been manufactured by
15 European pharmaceutical or, you know, it's a
16 pharmaceutical and it hasn't gone through the FDA review
17 process, brand new drug. It's not FDA-approved. It's
18 really not even approved -- it's not even approved for
19 sale on the market. We won't cover those.

20 Q Okay. Okay. But you will cover drugs that
21 are FDA-approved for uses that in and of themselves are
22 not FDA-approved, for off-label uses?

23 A Yes, we have a procedure for that.

24 Q Okay. Do you ever program into the system the
25 use of a drug for a condition for which the drug is not

1 FDA-approved?

2 A I can't speak to a hundred percent for that,
3 but it seems it'd be counter to the process we have in
4 place for reviewing off-label use for drugs.

5 Q Okay. And what is that process?

6 A So, it's a three-prong process. Step one is
7 that there has to be a trial period for FDA-approved
8 drugs for that clinical indication to have tried to have
9 been used. And, of course, if the FDA-approved drugs
10 for that kind of indication are not successful, then
11 the -- then it moves to the second prong, which, you
12 know, that requires like phase-three clinical trials
13 having had to be completed on that drug. Then the third
14 step is that the peer-review literature and one of the
15 three drug compendia that we mentioned earlier has to
16 pass the list or support it.

17 Q So you're looking at when determining whether
18 or not you'll authorize coverage for a prescribed drug,
19 you're looking at more than just whether the indication
20 for which it's being prescribed is listed in the
21 compendia?

22 A Yes, it's a little bit more comprehensive,
23 correct.

24 Q Yeah. And so first you look at the individual
25 Medicaid recipient and you determine whether or not they

1 tried other drugs?

2 A That's correct, yeah.

3 Q Okay.

4 A It would be an individualized basis.

5 Q Okay. And then the second step was what?

6 A A phase-three -- the drug had to have
7 completed phase three clinical trials.

8 Q And then the third step is you look to see if
9 the indication that's being prescribed for is listed in
10 the compendia plus --

11 A Plus support in the peer-reviewed literature.

12 Q Okay. Let's look back at Exhibit 3.

13 MS. DEBRIERE: Simone, do you have that handy?
14 That's the cross-sex hormone therapy GAPMS.

15 MS. CHRISS: You should still have those two
16 versions.

17 MS. DEBRIERE: I might have it. I have a
18 notice of deposition and I have a cross-sex hormone
19 therapy. Here it is.

20 BY MS. DEBRIERE::

21 Q Is there anywhere on this GAPMS that describes
22 the process for the criteria used?

23 A It's on page nine, if you're referring to the
24 off-label use.

25 Q Okay. And that starts with the criteria that

1 utilized under the Florida Medicaid program and
2 authorization for drugs for off-label purposes are as
3 follows?

4 A Uh-huh.

5 Q Okay. And that's what you just described to
6 me?

7 A Yes.

8 Q Yeah. Okay. All right. Turning to past
9 GAPMS regarding gender dysphoria.

10 A Okay.

11 Q We are aware, plaintiff's counsel is aware of
12 three pre-2022, at least draft GAPMS reports regarding
13 Medicaid coverage of the treatment for gender dysphoria.
14 One we've already marked as Exhibit 3, and that is the
15 May 20th, 2022 version of the GAPMS for cross-sex
16 hormone therapy. We actually know of two other
17 versions, one dated June 23rd, 2017 and one dated April
18 19th, 2022. So we're going to mark the June 23rd one as
19 Exhibit 5?

20 MS. DUNN: Yes.

21 (Whereupon, Exhibit No. 5 was marked for
22 identification.)

23 THE WITNESS: Yeah. I have to apologize for
24 the auto-dating on those documents, so I can
25 probably give you more accurate dates --

1 BY MS. DEBRIERE::

2 Q Yeah, let's get the documents in front of you,
3 and then that's exactly what we were wondering about.
4 It can get confusing.

5 A I can give you more --

6 Q That would be -- that's exactly what we're
7 after. We appreciate that.

8 MR. JAZIL: They're identical except for the
9 date, right?

10 MS. DEBRIERE: Yes. Yeah -- well, that's not
11 true. Yeah --

12 THE WITNESS: Well, I have this one. I mean,
13 it's fine. There's one -- there should be one for
14 surgeries.

15 MS. DEBRIERE: No, no. We're just looking at
16 the versions of cross-sex hormone therapy right
17 now. We have three different versions, at least,
18 that we've found so far.

19 MR. JAZIL: Thank you.

20 BY MS. DEBRIERE::

21 Q Okay. So let's first look at the one with the
22 June 23rd date.

23 A Okay.

24 Q June 23rd, 2017. Who authored the version of
25 this report?

1 A So listed in our assignment writing and
2 tracking page in SharePoint, the author of this was
3 Sarah Craig.

4 Q Okay. And do we have that routing form?

5 MR. JAZIL: You should.

6 THE WITNESS: They should have it. We -- I did
7 produce it for everybody.

8 BY MS. DEBRIERE::

9 Q Okay. And then that was back in 2017 when she
10 authored this?

11 A She authored it in 2016. This is actually --
12 so to provide a little context.

13 Q Please.

14 A So in 2016, this was before I came to the
15 Bureau of Medicaid Policy, there wasn't -- there wasn't
16 a GAPMS position. Because they were accumulating a lot
17 of services, a lot of requests for coverage, they
18 created two GAPMS positions in the fall of 2016. They
19 were filled in January 2017. So GAPMS reports often
20 went to subject matter experts. So that's -- so in 2016
21 when this one was completed, the person who completed
22 it, their primary job was not GAPMS.

23 Q Okay. What was Sarah Craig a subject matter
24 expert in?

25 A She was one of our pharmacists.

1 Q Okay. And right now, just for clarity of the
2 record, we're looking at June 23rd, 2017. That's
3 labeled Exhibit 6.

4 (Whereupon, Exhibit No. 6 was marked for
5 identification.)

6 BY MS. DEBRIERE::

7 Q Who -- so saying that, let's move on to the
8 April 19th, 2022, which is labeled as Exhibit 5, who
9 authored this report -- or made the revisions, I should
10 say, in the April 19th, 2022 version?

11 A The only person I'm aware of who worked on
12 this one was Sarah Craig. Since this was done before my
13 entrance into the Bureau, and she's the only author
14 listed in our system.

15 Q And were any changes made on the April 19th,
16 2022?

17 A No. That may have been a day when it was
18 pulled out to be printed.

19 Q Okay. Why would it have been pulled out to be
20 printed?

21 A I think -- because there had been some
22 questions about the history of whether the Agency had
23 previously done any work on this subject.

24 Q Okay. And why did those questions arise?

25 A Those questions had arisen as part of the

1 request process for the GAPMS report we did, and that
2 was approved on June 2nd.

3 Q And that's related to the treatment of gender
4 dysphoria?

5 A That's correct.

6 Q Okay. Does Sarah Craig still work at the
7 Agency?

8 A Sarah Craig, I think, left in 2020.

9 Q Okay. Do you know where she went?

10 A I do not.

11 Q Were there any changes -- looking back at
12 Exhibit 3, which is dated May 20th, 2022, there are some
13 revisions on this one.

14 A Okay.

15 Q For example, Beth Kidder is crossed out and
16 Ashley Peterson's name is put in. And the subject line
17 is crossed out and there's just some edits and comments.
18 And it looks like some text was added, for example, on
19 page three.

20 A I was not privy to any edits or changes being
21 made after -- I was not privy to any changes being made
22 to that document.

23 Q Okay. Well, just to be clear, you're here as
24 the Agency representative and not in your individual
25 capacity, so you should have some knowledge about any

1 revisions to these reports, based on your designation as
2 the Agency representative. Can you not speak in that
3 capacity to it?

4 A As far as the work goes during the time period
5 that we were working on the June 2nd GAPMS?

6 Q Uh-huh.

7 A That -- the work for the determination of the
8 transgender dysphoria in relation to consistency with
9 GAPMS, that task was specifically designated to myself,
10 and Nai Chen and Devona Pickle in supporting roles.

11 Q Okay. Right now, though, I'm just asking
12 about revisions made to the May 20th, 2022 version. You
13 do not know who made these revisions, is that correct?

14 A I do not know who made those revisions,
15 because -- as the Agency witness. Nobody was requiring
16 revisions to that document.

17 Q But there were revisions made based on what
18 I'm looking at.

19 A Whoever did so was doing so on their own
20 accord.

21 Q Okay. Who had access to this document?

22 A Well, given that any -- actually, anybody has
23 access to that document because the documents -- it's
24 available on our SharePoint site. It doesn't require a
25 password. Anyone in the bureau, anyone who's

1 knowledgeable of our repository could go through and
2 pull up that document.

3 Q Okay. Could it have been Ashley Peterson who
4 made the revisions?

5 A It's possible. We would have to find out from
6 our IT department.

7 Q Okay. I think we do need that information.
8 And then who's GS? There's some comments on the side
9 there on the front page, Exhibit 3. It says GS 1.

10 A Well, GS would be initials. Would usually
11 like last name first, first name second. I might --
12 might occur to me later on. I can't --

13 Q Would it be Sheena Grantham?

14 A It's possible. I don't know.

15 Q Okay. Can you track who has access to this
16 document?

17 A Yeah, our IT department can track whoever had
18 made edits to that.

19 Q Okay. Okay. So we can find out the answer to
20 that question?

21 A Yes.

22 MS. DEBRIERE: Let's flag that.

23 BY MS. DEBRIERE::

24 Q Was this report ever finalized?

25 A To my knowledge, and I did actually do some

1 history -- do historical digging on this one. Since our
2 pharmacy manager at the time, and I do need to add it
3 because I forgot to add, that I did consult Arlene
4 Elliot, who was the pharmacy manager at the time that
5 this report was initially prepared, I did confer with
6 her to determine whether or not it was finalized. And
7 what I mean by finalized, it went through the review
8 process and was signed off by the deputy secretary. She
9 let me know that it had not.

10 Q Okay. Do you know why or why not? Why was it
11 never finalized?

12 A Well, generally, and this is often the case
13 with GAPMS reports, is that because it's -- well,
14 Medicaid is a -- it's very busy -- we're a very busy
15 division. We have lots of requests, lots of asks, lots
16 of projects, and often GAPMS reports, usually, for those
17 of us who like to be very detailed and very analytical,
18 we, you know, it's -- it's a craft. It's almost like
19 each one is like a seminar paper or scholarly article.
20 It takes time to read and review. And usually it's --
21 and sometimes often, because unless somebody's asking
22 for it, or if it's deemed a low priority, often it
23 just -- it just often waits. And that may have been
24 why. That's speculation, though.

25 Q Okay.

1 A But it's not surprising that a GAPMS draft is
2 out there and didn't complete the review process.
3 Solely it's because there's just too many other projects
4 going on.

5 Q And GAPMS is generally low priority?

6 A It depends.

7 Q What does it depend on?

8 A Depends on the situation, because often when
9 the managed care plan requests for the GAPMS, that's
10 usually -- those usually have to be addressed quickly.

11 Q Okay. Let's set expedited GAPMS aside. Just
12 traditional GAPMS, are they generally low priority?

13 A A traditional GAPMS? Well, like I said --
14 like I said, it often depends on the context. It
15 depends on the request. Sometimes it could be --
16 sometimes it's a stakeholder who made their voice known
17 downtown. Sometimes -- I mean, it really depends on the
18 context.

19 Q Okay. When you're referencing downtown, what
20 do you mean by that?

21 A The Capitol.

22 Q Okay. So sometimes GAPMS will get bumped up
23 if the Capitol is the person who's raising --

24 A It just depends on the situation/I just don't
25 want to commit to an absolute answer saying that they're

1 all low priority, because not every single circumstance
2 or every single GAPMS means that it will be.

3 Q Okay, but with the cross-sex hormone therapy
4 GAPMS, you're guessing that one reason why it was never
5 finalized is because it was low priority?

6 A That's a guess in relation to my experience
7 when I had the role.

8 Q Okay. And what was your experience when you
9 had the role?

10 A When I -- when I had the role, I had it for
11 about 10 months, and I think I drafted ten reports and
12 two of them made through the review process. Those two
13 I reviewed in January. They weren't finalized and
14 signed off on until July of that year. So often, it was
15 more trying to -- you know, reminding supervisors at
16 different levels to review them so they can move
17 forward. And given how busy everything was, especially
18 with legislative session going on or other special
19 projects taking precedence, often if it could be done --
20 put on hold until the next day or later, it was.

21 Q Okay. And so for the two of the ten reports
22 that were finalized, it took seven months for the
23 reports to be finalized, reviewed and finalized?

24 A Yes.

25 Q Prior to its adoption, prior to AHCA's

1 adoption of the categorical exclusion of treatment for
2 gender dysphoria, did Florida Medicaid -- were there any
3 instances where Florida Medicaid ever authorized
4 coverage for cross-sex hormone therapy to treat gender
5 dysphoria?

6 A Were there any circumstances? The Agency
7 didn't have a policy or criteria regarding cross-sex
8 hormones or, like, hormones for that clinical
9 indication.

10 Q So that wasn't quite my question. My question
11 is prior to the adoption of the categorical exclusion of
12 treatment for gender dysphoria, were there any
13 instances, so --

14 A Under -- so, well --

15 Q Did Florida Medicaid ever cover treatment of
16 gender -- use of -- did Florida Medicaid ever authorize
17 coverage for cross-sex hormone therapy to treat gender
18 dysphoria?

19 A So by Florida Medicaid, are you referring to
20 the Agency?

21 Q AHCA or any of its contractors, Medicaid
22 managed care plans or EQ Health or --

23 A Under fee-for-service, that was -- no, it was
24 not an approved clinical indication. Obviously, with
25 managed care plans, since they have the flexibility to

1 cover services that, you know, that are not necessarily
2 clarified in our coverage policies so -- I mean, it's
3 possible that we could have done that, yes.

4 Q Okay. So, to be clear, in fee -- under
5 fee-for-service, prior to the adoption of the
6 categorical exclusion for the treatment of gender
7 dysphoria, there was never an instance of Florida
8 Medicaid covering cross-sex hormone therapies to treat
9 gender dysphoria?

10 A Are you referring to the fee-for-service?

11 Q Fee-for-service only.

12 A We don't necessarily have that information
13 available.

14 Q Why?

15 A Well, not offhand.

16 Q Why?

17 A Well, going -- because we want to go back
18 several years. We're assessing an extensive data pull.

19 Q Or even just six months prior to August 21st,
20 2022.

21 A So I think we did do a data pull for the past
22 year. And that data pull, of course, show the results
23 of what services we were covering, had the number of
24 recipients with the diagnosis for gender dysphoria, and
25 those who received treatment. So I'll defer to that

1 data.

2 Q So we don't have that data in front of us.
3 And, again, you were produced as the 30(b)(6)
4 representative, so what did that data show?

5 A That data did show that some -- that there
6 were a handful of recipients who were receiving the
7 services.

8 Q In fee-for-service?

9 A I think fee-for-service. I think managed
10 care.

11 Q Okay. So there were times, prior to the
12 adoption of the categorical exclusion for the treatment
13 of gender dysphoria, that Florida Medicaid covered
14 cross-sex hormone therapy for treatment of gender
15 dysphoria?

16 A Cumulatively for the whole program, yes, there
17 were.

18 Q Okay. So another previous GAPMS regarding
19 gender dysphoria is the GAPMS entitled puberty
20 suppression therapy, and that begins at DEF_ 000288776.
21 Although, for clarity of the record, I do want to say we
22 received multiple versions of this document, as well.

23 MS. DEBRIERE: Do we have the final one, by any
24 chance? I'm positive it was my mistake in terms of
25 listing exhibits.

1 MS. DUNN: The one that was signed?

2 MS. DEBRIERE: Yeah.

3 MS. DUNN: That's a whole different -- it has a
4 different name.

5 MS. DEBRIERE: I'm sorry, guys. That's my
6 fault. My fault.

7 MR. JAZIL: Counsel, do you want him to clarify
8 that date issue? I think he mentioned it as you
9 were --

10 MS. DEBRIERE: Oh, yeah, I thought he did. I'm
11 sorry if -- please, go ahead and clarify the date
12 issue.

13 THE WITNESS: So both of these GAPMS were
14 initiated in 2016.

15 BY MS. DEBRIERE::

16 Q Okay. When you say both of these GAPMS,
17 you're referring to --

18 A Referring to the one on the cross-sex hormone
19 therapy.

20 Q Okay.

21 A And the one on the puberty suppression.

22 Q Okay. Let's not talk about the puberty
23 suppression one just yet, because I want to get the
24 right exhibit into the record first.

25 A Okay, but as far as the date goes, these were

1 projects from 2016.

2 Q Okay. Okay.

3 MR. JAZIL: Counsel, if you'd like me to just
4 make additional copies of that, I'm sure we can.

5 MS. DEBRIERE: So there are multiple versions
6 that were provided to us of this document. We are
7 looking for another version that has a signature on
8 it, although I'm sure Mr. Brackett can speak to it
9 being finalized. But just to make everyone's life
10 easier in the long run, we are going to try to --
11 yeah, this is great. Okay.

12 Chelsea, should we mark it?

13 MS. DUNN: Yeah. Do you want that Exhibit 7?

14 MS. DEBRIERE: Are we on 7? Okay.

15 (Whereupon, Exhibit No. 7 was marked for
16 identification.)

17 BY MS. DEBRIERE::

18 Q All right. We have only one copy of this, and
19 it's DEF_000288776, entitled puberty suppression
20 therapy, dated September 14th, 2016. And the reason we
21 were -- and that's going to be marked as Exhibit 7. The
22 reason we wanted that one is because if you turn to the
23 back page, it's signed by Mr. Senior. So we assume then
24 that's the final report?

25 A This would be the final report if he signed

1 it.

2 Q Okay. So it was adopted by the Agency?

3 A The recommendations in this GAPMS were -- yes,
4 they would be adopted.

5 Q Who authored this report?

6 A So in the --in our system, our SharePoint
7 system, that was the individual listed for this report
8 was Monique Johnson.

9 Q Okay. And who was Ms. Johnson? What was her
10 subject matter expertise?

11 A So she was a program administrator and she
12 oversaw the primary care services team, which is
13 primarily like surgeries, inpatient -- inpatient
14 services, dental services. Like, I think like surgical
15 procedures, things like that. Of course, child health
16 checkup procedures. Generally be like primary care and
17 preventive, anything that would fall into those
18 categories.

19 Q Why would she then look at puberty suppression
20 therapy?

21 A So this was, at the time before we had the
22 defined GAPMS individuals, so I can only speculate as to
23 why she was selected. It may have been she had
24 bandwidth at the time to do it, but since there was no
25 one who actually did GAPMS full time, I don't -- I can't

1 speak as to -- because I'm not that familiar with her
2 background, I can't -- and, of course, this was 2016,
3 but more or less, there may have been a number of
4 reasons for why she was selected for this.

5 Q Okay. Why wouldn't it have gone to a
6 pharmacist?

7 A We don't have the -- an answer for that.

8 Q Was Ms. Johnson a pharmacist or pharmacy tech
9 or had any --

10 A I think she was an RN.

11 Q Okay.

12 MR. JAZIL: Counsel, just so the record's
13 clear, this copy of Exhibit 7 has highlights on it.
14 Did you --

15 MS. DEBRIERE: It would have not been -- it
16 would have been highlighted by us. Is that right?
17 Yeah. So my apologies.

18 MS. DUNN: It's the only copy we have, but we
19 can potentially print a clean copy.

20 MS. DEBRIERE: And it's Bates-stamped.

21 MR. JAZIL: It's fine. I just want the record
22 to be clear that it's highlighted and the
23 highlights were added by counsel for plaintiffs,
24 not the witness.

25 MS. DEBRIERE: Yes. Thank you for that, Mo.

1 BY MS. DEBRIERE::

2 Q Okay. So going back to Exhibit 4, pubertal
3 suppression -- yep. This is the special services
4 criteria. This was developed only six days after the
5 puberty suppression therapy GAPMS report. Is that
6 correct?

7 A You mean the criteria?

8 Q Yes. Yes. Exhibit 4.

9 A Based -- I'm going to defer to the dates on
10 this, because it predates my time in the Bureau of
11 Medicaid Policy. So if the dates say 30 days, then that
12 would be --

13 Q The dates say six days.

14 A The dates say six days?

15 Q Yeah.

16 A I'll defer to that.

17 Q Okay. Are these two documents related?

18 A Can you provide some context on what related
19 means?

20 Q Is one based off another?

21 A It seems -- it would appear that following the
22 completion and approval of the GAPMS process, that this
23 document was completed, routed and then approved, based
24 on the time stamps.

25 Q Okay. So was the special services criteria at

1 Exhibit 3, was it drafted based on the information
2 contained in the GAPMS report related to puberty
3 suppression therapy?

4 MR. JAZIL: Exhibit 4?

5 MS. DEBRIERE: Did I say 3? I'm sorry.

6 Exhibit 4. Thank you, Mo.

7 THE WITNESS: It looks like it's fairly
8 consistent.

9 MS. DEBRIERE: Okay.

10 THE WITNESS: Based on the EPSDT consideration
11 portion.

12 BY MS. DEBRIERE: :

13 Q So based on your understanding of office
14 operations, then it's likely that the special services
15 criteria was drafted in response to the puberty
16 suppression therapy GAPMS?

17 A Yes.

18 Q Okay. And this is the -- this policy, Exhibit
19 4, is the criteria that AHCA used prior to its adoption
20 of the categorical exclusion of treatment for gender
21 dysphoria to determine whether gonadotropin-releasing
22 hormone analog would be prior authorized for pubertal
23 suppression and treating gender dysphoria, correct?

24 A Yes, correct.

25 Q Okay. Between the time this policy was

1 adopted, which was October 6th, 2016, and the time AHCA
2 adopted the categorical exclusion of treatment for
3 gender dysphoria in August of 2022, if an individual's
4 condition met the criteria laid out in this policy, then
5 Florida Medicaid would cover the cost of the drug for
6 pubertal suppression and the treatment of gender
7 dysphoria, is that correct?

8 A Providing that the criteria, and prior to the
9 challenge exclusion, yes.

10 Q Okay. Between October 6, 2016, and the time
11 AHCA adopted its categorical exclusion of treatment for
12 gender dysphoria, how many times did AHCA authorize the
13 drug set forth in this policy for the treatment of
14 gender dysphoria?

15 A We would have to defer at least -- at least
16 prior to the challenge exclusion being implemented, we'd
17 have to defer that data for that time period, but we'd
18 have to go all the way back to 2016 as far as the data
19 goes, at least in fee-for-service, to determine how many
20 recipients actually received the -- actually received
21 authorization for it.

22 Q Do you have any knowledge of any time period
23 in which fee-for-service covered it, based on the
24 criteria in this policy?

25 A So this -- so once this policy -- so once this

1 criteria was released to Magellan, Magellan was our PBM
2 for fee-for-service. So they did the prior
3 authorizations for fee-for-service. So Magellan would
4 review each case individually.

5 Q Okay. Do you know how many times Magellan
6 authorized it based on the criteria?

7 A I do not have those numbers.

8 Q Okay. Can we get those numbers?

9 A We can try to find them. We can try to get
10 those numbers. It's a very long time period.

11 Q But it is your understanding that in certain
12 instances, Magellan did authorize it?

13 A We would have to -- we would have to look at
14 those numbers.

15 Q Okay. Because previously, when we were
16 discussing cross-sex hormone therapy, you did know that
17 in some instances fee-for-service had covered the drug
18 to treat gender dysphoria, but you don't have that same
19 information for pubertal suppression?

20 A That's speaking more about Medicaid,
21 cumulatively as far as the differences between
22 fee-for-service and managed care encounters, I would
23 have to take a look at the data to get the exact numbers
24 of what was in the fee-for-service system versus the
25 encounters for the managed care were. But we would --

1 have we would have to go ahead and get this information
2 from Magellan going back to find out exactly how many
3 times that they get pre-authorization requests versus
4 how many approval/how many denials.

5 Q Okay. Let's just look quickly at exhibit --
6 it's going to take me a second to find it.

7 MS. DEBRIERE: Simone, is the list of Medicaid
8 recipients and discussion of their
9 authorizations -- yeah. I don't know. Yeah,
10 that's it. Not surgery, though. There should be a
11 drug one. Maybe I'm wrong. They probably didn't
12 include it.

13 BY MS. DEBRIERE::

14 Q Mr. Brackett, while we're looking for that,
15 let's go back to the notice of deposition. In the
16 deposition topics, we do list the number of Florida
17 Medicaid recipients who -- participants who have sought
18 any form of care for gender dysphoria from January 1st,
19 2015 until the enactment of the challenged exclusion.
20 And so as we're sitting here today, you're telling me
21 you can't answer whether -- or how many times AHCA or
22 one of its contractors authorized coverage of pubertal
23 suppression therapy for treatment of gender dysphoria,
24 is that correct?

25 A That's correct, as of now, but we can get that

1 information.

2 Q And you will provide us that information?

3 A We will obtain that information.

4 Q Okay.

5 MS. DEBRIERE: So I think that given that there
6 are a few places where we have follow-up questions
7 I do, at this point, just want to say that once
8 those questions are answered, we're going to
9 reserve some time for this deposition so that we
10 can do follow-up questions based on the information
11 that's provided to us, because right now there's
12 some holes that Mr. Brackett is not able to fill,
13 and once that information is provided to us, of
14 course, we will probably have follow-up questions.
15 So we just need to reserve some time for --

16 MR. JAZIL: Okay. And just so the record's
17 clear, I think I provided objections to the last
18 set of depo topics. There may have been an
19 objection to this particular topic, going back to
20 2015, but we'll work with you. If we can gather
21 the information, we'll provide it.

22 MS. DEBRIERE: Okay.

23 BY MS. DEBRIERE: :

24 Q So looking at the final GAPMS report related
25 to treatment of gender dysphoria, it's entitled gender

1 confirmation surgery.

2 MS. DEBRIERE: Oh, gosh. Do we have it from
3 the past deposition? I'm sorry. We had, like,
4 over 50 exhibits and clearly it's completely my
5 fault not putting them in the list. We can always
6 pull back around to them and print it out at lunch,
7 too. There it is. Okay. We're going to mark this
8 one as Exhibit 8, and it's entitled GAPMS gender
9 confirmation surgery, dated July 19th, 2017.

10 (Whereupon, Exhibit No. 8 was marked for
11 identification.)

12 BY MS. DEBRIERE::

13 Q And this one does have markups on it that are
14 not our markups, they're from the Agency. Who authored
15 this report?

16 A So this report is authored by Rebecca Buceo.

17 Q Okay. When?

18 A This was authored in the summer of 2017.

19 Q How do you know who was authored by?

20 A I was in the bureau at the time and was
21 present when the project was being assigned out.

22 Q Okay. Why weren't you assigned the project?

23 A I was actually being assigned -- I was working
24 on another project related to designated state health
25 programs and getting approval for those through the

1 Centers for Medicaid -- Medicare and Medicaid Services.
2 So I was actually on a kind of a legislative priority
3 project. And so I was not assigned to this one.

4 Q It's my understanding that there's only one
5 hard copy of this report, is that correct?

6 A That's correct.

7 Q Okay. Whose office was it found in?

8 A So, I -- this report, I did -- it was in a
9 binder with -- so this report was found in Rebecca
10 Buceo's old office. So she had an office in the bureau.
11 I know she maintained her GAPMS materials there.

12 Q Okay. And what else was in that binder?

13 A I think some of the research articles she
14 used.

15 Q Is that it?

16 A That was it.

17 Q Okay. Is Rebecca Buceo still with AHCA?

18 A No, she's not.

19 Q When did she leave?

20 A I believe she left in 2019.

21 Q Okay. And what was her subject matter
22 expertise?

23 A She had a behavioral health background. That
24 was her -- that was her subject matter expertise.

25 Q Did she have any expertise in surgery?

1 A Not professionally, no.

2 Q What about not professionally?

3 A In other words, she's never worked as a
4 surgeon or anything like that. But, I mean -- but I
5 mean -- or in the formal education in that area.

6 Q Okay. But did she have any experience with
7 surgery that would help her inform the drafting of this
8 GAPMS?

9 A I couldn't speak to that.

10 Q Did AHCA ever rely on the conclusions in this
11 report?

12 A So this report did not get past her immediate
13 supervisor, so, no.

14 Q Okay. Prior to its adoption of the
15 categorical exclusion of treatment for gender dysphoria,
16 did Florida Medicaid ever cover gender confirmation
17 surgery for the treatment of gender dysphoria?

18 A Under fee-for-service, to the best of my
19 knowledge, we didn't. In managed care, there were a few
20 instances where the managed care plan did approve the
21 procedure.

22 MS. DEBRIERE: Okay. Can we look at those
23 exhibits now? The -- I forget what they're called.
24 They're a weird name. ATTB, ATTA. It's a weird
25 name. It wouldn't come to me.

1 BY MS. DEBRIERE::

2 Q Okay. So I'm handing you -- these were
3 natives, so they were not Bates-stamped, but I'm handing
4 you documents produced to plaintiffs in discovery. They
5 were also not labeled, and I just want to ask you some
6 questions about what they mean. We'll mark that as
7 exhibit -- actually, I'll take those copies. I'm sorry.
8 Well mark this as Exhibit 9 and 10. And, I'm sorry,
9 because they're natives, they don't have Bates stamps.

10 (Whereupon, Exhibit Nos. 9 - 10 were marked
11 for identification.)

12 BY MS. DEBRIERE::

13 Q So looking at Exhibit 9 first, which is two
14 pages total, front and back.

15 MS. DEBRIERE: Seems like they -- yeah, it
16 printed out -- I see. Do I put it together? What
17 do we do?

18 BY MS. DEBRIERE::

19 Q Let's look at under service type, outpatient
20 surgery. Line item status is approve. Does that mean
21 that Florida Medicaid approved outpatient surgery?

22 A Yes, that would mean it was approved.

23 Q Okay. And the product description was
24 mastectomy with a primary diagnosis code of F649?

25 A Uh-huh.

1 Q So that means that the outpatient surgery was
2 approved for a mastectomy for a diagnosis code of F649,
3 is that correct?

4 A That's correct.

5 Q Okay. And F649, what is that diagnosis code?

6 A That's gender dysphoria.

7 Q Do you know if -- can you tell by this
8 document whether -- it appears that it was approved by
9 children's medical services under product roll-up.

10 A So based on these two -- so based on these
11 two, I can't tell if the recipient is in managed care or
12 if they're in fee-for-service. So in Exhibit 10 --

13 Q Yeah.

14 A -- this looks like this would be managed care.

15 Q Okay. And how do you know that?

16 A Because it has, like, the member effective
17 category.

18 Q Okay. If the title of both of these documents
19 had the term CMS on it, would that mean that it's
20 managed care?

21 A Children's Medical Services is overseen by
22 Sunshine Health. So, yes, it's managed care.

23 Q And looking at Exhibit 10, the Medicaid ID,
24 does that correspond to individual Medicaid recipients?

25 A Each Medicaid recipient has a unique Medicaid

1 ID assigned to them. That's correct.

2 Q Okay. And these documents are indicating that
3 there were authorizations of surgeries for primary
4 diagnosis codes of F640 and F649, is that correct?

5 A Yeah, that's correct.

6 Q Okay. And F640 is a diagnostic code for what?

7 A So F64, generally, there is a decimal point
8 after the 4. So it was F64. The way ICD-10 codes work,
9 it's kind of like a taxonomy. So F64, categorically, is
10 gender dysphoria. So F64.9 would be like a -- like a
11 subcategory of that general diagnosis.

12 Q So these documents are showing that, at least
13 in managed care, prior to the categorical exclusion --
14 prior to AHCA's adoption of the categorical exclusion
15 for the treatment of gender dysphoria, there were times
16 in which Florida Medicaid covered surgery to treat
17 gender dysphoria; is that correct?

18 A That would be correct.

19 Q Okay. Let's turn to the June 2022 GAPMS. We
20 have this exhibit. And Exhibit 11 will be the June 2nd,
21 2022 GAPMS related to the treatment of gender dysphoria.

22 (Whereupon, Exhibit No. 11 was marked for
23 identification.)

24 BY MS. DEBRIERE::

25 Q I'm going to refer to this throughout as the

1 June 2022 GAPMS.

2 A That's fine.

3 Q When was the request to initiate this GAPMS
4 made?

5 A So the formal request was made on April 20th.
6 That was the date of the Secretary's letter.

7 Q Were there any informal requests prior to that
8 time?

9 A There were some informal, I guess, indicators
10 of, you know, trying -- when they were trying to
11 determine whether or not we had bandwidth, you know, and
12 so there was some informal indicators that this project
13 would be coming down the pipeline because they were
14 trying to figure out who to do it. So we were aware of
15 the Secretary's letter it would be coming to us.

16 Q Okay. When you say they were trying to figure
17 out. Who is they?

18 A Our Agency leadership.

19 Q And who is that comprised of?

20 A So that was primarily for the Bureau of
21 Medicaid Policy, Ann Dalton was our bureau -- is still
22 our bureau chief at the time.

23 Q So Ann Dalton had knowledge of the potential
24 for this project coming down prior to April 20th, 2022;
25 is that correct?

1 A Yes.

2 Q Okay. Who else in leadership was aware that
3 this would be coming to AHCA prior to April 20th, 2022?

4 A At the time, Secretary Weida was serving as
5 Assistant Deputy Secretary. He did have knowledge.

6 Q Okay. Anybody else?

7 A To my --to my knowledge, those two were the
8 ones with the knowledge of this project.

9 Q Okay. When did you have knowledge of the
10 project?

11 A Just probably a few days before we were given
12 the letter.

13 Q Okay. So, like, April 17th?

14 A Something around there. Yeah, I don't
15 remember the exact date.

16 Q Okay. Who did you gain the knowledge -- who
17 did AHCA leadership gain the knowledge from?

18 A As far as the project goes, the decision to do
19 a GAPMS to my -- so that was to do a GAPMS report, that
20 was determined by our legal as the best route to
21 evaluate the medical necessity for treatments for gender
22 dysphoria. It was that -- it was subjected to the GAPMS
23 process.

24 Q Okay. And which counsel was that?

25 A Andrew Sheeran, who's now our General Counsel.

1 Q Okay. And who contacted -- was Mr. Sheeran
2 the first point of contact related to what eventually
3 became the June 2022 GAPMS?

4 A No, I don't think he would have been the first
5 point of contact.

6 Q Who would have been the first point of
7 contact?

8 A Generally, our first point of contact would
9 have been our General Counsel at the time.

10 Q And that was?

11 A Josephina Tamayo.

12 Q Okay. And who contacted Josephina Tamayo
13 about this project?

14 A So this project, about the GAPMS in
15 particular --

16 Q No.

17 A -- or about requesting a Medicaid review?

18 Q Requesting a Medicaid review.

19 A So that, of course, that did come down from
20 the Governor's office.

21 Q Okay. Who in the Governor's office made the
22 request?

23 A So that is -- so it was a multi-party meeting.
24 So the three staffers from the Governor's office that
25 were involved were, I think, Katie Strickland, Ryan

1 Newman and Maureen Farino.

2 Q Okay. What other agencies were involved?

3 A As far as the decision for Medicaid's review?

4 Q No, as far as that initial request coming from
5 the Governor's office. You said there was a multi-party
6 meeting.

7 A Well, between AHCA's staff and Governor's
8 office staff.

9 Q I see. Okay. What other AHCA staff were
10 present at that meeting besides Ms. Tamayo?

11 A I think at that meeting, I think Deputy
12 Secretary Weida may have been present, I think the
13 General Counsel, I think, Andrew Sheeran, may have been
14 present as well.

15 Q Okay. Anybody else present at that meeting,
16 besides those people that you just named?

17 A I can't name them with any specificity.

18 Q Okay. Were they from other agencies other
19 than the Governor's office or AHCA?

20 A So in regards specifically to this project?

21 Q Are there other projects we should be aware
22 of?

23 A Well, I -- there were, I think, some people
24 present from the Department of Health.

25 Q Regarding what project?

1 A But that was regarding their review of
2 treatments for gender dysphoria.

3 Q Based on actions related to the Board of
4 Medicine or based on CMS guidance?

5 A What do you mean -- when you say CMS, are you
6 referring to Children's Medical Services or --

7 Q No. Centers for Medicare. Great question.

8 A That guidance was actually not by CMS, it was
9 from HHS.

10 Q Excuse me, HHS.

11 A It was in regard to that guidance.

12 Q Okay. So there was some presence of
13 Department of Health there, as well, but not related to
14 Medicaid?

15 A Right.

16 Q Okay. And what was the date of that initial
17 meeting?

18 A I don't have -- know the date offhand. I
19 think it was like early April.

20 Q Okay. And at that meeting, it had not yet
21 been determined that AHCA would use the GAPMS process to
22 evaluate whether treatment for gender dysphoria was
23 experimental, is that correct?

24 A I think that -- yes, I believe that is
25 correct, based on -- based on the information we've

1 gathered, is that the decision is to route it to the
2 GAPMS process was done after that conversation.

3 Q Okay. So what was the Governor's office
4 request for the meeting?

5 A The Governor's office request was to -- in
6 response to the HHS documents, the Department of Justice
7 documents, Department of Education documents regarding
8 gender dysphoria, designing treatments for gender
9 dysphoria, the evidence for gender dysphoria, it was
10 that the Department of Health and AHCA both undertake
11 reviews.

12 Q Did the Governor's office instruct AHCA to
13 find -- did the Governor's office instruct AHCA to
14 ensure that Florida Medicaid would not cover treatment
15 for gender dysphoria?

16 A No.

17 Q Okay. Did the Governor's office make any
18 specific requests about Florida Medicaid coverage as it
19 related to the treatment of gender dysphoria?

20 A The Governor's office wanted the Agency to
21 undertake the review.

22 Q But what type of review did it want the Agency
23 to undertake?

24 A It wanted to take a look at -- a detailed look
25 at the available medical evidence, or at least the

1 peer-reviewed literature, and to see what it says.

2 Q Okay. You referenced earlier the Florida
3 Department of Health's investigation on the HHS fact
4 sheet. What did that investigation find?

5 A So the Department of Health's fact sheet, of
6 course, provide some cursory information, like go into
7 some snapshots of some literature out there, you know,
8 stating that the evidence for support -- that was
9 supporting gender dysphoria treatment was too weak for
10 this to be considered a standard treatment for that
11 condition.

12 Q Okay. And so at the time of this initial
13 meeting in early April, when there was a discussion of
14 DOH's findings, at that point there was a conclusion
15 that the information or evidence to support treatment of
16 gender dysphoria was weak?

17 MR. JAZIL: Object to form.

18 MS. DEBRIERE: I can strike that.

19 BY MS. DEBRIERE::

20 Q Why did the Governor's office want AHCA to
21 review Medicaid coverage for treatments of gender
22 dysphoria?

23 A So in response to these documents, there were
24 questions about whether or not the evidence supported
25 what HHS, DOJ and DOE was -- at least the United States

1 DOJ, United States DOE, the claims they were making.
2 They wanted to do a review to see whether or not this --
3 the evidence that's supporting was -- actually
4 sufficiently supported those claims.

5 Q Did the Governor have a specific position on
6 whether HHS' findings were accurate, prior to AHCA's
7 review?

8 MR. JAZIL: Object to form.

9 THE WITNESS: No.

10 BY MS. DEBRIERE::

11 Q Did DOH have a position on whether HHS'
12 findings were accurate prior to AHCA's review?

13 MR. JAZIL: Object to form.

14 THE WITNESS: Can you rephrase that question?

15 BY MS. DEBRIERE::

16 Q Yeah. Did DOH -- at that initial meeting,
17 what conclusions had DOH drawn about the HHS report?

18 A So DOH, they didn't -- they didn't release
19 their opinions until April 20th, the day we got the
20 letter.

21 Q Okay. But had they -- at that meeting, had
22 they formulated those opinions?

23 A To my -- based on the information given to me,
24 they had not yet formulated those.

25 Q So why did AHCA general counsel decide that

1 the best process to undertake the review was the GAPMS
2 process?

3 A Because, well, I'm speaking based on our -- on
4 how policy works is that, of course, the medical
5 necessity definition does have a prong saying that the
6 service has to be consistent with generally accepted
7 professional medical standards. So the best way to do a
8 review to either -- to determine whether or not
9 something is consistent with GAPMS is to do that,
10 undertake that review process, and that really provides
11 the best opportunity to go through the literature on a
12 large scale and to make a conclusion.

13 Q Okay. To your knowledge, had there ever been
14 a time previous where a GAPMS was used to determine the
15 experimental nature of services previously covered by
16 Florida Medicaid?

17 A To my knowledge, there was not.

18 Q So this is the first time the GAPMS process
19 was used to determine whether services that were already
20 being covered by Florida Medicaid were experimental?

21 A To my knowledge, yes.

22 Q The folks at the initial early April meeting,
23 did they reach out to HHS to get the info they relied on
24 before conducting their own review?

25 A Are you talking about the Florida Department

1 of Health folks?

2 Q Or the Governor's office, anyone involved in
3 that meeting.

4 A No, we -- with the releases, the document
5 releases from those -- from those federal agencies was
6 sufficient.

7 Q So AHCA did not reach out to HHS either?

8 A No, we had their documents. We didn't -- we
9 didn't have any need to question them on them.

10 Q In the letter you're referring to from
11 Secretary Marstiller dated April 20th, 2022, is that
12 correct?

13 A Uh-huh.

14 Q That's the letter that directed Tom Wallace,
15 the Director -- I'm sorry --

16 A State Medicaid Director, Deputy Secretary.

17 Q Thank you. That was the letter directing him
18 to undertake GAPMS related to treatment of gender
19 dysphoria, right?

20 A Yes.

21 Q Why did Secretary Marstiller's letter say that
22 she was making the request in response to DOH guidance
23 rather than a request from the Governor?

24 A Because the DOH guidance had just been
25 published.

1 Q Okay. But she was asking Mr. Wallace to
2 undertake that GAPMS process because it was a request
3 from the Governor's office, correct?

4 A A request for the state agencies to look at
5 the existing evidence and making recommendations, that
6 initially came from the Governor's office. Since I
7 wasn't physically -- since I personally was not present
8 for those meetings, I can't exactly speak to the
9 sequence, but DOH would undertake its review. And, of
10 course, once they published their guidance, we undertook
11 ours.

12 Q Okay. Just to be clear, there's a few times
13 that you said to your knowledge, but, again, you're
14 testifying as an Agency representative?

15 A Yes.

16 Q So this is to the knowledge of the Agency,
17 correct?

18 A To the knowledge of the Agency, yes.

19 Q When did AHCA begin work on the 2022 GAPMS?
20 What date?

21 A We started work on April 20th.

22 Q You didn't do anything prior to that?

23 A No. I mean, I may have done, like, an article
24 search, just to see what was out there, but as far as
25 any large-scale work goes, no, we didn't do -- we didn't

1 do anything like that.

2 Q Okay. And, again, just to be clear, no one at
3 the Agency, because you're in the capacity as an Agency
4 representative. So my question is not just about
5 whether you started anything related to the 2022 GAPMS.

6 A The Agency did not -- did not start work until
7 April 20th.

8 Q Who worked on the 2022 GAPMS at the Agency?

9 A You mean the June 2022 GAPMS?

10 Q Yes.

11 A So I was primarily the author. It was myself,
12 Devona Pickle prepared the maps of the United State
13 Medicaid programs. Nai Chen prepared the maps for the
14 internet -- for the European countries to classify who
15 covered what, but that was it. It was the three of us.

16 Q Okay. And I apologize. Can you just one more
17 time run through what everybody's roles were? You were
18 the primary author. Mr. Chen worked on the maps.

19 A Worked on the maps for Western Europe.

20 Q Okay. And what did Dede Pickle do?

21 A The maps for the State Medicaid programs.

22 Q Okay. And as primary author -- so you wrote
23 everything else except for the maps in the state
24 Medicaid coverage, then?

25 A That's correct.

1 Q Okay. And did you have any assistance?

2 A It's -- GAPMS are a solitary project, any
3 extensive research project is, because once you immerse
4 yourself in the literature, it's very difficult to have
5 assistance because you're trying to get up to -- you
6 have to transplant knowledge from yourself to them.
7 It's actually just easier to do it, to kind of sail the
8 waters on your own. And this is coming from speaking
9 from experience on, like, a myriad of research projects,
10 from scholarly articles, master's theses for, like,
11 works -- other works for the Agency, previous GAPMS
12 reports. Once you under -- once you reach a certain
13 understanding of that knowledge, it comes a point where
14 you -- it makes sense -- it's more efficient for you to
15 do it in a solitary fashion.

16 Q Okay. So you were the only one involved in
17 outlining and reviewing the literature that became the
18 June 2022 GAPMS?

19 A Yes.

20 Q Okay. Was there anyone else at the Agency --
21 so you didn't work with Mr. Chen on the literature or --

22 A Nai, he did -- he occasionally he'd find an
23 article and give it to me, but other than give me the
24 occasional article, that was -- that was it. I went
25 through, reviewed the article, like, broke it down. As

1 far as any content or analysis, he just gave me copies
2 of articles.

3 Q Okay. Okay. And so no one else at the
4 Agency -- did anybody else at the Agency take on that
5 role to where they were sending you articles or anything
6 related to that? I guess what I'm trying to determine
7 is whether anyone else assisted you with drafting?

8 A Nobody assisted me with the drafting.

9 Q Inside or outside the Agency?

10 A We did have a few consultations with some of
11 our contracted experts --

12 Q Were they a verbal consultations?

13 A They were verbal.

14 Q Only verbal?

15 A Yeah, but as far as drafting went, they
16 weren't involved in that process.

17 Q Okay. So they didn't write any of the main
18 report?

19 A They did not write any of the main report.

20 Q Or outline it or anything?

21 A No.

22 Q Okay. Looking at -- I have another exhibit,
23 the Van Mol ATF. We're going to mark this as Exhibit --
24 Exhibit 12. What is wrong with me today? And it's
25 entitled Agency for Health Care Administration

1 after-the-fact request form under 35k.

2 (Whereupon, Exhibit No. 12 was marked for
3 identification.)

4 BY MS. DEBRIERE::

5 Q So, reason for occurrences, where I'm reading
6 and second sentence to the last, due to the need to
7 start work quickly, all of the purchase order elements
8 were not available until May 6th. Why was there a need
9 to start work quickly?

10 A Since this is -- since we did have a request,
11 and since we were writing in response to the Department
12 of Health, which had already had published their
13 findings, the Agency, of course, we considered this a
14 priority project, and this was mostly that's -- that's
15 pretty much, it was a priority project.

16 Q I'm sorry. Why was it a priority project?

17 A It was priority project because in relation
18 to -- in relation to the Department Health guidelines,
19 which had been released, then, of course, because, you
20 know, as the state of Florida wanted to respond to the
21 HHS documents, which had also been released, because we
22 didn't want a significant amount of time, like, five or
23 six or seven months to elapse before the Agency had
24 gotten its response out.

25 Q Okay. So you wanted to make sure that there

1 would be a quick response to the HHS guidance?

2 A Yes.

3 Q Okay. When I say a decision tree checklist
4 for GAPMS, do you know what I mean?

5 A Are you referring to, like, to a checklist?

6 Q Yes.

7 A Yes, I do know what you're referring to.

8 Q Okay. Did AHCA do a decision tree checklist
9 for this report?

10 A So that decision tree checklist, that was a --
11 is an internal process, and each person who does GAPMS
12 often kind of brought their own unique perspective or
13 unique approach to them, since these are research
14 projects and there's not really a formula for it, but I
15 believe -- I think Jeffrey English, I think, helped to
16 develop a checklist, which I think he used when making
17 evaluations. I kind of have my own mental checklist
18 when I did them. And also, actually, I actually wanted
19 to kind of help refine, to help cut down the number of
20 GAPMS requests we had. As we started going through
21 requests, we started realizing, well, some of these
22 really aren't GAPMS, these are just coverage
23 determinations.

24 Q What -- How did you know that?

25 A Generally -- okay, well, FDA approval for the

1 clinical indication.

2 Q Okay.

3 A If a national coverage determination's been
4 released by Medicare, things like that.

5 Q Okay. What about if it was already listed on
6 AHCA's fee schedule?

7 A Not necessarily.

8 Q Why?

9 A Because -- just because it's listed on AHCA's
10 fee schedule, it does not necessarily mean that it's --
11 wouldn't be experimental or investigational for another
12 clinical indication.

13 Q So based on the checklist, if it was listed on
14 the fee schedule, that one isn't going to determine
15 whether or not it should go through GAPMS?

16 A It shouldn't, no. And that was -- when I --
17 when I did GAPMS, that was not part of my criteria.

18 Q After the checklist was developed, how many
19 GAPMS did you do?

20 A The checklist was developed well after I had
21 left that role.

22 Q Okay. So -- but we know you did the June 2022
23 GAPMS, so at least one right?

24 A Uh-huh.

25 Q Okay. After the checklist was developed, for

1 any other time that AHCA undertook a GAPMS, was a
2 checklist completed?

3 A I think there were some completed checklists
4 that I was able to find in our PDM, but that was after
5 the fact. When I embarked on this one, I was not aware
6 a checklist even existed. Not that I didn't apply kind
7 of a mental checklist when I was going through it to
8 check to see if there were certain elements in there
9 that would either come to the conclusion that this
10 shouldn't be that way through GAPMS or not.

11 Q What was your mental checklist?

12 A FDA approval for a clinical indication, which
13 would mean that there was already substantiating
14 research for it, which had been done by federal agency,
15 which would kind of render GAPMS point moot, or a
16 national coverage determination by Medicare. And the
17 national coverage determination is pretty much -- it's
18 like a Medicare GAPMS, and it's -- there aren't that
19 many NCD's out there because there's a risk involved in
20 getting an NCD, but if -- but Medicare NCD's are backed
21 by substantial amounts of research. So if there's an
22 NCD out there supporting a treatment and mandating
23 coverage for a specific service, and all the research
24 they do behind it, it kind of also -- it renders doing
25 the GAPMS moot.

1 Q Okay. Any other -- anything else on your
2 checklist?

3 A No, those were the two items I usually look
4 for.

5 Q So that's it. And then if they didn't pass
6 those two tests, they went to a GAPMS?

7 A Went to a GAPMS.

8 Q Okay. So -- I'm sorry. I just need to find
9 my place in the outline. When was the checklist
10 developed? Remind me. 2017?

11 A No, the checklist would have been developing
12 in 2019.

13 Q 2019. Okay. During the 2022 -- the start of
14 the 22 -- 2022 GAPMS, you mentioned that you were having
15 conversations with the Governor -- or there was an
16 initial meeting with the Governor's office when the
17 request was made and DOH was also present?

18 A Prior to the request being made.

19 Q After the request was made, was there any
20 communication with the Governor's office?

21 A No.

22 Q After the request was made, was there any
23 communication with the Department of Health?

24 A No.

25 Q What about HHS?

1 A No.

2 Q And what about Alliance Defending Freedom?

3 A No.

4 Q Liberty Counsel?

5 A No.

6 Q Okay. What consultants were used by AHCA in
7 the development of the GAPMS.

8 A So during the development, we have a few
9 verbal conversations with Doctors Miriam Grossman and
10 Andre Van Mol.

11 Q Okay. And what did those conversations
12 entail?

13 A Well, Dr. Van Mol, he just offered suggestions
14 for articles and research for us to look at. He did
15 provide us with a bibliography for our consideration, as
16 far as -- mostly just leads on research to help save
17 time in finding resources. And Dr. Grossman, of course,
18 she provide us with some history of gender dysphoria
19 treatments, and gave us more reviews of some scientific
20 techniques.

21 Q How did you get connected with Dr. Van Mol?

22 A So Dr. Van Mol, like all of our experts, who
23 also provide published reports, so the process for those
24 was that we did get a name at the very outset of the
25 process, which was Michelle Cretella. And by contacting

1 her, she led us to other providers -- or other
2 practitioners who had expertise in the fields, and
3 that's how AHCA made contact with these individuals.

4 Q So Michelle was the only person who connected
5 AHCA to the consultants it relied on for the 20 -- June
6 2022 GAPMS?

7 A Yeah.

8 Q Okay. And who Michelle?

9 A Michelle -- Dr. Michelle Cretella?

10 Q Uh-huh.

11 A She's a physician. I think she has some
12 affiliations with, like, a couple of -- I think American
13 College of Pediatrics, I think. I'm not sure what her
14 other affiliations are.

15 Q How did you find her?

16 A Well, her name was passed on to us from the
17 Department of Health.

18 Q Okay. What's her relationship with to the
19 Department of Health?

20 A I -- the Agency does not know what her
21 relation to the Department of Health is.

22 Q Okay. So you just accepted this
23 recommendation by the Department of Health as the person
24 who would connect you to the consultants you would use
25 to develop the 2022 GAPMS?

1 A Yes.

2 Q You didn't do any outside research on whether
3 you should seek out other consultants?

4 A Well, we were vouching for our -- for the
5 consultants. I mean and so we did want individuals who
6 had expertise in their respective fields of medicine,
7 and who also were going to take an evidence-based
8 approach.

9 Q Okay. Who at Department of Health recommended
10 Dr. Cretella?

11 A Don't -- we don't have the name of the
12 individual.

13 Q Because it was sent in an anonymous email?
14 Why don't you have the name?

15 A We can get that information for you.

16 Q So you don't have the name, but the Agency has
17 the name, correct?

18 A The Agency might have a name. We need to
19 confirm that.

20 Q And who at the Agency was this communication
21 sent to? I mean, how was it communicated?

22 A To my knowledge, it was verbal. It was a
23 verbal exchange.

24 Q Okay. So who at AHCA was part of that
25 conversation?

1 A So I think when it came down to, you know,
2 reaching out to experts and determining who the experts
3 we should use were, I think Andrew Sheeran and Jason
4 Weida were involved.

5 Q Okay. So it was either Andrew Sheeran or
6 Jason Weida who received that information from the
7 Department of Health related to Dr. Cretella?

8 A Yes.

9 Q Could it have been anybody else at the Agency?

10 A I don't think so. I mean --

11 Q It seems like you have a name in mind.

12 A Well, I mean, there were other senior leaders.
13 The Secretary may have been given the name, or Chief of
14 Staff may have been given the name, so, but --

15 Q Who was the chief of staff?

16 A Cody Farrell.

17 Q And who was the person who spoke with Dr.
18 Cretella about her recommendations?

19 A I think -- I think Andrew Sheeran and Jason
20 spoke about that -- spoke to them about the
21 recommendations.

22 Q And she recommended everyone, is that correct?

23 A Well, she -- from what I gathered, there was,
24 like, recommendations. She gave some names. And not
25 everyone she recommended, of course, we decided to go

1 with. So there were some that we did turn down.

2 Q Who did you turn down?

3 A We can get that -- we can get that -- we can
4 get those names for you.

5 Q With Dr. Cretella, was there any consideration
6 given to the associations, the medical associations of
7 which she was a member?

8 A No.

9 Q Okay. So you didn't look to see if she was
10 associated with any particular medical association?

11 A No.

12 Q You just went off the recommendation of
13 Department of Health?

14 A Yes.

15 Q Was Dr. Cretella paid for her assistance
16 with -- to AHCA?

17 A No.

18 Q So DOH didn't pay her or anything?

19 A Well, I don't know at DOH, that's a question
20 for the Department of Health. AHCA did not -- we did
21 not establish a financial arrangement with her.

22 Q Okay. Are you -- are you personally aware of
23 any financial arrangement between Dr. Cretella and
24 Department of Health?

25 A No.

1 Q Okay. I'm sorry. Who did you turn down?

2 A We would have to get those for you.

3 Q Okay. And so Dr. Grossman and Dr. Van Mol
4 just gave you some article leads, and that's all?

5 A Gave some article leads, some background
6 information. Yeah, it was -- I mean, as far as
7 providing us with content to include in the report, they
8 did not.

9 Q Why not?

10 A Because it was an independent assessment by
11 the Agency.

12 Q Okay. Did -- but they didn't write any of the
13 reports that were in the attachments to the June 2022
14 GAPMS either?

15 A Right?

16 Q Why not?

17 A I think because we had experts. We already
18 had a psych -- one psychologist who was writing one. We
19 already had -- we, of course, we had physicians for,
20 like, plastic surgery. We had a bioethicist, as well.
21 Since those bases were covered, we felt they would best
22 benefit us by helping provide guide -- guidance with
23 research.

24 Q Were they ever given the option of writing a
25 report for one of the attachments?

1 A No, we didn't ask them to write a report.

2 Q Okay. Did they ask if they could write a
3 report?

4 A No, they did not.

5 Q How did you identify Dr. Romina
6 Brignardello-Petersen?

7 A So through the contacts we were making, her
8 name was passed on to us as someone at McMaster
9 University who had some experience in doing evidence
10 evaluation.

11 Q Did Dr. Cretella pass on that name?

12 A As far as the actual contact that gave us that
13 name?

14 Q Uh-huh.

15 A Dr. Cretella was kind of the head of the tree
16 of the contacts. We would have to go back and get that
17 information on who gave us the exact name for Dr.
18 Brignardello-Petersen.

19 Q Okay. But Dr. Cretella was the one who -- so
20 what -- if Dr. Cretella didn't recommend Dr.
21 Brignardello-Petersen, who would have?

22 A We would have to get that information for you.

23 Q Would it have been another physician?

24 A Yes, it likely -- yes, it would have probably
25 been another physician.

1 Q What other physicians provided recommendations
2 for consultants?

3 A We would have to get that information.

4 Q What all physicians did you talk to you prior
5 to -- or in the process of drafting the --

6 A So in the process of drafting the report, we
7 really -- we talked to Doctors Grossman, Van Mol. There
8 were a couple conference calls with the experts who
9 provided the reports, but those weren't about our
10 report, that was just mostly more -- that was talking to
11 them about them doing their reports.

12 Q Okay. So who recommended Dr. Cantor?

13 A We -- that may have been Dr. Cretella who had
14 recommended him. We would need to confirm that.

15 Q Okay. So, again, just pointing to topic 24 in
16 the notice of deposition, we asked for an Agency
17 representative who was knowledgeable as to --

18 MS. DEBRIERE: No, no. I just don't know
19 what -- I have no idea where it is.

20 BY MS. DEBRIERE::

21 Q So looking at topic 24, and we asked very
22 specifically about the identification of Dr.
23 Brignardello-Petersen, Dr. Cantor, Dr. Van Meter, Dr.
24 Lappert, Dr. Donovan, in the inclusion of the written
25 assessment. So I don't know what to say. I mean, it

1 seems like you're not able to answer the question.

2 MR. JAZIL: So, counsel, the topic says the
3 process by which AHCA prepared the memo, and I read
4 that to mean the process by which we identify these
5 experts. And so he's detailed the process. It was
6 an initial consultation with one physician, and
7 then it was -- one person recommends another,
8 recommends another. And I think he said that a lot
9 of these were oral. To the extent that we have any
10 written records of who specifically said, hire Dr.
11 Romina Brignardello-Petersen, we'll supplement the
12 production with that.

13 MS. DEBRIERE: Other than written records, Mo,
14 can you get us -- can you just do an investigation
15 of who spoke with these individuals and collected
16 this?

17 MR. JAZIL: So who -- so I think he's answered
18 that, it was General Counsel's Office, and it's now
19 Secretary Weida, who spoke to these individuals.
20 If the question is who specifically recommended
21 each expert --

22 MS. DEBRIERE: Yes.

23 MR. JAZIL: -- I'll ask. And if there's a
24 written record, it would have been turned over to
25 you already. If there's an oral record, beyond

1 what he's talked about, well --

2 MS. DEBRIERE: If someone knows. Because if
3 someone knows at the Agency --

4 MR. JAZIL: -- you know, Bob talked to Jill,
5 Jill talked to Jane, Jane talked to Jason and said,
6 hey, hire Brignardello-Petersen, I'll get that
7 information for you.

8 MS. DEBRIERE: Thank you.

9 BY MS. DEBRIERE::

10 Q Whose decision was it to engage with Dr. Van
11 Meter? I'm sorry. Who recommended Dr. Van Meter? I
12 apologize.

13 A That's information we would have to --

14 Q So you don't know who recommended any of these
15 individuals other than Dr. Cretella?

16 A Right.

17 Q Okay. When did AHCA first become aware of the
18 HHS fact sheet on gender-affirming care in young people?

19 A We became aware of it, since we do follow HHS
20 publications, much of our staff in Medicaid, so forth,
21 they are actually on -- they receive automatic updates,
22 so we became aware of them as they came out.

23 Q What was AHCA's independent reaction to the
24 fact sheet?

25 A Well, as the Agency initially didn't -- didn't

1 have a reaction. There was -- we didn't -- we don't
2 react publicly to HHS documents.

3 Q Okay. So did AHCA -- you stated in your
4 declaration filed with the court on January 23rd -- are
5 you aware of what I'm talking about? I can get you a
6 copy, if not.

7 A I should be aware of it. I've reviewed it.

8 Q Okay. That litigation was highly likely
9 because in drafting the GAPMS report, the GAPMS
10 determination might conflict with federal standards. Do
11 you remember saying that?

12 A Yeah. If I -- yeah, I mean, it's written and
13 signed off on, then, yes.

14 Q Okay. With what federal standards, did you
15 think it might conflict?

16 A Well, it might -- it would probably conflict
17 with that guidance that was released from HHS.

18 Q Any other federal standards?

19 A No.

20 Q Why did you think it would conflict with the
21 guidance from HHS?

22 A Because the guidance from HHS, the conclusions
23 we made -- that we made following an independent
24 assessment, conflicted with the HHS guidance. The HHS
25 guidance did state that these were, like, medically

1 necessary treatments, that evidence supporting them, so
2 that they would alleviate mental health systems
3 symptoms, et cetera. Our concluded -- our conclusions
4 and our assessment of literature deemed otherwise, so we
5 knew that there would be a potential conflict.

6 Q At what point did you realize that there would
7 be a potential conflict?

8 A When we -- during the drafting process. So we
9 realized that the evidence was inadequate to support the
10 claims that HHS was making, or that -- that's when we
11 realized that there would be -- there would be a
12 conflict.

13 Q Okay. Did you anticipate that the GAPMS
14 report would conclude that the relevant services were
15 experimental?

16 A When I started working on it, I did not know
17 where the evidence would take me.

18 Q At what point did you realize that you were
19 going to conclude that the services were experimental?

20 A As -- the more and more I read the articles
21 that focused on the mental health benefits, the methods
22 and so forth, the more I realized that all those
23 articles left way too many unanswered questions.
24 This -- there was also -- there wasn't any evidence
25 available to answer those outstanding questions. I

1 realized that I couldn't -- that there was not going to
2 be -- that the conclusion was going to be, no, it was
3 not consistent.

4 Q Okay. So your analysis of those services. So
5 I think one of your concerns related to the treatment of
6 services for gender dysphoria that is now excluded under
7 59-G-1.050(7), was that the services were not supported
8 by randomized controlled trials, is that correct?

9 A That was one element of many elements.

10 Q Okay. Does AHCA ever require that -- does
11 every -- does AHCA require that every treatment or
12 procedure it covers be supported by randomized
13 controlled trials?

14 A So to contextualize that question, every
15 medical service is unique. So we don't apply a uniform
16 set of standards to every single medical service,
17 because every single medical service is for a specific
18 condition, every medical service carries its own pros
19 and cons, risks versus benefits. So we don't
20 necessarily -- we don't have a one-size-fits-all model
21 for evaluating each and every medical service.

22 Q You mentioned unanswered questions as you were
23 reviewing the literature for treatment of gender
24 dysphoria, or the services you were analyzing. What
25 were those?

1 A So those are iterated in the GAPMS report, but
2 generally like -- well, number one, long-term. And
3 other unanswered questions, like a lot of these studies
4 were based on anonymous surveys. How are we supposed to
5 know whether or not these responses are credible, if we
6 don't have any longitudinal history of these
7 individuals? I mean, one of the things that we came up
8 with when we were doing the literature review is the
9 etiology. There are lots of potential causes and
10 associations with gender dysphoria, not -- not including
11 but not limited to autism, trauma, neglect, abuse,
12 abandonment, things like that. So because there was so
13 many unanswered questions, I mean, how are we supposed
14 to know whether or not a one-time survey is going to
15 accurately capture all of that, especially if it's
16 done -- being taken by anonymous people, or if the
17 survey -- or for those that weren't anonymous, the
18 sample sizes were very, very small. So and, of course,
19 you're talking about one- or two-year periods. These --
20 the changes prompted by these treatments are permanent.

21 Q Did you adopt any of the conclusions about
22 treatment for gender dysphoria relied upon by the
23 American Academy of Child and Adolescent Psychiatry?

24 A The American College of -- can you repeat
25 that?

1 Q American Academy of Child and Adolescent
2 Psychiatry. I think it's AACAP.

3 A No, I don't recall we -- us using their
4 recommendations.

5 Q What about the American Academy of Family
6 Physicians?

7 A No, we didn't use theirs.

8 Q What about the American Academy of Pediatrics?

9 A We did do an evaluation of theirs.

10 Q Did you rely on them, their conclusions?

11 A So what do you mean by --

12 Q Did you -- did you lend credence to their
13 conclusions?

14 A Yeah, yeah. It was -- their conclusions
15 required thoughtful analysis and probing of the
16 evidence. We do take the recommendations of clinical
17 organizations very seriously, but we also do reserve the
18 right to question those recommendations and we did
19 review those and we did analyze them.

20 Q And after you reviewed and analyzed them, did
21 you adopt them?

22 A No, we found that they were based on very weak
23 evidence.

24 Q Okay. What about the American College of
25 Obstetricians and Gynecologists?

1 A No. I mean -- I mean, there -- we didn't --
2 so, aside from AAP, we did notice, like most of the
3 recommendations, guidelines, were very, very similar,
4 very straightforward, and they usually are based on
5 Endocrine Society and WPATH guidelines.

6 Q And did you adopt the recommendations from the
7 Endocrine Society and the Pediatric Endocrine Society?

8 A No, we did not. We did review those in close
9 detail, though, and analyze them.

10 Q What about -- I'm sorry. The other WPATH?

11 A Yes. So the World Professional Association
12 for Transgender Health, we did closely review their
13 guidelines. We did -- we did analyze them. And, of
14 course, we do discuss them in lengthy detail in multiple
15 areas of the GAPMS report.

16 Q And ultimately you disagreed with their
17 standards?

18 A Ultimately, yes.

19 Q What about the American Psychiatric
20 Association?

21 A I think we actually didn't make reference to
22 them in the GAPMS report.

23 Q Did you adopt their conclusions related to the
24 treatment of gender dysphoria?

25 A No, we did not.

1 Q What about the American Psychological
2 Association?

3 A No, we did not.

4 Q American Medical Association?

5 A We did not.

6 Q When you say we, you mean --

7 A The Agency.

8 VIDEOGRAPHER: Excuse me, counsel. Sometime
9 soon, I need to take a short --

10 MS. DEBRIERE: Oh, yes.

11 VIDEOGRAPHER: -- to start the next video. Do
12 you want to take a break? We could take a -- do
13 you want to take a 30-minute lunch break or --

14 THE WITNESS: I'm good with that, yeah.

15 VIDEOGRAPHER: Okay. This concludes video two.
16 The time is 12:42 p.m.

17 (Whereupon, the deposition resumes in Volume
18 2.)

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CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF LEON)

I, the undersigned authority, certify that the above-named witness personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 21st day of February, 2023.



DANA W. REEVES
NOTARY PUBLIC
COMMISSION #GG970595
EXPIRES MARCH 22, 2024

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CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, DANA W. REEVES, Professional Court Reporter, certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages, numbered 5 through 120, are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 21st day of February, 2023.



DANA W. REEVES
NOTARY PUBLIC
COMMISSION #GG970595
EXPIRES MARCH 22, 2024

1 Gary V. Perko, Esq.
gperko@holtzmanvogel.com

2
3 February 21, 2023
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5 RE: August Dekker, et al. vs. Jason Weida, et al.
6 February 8, 2023/Matthew Brackett/5696545
7

8 The above-referenced transcript is available for review.
9 The witness should read the testimony to verify its
10 accuracy. If there are any changes, the witness should
11 note those with the reason on the attached Errata Sheet.
12 The witness should, please, date and sign the Errata
13 Sheet and email to the deposing attorney as well as to
14 Veritext at Transcripts-fl@veritext.com and copies will
15 be emailed to all ordering parties. It is suggested
16 that the completed errata be returned 30 days from
17 receipt of testimony, as considered reasonable under
18 Federal rules*, however, there is no Florida statute to
19 this regard. If the witness fail(s) to do so, the
20 transcript may be used as if signed.
21
22
23
24
25

Yours,

Veritext Legal Solutions

*Federal Civil Procedure Rule 30(e)/Florida Civil
Procedure Rule 1.310(e).

1 August Dekker, et al. vs. Jason Weida, et al.

2 February 8, 2023/Matthew Brackett

3 E R R A T A S H E E T

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18 REASON _____

19 Under penalties of perjury, I declare that I have read
20 the foregoing document and that the facts stated in it
21 are true.

22 _____

23 _____

24 Matthew Brackett

DATE

25 _____

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate.

The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1,

2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES

OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO. 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiffs,

vs.

JASON WEIDA, et al.,

Defendants

_____/

Volume 2, Pgs. 125 - 261

VIDEOTAPED DEPOSITION OF: MATTHEW BRACKETT

AT THE INSTANCE OF: THE PLAINTIFFS

DATE: FEBRUARY 8, 2023

TIME: COMMENCED: 1:30 P.M.

LOCATION: AGENCY FOR HEALTH CARE
ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FLORIDA 32308

REPORTED BY: DANA W. REEVES
Court Reporter and
Notary Public in and for
State of Florida at Large

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24

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*Uh-uh is a negative response
*Uh-huh is a positive response

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D E P O S I T I O N

Whereupon,

MATTHEW BRACKETT

was called as a witness, having been previously duly sworn to speak the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

VIDEOGRAPHER: This is beginning of video three. The time is 1:30 p.m. We're on the record.

EXAMINATION

BY MS. DEBRIERE::

Q So prior to break, we were talking a little bit about Dr. Van Mol and Dr. Grossman's involvement in the 2022 GAPMS. How did AHCA identify them to participate in the July 8th rule hearing that was related to?

A So the -- are we talking about the rule hearing?

Q Yes, related to the June 2022 GAPMS.

A So since we had already been working with them in relation to the GAPMS project, because Dr. Grossman is a psychiatrist, and Dr. Van Mol is a family -- family practice practitioner, that's based on their backgrounds and their knowledge of the existing evidence, that was our basis for selecting them to be on the panel for the July 8th hearing.

1 Q And turning back to the individuals who wrote
2 reports for the June 2022 GAPMS, who made the decision
3 to contract with them to prepare those reports?

4 A So after establishing each one, we wanted
5 to -- their backgrounds and their suitability to provide
6 reports, that decision was made by, I think, now
7 Secretary Weida.

8 Q And who was involved in determining whether
9 they had the appropriate backgrounds to write the
10 reports?

11 A So I think those individuals who were working
12 with the experts, I think that was, of course, now
13 Secretary Weida, I think at our time, General Counsel
14 Josephina Tamayo.

15 Q Okay. Anybody else?

16 A I don't --

17 Q Were you involved?

18 A I was not.

19 Q Was Nai Chen involved?

20 A He was not.

21 Q Was Dede Pickle involved?

22 A She was not.

23 Q Okay. So now Secretary Weida and Josephina
24 Tamayo were the two people who decided whether the
25 consultants who read the reports were qualified to do

1 so?

2 MR. JAZIL: Object to form.

3 THE WITNESS: So are you asking that whether or
4 not those two only assessed their credentials?

5 BY MS. DEBRIERE::

6 Q Yes.

7 A I mean, yeah. I mean, they assessed their
8 credentials and looked at their background and
9 experience and knowledge.

10 Q Were those the only two people that assessed
11 their credentials before deciding whether to engage
12 them?

13 A In regarding the Agency, I mean, the -- Andrew
14 Sheeran may have been involved. So it's possible a
15 couple others with the principal decision to rely on
16 those experts was theirs.

17 Q Okay. And so just to be clear, you were not
18 involved in that decision?

19 A I was not involved in that decision.

20 Q And Nai Chen was not involved in that
21 decision?

22 A That's correct.

23 Q And Dede Pickle was not involved in that
24 decision?

25 A Correct.

1 Q When making that decision, did AHCA
2 investigate whether any of the consultants had a stance
3 related to the treatment of gender dysphoria?

4 A We, of course, were looking for those that
5 had -- were knowledgeable about the existing literature
6 of gender dysphoria, and those who would, for the
7 supplemental reports, would take an evidence-based
8 approach.

9 Q Did it -- so those were the only two criteria
10 that you used to determine which consultants you would
11 engage with?

12 A Correct.

13 Q And so opposition to gender-affirming care was
14 not a factor in who you chose?

15 A We were specifically looking -- I think we
16 might be talking semantics on what we consider
17 opposition, but we were looking for individuals who were
18 going to make reports and recommendations based on the
19 existing evidence.

20 Q Okay. Was whether the vendor had experienced
21 treating -- I'm sorry. Was whether the consultant had
22 experienced treating gender dysphoria a factor?

23 A Not so much a factor that would outweigh the
24 knowledge of the existing literature and the evidence,
25 since this was going to be a -- the GAPMS process really

1 takes into account peer-reviewed literature. It takes
2 into account evidence-based clinical guidelines, et
3 cetera, so those are our primary -- our primary factors
4 in evaluating the experts and their ability to
5 contribute to this report.

6 Q Would people who actually provide treatment in
7 gender dysphoria be most familiar with peer-reviewed
8 literature as it relates to their practice?

9 A Well, that is a complicated question. They
10 don't necessarily have to be. It's possible to -- I
11 mean, it is possible -- I mean, it is hypothetically
12 speaking, someone could engage in treatment of these
13 individuals and run and follow anecdotes.

14 Q So it's not important to AHCA that the
15 consultants with whom you engaged had actual experience
16 treating gender dysphoria?

17 A So based on how the GAPMS rule is written, the
18 needs of the report, we really -- the primary ask was
19 for individuals who were steeped in the evidence.

20 Q But didn't necessarily have actual real life
21 experience treating gender dysphoria?

22 A Right, that wasn't a primary consideration.

23 Q Okay. For -- was AHCA aware that all the
24 consultants with which you engaged took a stance to
25 oppose mainstream medical organizations' stance on

1 gender-affirming care?

2 MR. JAZIL: Object to form.

3 THE WITNESS: So are you talking about in
4 opposition or in contradiction?

5 BY MS. DEBRIERE::

6 Q Contradiction.

7 A We -- whether contradiction or alignment
8 really was irrelevant, it really was taking a look and
9 making evidence-based conclusions.

10 Q Speaking to Dr. Brignardello-Petersen -- I'm
11 sorry. I'll start here actually. In deciding on
12 whether to use these consultants, was any input provided
13 from the Alliance Defending Freedom?

14 A No.

15 Q What about the Heritage Foundation?

16 A No.

17 Q Liberty Council?

18 A No.

19 Q Society for Evidence-Based Gender Medicine?

20 A We may have gotten Romina's name from that
21 organization.

22 Q Okay. And what about the Family Christian
23 Coalition?

24 A No.

25 Q Did you get anybody else's name from the

1 Society for Evidence-Based Gender Medicine?

2 A Because the -- because it was verbal
3 conversations, so don't -- don't think so, but the kind
4 of details -- because there's a lot of verbal
5 conversations and no written record, so --

6 Q Maybe?

7 A It could be a maybe at best.

8 Q And did the Family Christian Coalition
9 recommend any of -- or play any role in the
10 recommendation of the consultants --

11 A No.

12 Q -- with AHCA engaged? What about the Florida
13 Citizens Alliance?

14 A No.

15 Q The Florida Department of Health?

16 A Well, the Florida Department of Health passed
17 along to the name of Dr. Michelle Cretella. So, yes.

18 Q What about the Governor's office?

19 A No.

20 Q The Surgeon General Ladapo?

21 A Well, he would be acting in his capacity as,
22 of course, the agency head for the Department of Health.
23 So the Department of Health, cumulatively, gave us that
24 name.

25 Q Did he personally?

1 A There was a conversation, like, once with our
2 general counsel Tamayo at the time with Dr. Ladapo, but
3 we don't recall whether or not the name was given during
4 that conversation.

5 Q I think you touched on this a bit earlier, so
6 I apologize for circling back around, but did AHCA
7 consider using any other consultants in the development
8 of the June 2022 GAPMS?

9 A By any other --

10 Q Other than those that wrote the reports or
11 Grossman or Dr. Van Mol?

12 A There were those who were contacted. Of
13 course, there was -- it was all verbal conversations,
14 but not necessarily -- not necessarily considered to
15 write a report either.

16 Q And do you remember who you were -- who you
17 contacted?

18 A Since it was all through verbal conversations,
19 it was eight months ago, it wasn't through written
20 correspondence, the -- we're not really aware of all
21 those details.

22 Q And who was the one who did the contacting?

23 A The contacting was done, I think -- I think by
24 Andrew Sheeran. He's now our General Counsel. I think
25 Josephina Tamayo -- Tamayo. Sorry. I think she also

1 was involved in contacting them.

2 Q Okay. And those were all phone calls?

3 A These were verbal conversations, yes.

4 Q So no communication by email?

5 A No.

6 Q Did you use the folks who ended up not
7 offering the reports -- aside from Dr. Van Mol and Dr.
8 Grossman and the individuals who authored the reports,
9 did you use the people that you contacted in any other
10 capacity?

11 A No.

12 Q And what was the scope of the agreement
13 between AHCA and each consultant?

14 A So each consultant, of course, they provide us
15 their hourly rate. We wrote up purchase agreements that
16 those amounts cannot exceed \$35,000 because of the
17 nature of the procurement.

18 Q Can you speak a little bit more to that? I'm
19 not -- I'm unfamiliar with the way that -- the
20 regulations that govern that.

21 A So if it were to exceed \$35,000, it would have
22 to be a competitive procurement, and that's why -- so
23 the -- so we, of course, we enter in agreements with
24 each of these experts. The amounts paid to them cannot
25 exceed 35,000.

1 Q Okay. What was each vendor -- in procurement
2 of consultants, was this the usual procedure? I'm
3 sorry. In contracting.

4 A Yeah, this is the procedure that we can
5 follow.

6 Q That you can follow, but is it the usual
7 procedure?

8 A Well, I mean, what is defined by a usual
9 procedure? I mean --

10 Q How many times in prior GAPMS have you
11 contracted with a consultant to develop the GAPMS?

12 A Well, we haven't, but then there are
13 instances -- I know with coverage determinations, et
14 cetera, that sometimes we will actually send stuff for a
15 physician review, like over at EQ Health Solutions. So
16 it's not unusual for us to ask for medical experts or
17 clinical expertise on a prospectus.

18 Q Had you ever previously contracted and paid
19 the person for that clinical expertise?

20 A No, we had not.

21 Q What was the total budget allocated to the
22 development of the GAPMS?

23 A You know, 35,000 times seven. That'd be
24 210 -- 245,000.

25 Q So each consultant is capped at --

1 A That was the cap of the budget.

2 Q And is that 34,999, or 35 straight?

3 A I'm leaning towards 34,999, so we can subtract
4 \$7 from that amount.

5 Q Okay. Has each consultant been paid in full
6 for that work?

7 A Each consultant has been paid in full for the
8 work they completed.

9 Q Okay. Some of those consultants now, though,
10 are acting as experts in this case and being reimbursed
11 for that, as well?

12 A Those would be under separate agreements.

13 Q Okay. In the example you just gave about
14 using outside physician consultants for the other GAPMS,
15 did AHCA pay those other consultants?

16 A For other GAPMS? Those consultants are
17 usually salaried or have hourly rates from our
18 subcontractors.

19 Q Okay. Okay. But you didn't enter into any
20 kind of vendor agreement with them?

21 A No, they're already employed by one of our
22 subcontractors.

23 Q Okay. Did all of the \$35,000 paid to the
24 vendor -- paid to the consultants come directly from
25 AHCA?

1 A Yes.

2 Q Was AHCA reimbursed by anyone else for those
3 consultant payments?

4 A No.

5 Q Other than through its subcontractors, has
6 AHCA ever previously retained outside consultants to
7 undertake a review of the evidence-based clinical
8 practice guidelines for GAPMS?

9 A Well, previously, we did actually have -- of
10 course, we discontinued it, but we did have PAYS, which
11 was back -- and we had it throughout 2017 -- which was a
12 course and evidence review guide program that I had to
13 subscribed to. We did have that and often referenced
14 that in the early days, but after the amount of time,
15 and because it was an expensive subscription, we
16 discontinue it.

17 Q So that was a subscription service. Do you --
18 can you recall any time that you engaged with an outside
19 consultant, other than those employed by your
20 subcontractors?

21 A No.

22 Q What about to undertake a review of
23 professional literature?

24 A No.

25 Q To actively participate by making a

1 recommendation or assessment as to the experimental or
2 investigational nature of the service?

3 A No.

4 Q Why didn't you use the subcontractors -- AHCA
5 subcontractors, why didn't you rely on their expertise
6 in developing the June 2022 GAPMS?

7 A Because of this GAPMS and because of the
8 nature of the subject. We did anticipate litigation
9 after -- once the report was done and once we were
10 working on it. So because of that anticipation, we
11 needed to have experts that were -- that did have a
12 degree of expertise in this field. Our subcontractors,
13 their practices are more like general practitioners, or
14 may be specialized in other areas, and they wouldn't be
15 able to adapt quickly enough to the learning curve to
16 provide a valuable assessment.

17 Q So you were concerned about attacks litigation
18 might have on the integrity of that report itself?

19 A Can you repeat that?

20 Q Well, you said that because you anticipated
21 litigation, that's why you engaged with consultants who
22 had expertise, in particular --

23 A The Agency needed as robust a report as
24 possible. So because we needed such a robust report,
25 and because of the HHS guidance, the Department of

1 Health, so the fact that there were published documents
2 out there, the Agency did need to come up with a
3 response that we needed to disseminate as robust as
4 possible, and that's why we engaged with the outside
5 experts.

6 Q Why is gender-affirming care different from
7 any other Medicaid service?

8 A Well, I'm going to defer to GAPMS process and
9 our GAPMS report. For -- for the response to that is
10 that gender-affirming care, of course, we are looking
11 at, like, a treatment model that has very weak and
12 low-quality evidence supporting it. And because we did
13 a review and assessment of the literature, because there
14 are a lot of claims made, especially by HHS, in
15 particular, about its efficacy, because of its nature,
16 because of -- and because of the low-quality evidence,
17 that's how we deemed it. I mean, it is a different sort
18 of care than we can consider traditional.

19 Q The GAPMS process is used to determine whether
20 a Medicaid service is experimental, right?

21 A Yes.

22 Q So then that question is presented in any
23 Medicaid service you're evaluating under GAPMS?

24 A That's right.

25 Q So why is gender-affirming care different?

1 A I'm going to defer to the conclusions we drew
2 in the GAPMS report.

3 Q Why did you anticipate litigation before you
4 even reached a decision?

5 A Well, I think that's because, I mean, this is
6 often a very touchy subject. It's something that's
7 frequently seen in the mainstream media. And, of
8 course -- of course, the documents from HHS. It is a
9 high-profile issue. It's considered by many to be
10 controversial. So that should -- that's kind of why we
11 did anticipate potential litigation resulting from
12 whatever determination we made.

13 Q Why didn't you need gender dysphoria experts
14 from the prior gender dysphoria GAPMS?

15 A For the prior ones?

16 Q Uh-huh.

17 A So for the prior ones, I think at the time --
18 I mean, we have to take it in context at the time, and,
19 of course, these were done piecemeal, these were all
20 separate reports, not one large one. So in the
21 course -- at the time because this wasn't viewed as far
22 as a potential hot topic, there wasn't the HHS guidance
23 at the time, that's -- I think the best explanation as
24 far as to why we decided not to engage with consultants.

25 Q HHS releases guidance all the time, though,

1 about coverage?

2 A Uh-huh. That's correct. It does.

3 Q Did you anticipate litigation for the 2016
4 GAPMS memo on puberty suppression therapy?

5 A The staff of the Agency who were present for
6 that determination are no longer with the Agency, so we,
7 in our current capacity, can't speak to that.

8 Q Did you undertake any research to derive an
9 answer for that question?

10 A No, we didn't.

11 Q Did you look at any past memos related to
12 whether or not the GAPMS might have litigation
13 initiated?

14 A It's always a concern with every coverage
15 determination and every GAPMS we do because inevitably,
16 if we do say no to a service, there's going to be
17 disappointed party. So it is a consideration we always
18 have in place that there might be litigation.

19 Q Well, then that brings me back to the question
20 as to why gender-affirming -- why this GAPMS is
21 different?

22 A Well, this brings us back to the present
23 circumstances behind how much attention the subject's
24 been drawing in the media. The -- and it goes back also
25 to the HHS guidance, which was making claims based on

1 evidence that we determined was insufficient.

2 Q So I only listen to NPR, I'll be honest. I
3 don't watch any news. What media? Where's this a hot
4 topic in the media?

5 A Oh, I mean, let's see here. I mean, we can
6 name a lot of sources. I also -- I do listen to NPR
7 myself. So NPR actually does periodically have an
8 article on it. Then, of course, let's see here, there's
9 quite a few other sources of things listed here. CNN,
10 MSNBC, ABC, NBC. Your major outlets. New York Times.
11 The Guardian.

12 Q How long has the media coverage been going on
13 for?

14 A So as far as media coverage goes, well, the
15 media coverage, there's always been smatterings of it
16 here and there, but I think when -- as far as it
17 becoming a consistent theme probably the past year. But
18 that's not me speaking on behalf of the Agency, that's
19 me speaking from personal observation.

20 Q Okay. Fair enough. Did AHCA share any of the
21 draft consultant reports with external entities?

22 A We did not.

23 Q The Governor's office?

24 A We did not.

25 Q Department of Health?

1 A We did not.

2 Q No one?

3 A No, they stayed internal.

4 Q Did AHCA provide any material to the
5 consultants to review in drafting their reports?

6 A No, we did not.

7 Q Did AHCA edit the reports of the consultants?

8 A There was some copy editing for style and
9 grammar. Other than that, no, we did not make edits to
10 the content.

11 Q So no substantive edits?

12 A No substantive edits.

13 Q And that includes Lappert's report?

14 A That includes Dr. Lappert's report.

15 Q And Dr. Donovan's report?

16 A And that's for Dr. Donovan.

17 Q And did any of the consultants provide edits
18 to the AHCA GAPMS report?

19 A So after we finished the draft, we did send
20 drafts to Doctors Grossman and Dr. Van Wol and they
21 provided some feedback, but none of the feedback met --
22 were made -- resulted in drastic changes. I think -- I
23 think Dr. Van Mol suggested we -- there's one more
24 article we could discuss, and we added some content in
25 there regarding that. They did help us correct some

1 terminology errors. There are some -- so there are some
2 technical edits that were made. But as far as anything
3 substantive, my first draft, I mean, was largely intact
4 by -- from the first draft process to when we had the
5 final draft.

6 Q Okay. And you were the only person involved
7 in making the first draft?

8 A I can articulate a little bit more on how that
9 went. So while the experts -- while the experts were
10 composing their reports, I was composing mine. And once
11 we had their reports, then that was -- then we did
12 add -- we added some snippets from their reports in our
13 report to make it more, I guess you could say,
14 cumulative.

15 Q Okay. So only after the consultants who wrote
16 a report, those reports were done, then you pulled some
17 of that information into your --

18 A Correct. So my section was complete when we
19 started receiving their reports.

20 Q Okay. Okay. What was the date of your first
21 draft?

22 A I think the date of my first draft -- let's
23 see here -- want to say early to mid May.

24 Q Okay. So, like, second week of May-ish?

25 A Somewhere around there, yeah.

1 Q Going back to the edits that the consultants
2 provided to your report, what terminology had to be
3 corrected?

4 A What was it? I mean, it was some medical
5 terminology. I don't remember the specifics. I mean,
6 it was very, like, miniscule changes.

7 Q Where they red lines in, like, a Word
8 document?

9 A No, the edits were given to me verbally and I
10 made them -- sometimes I made them right there when we
11 were talking to them.

12 Q Okay. You stated in your declaration filed
13 with the court on January 25th, 2023, that the only
14 sources you relied on for the June 2022 GAPMS, were
15 those cited in the works cited section of the report; is
16 that a correct statement?

17 A That's correct.

18 Q So that means that the only sources that you
19 consulted or considered -- or cited in the June 2022
20 GAPMS report?

21 A During the -- yeah, during the writing of the
22 GAPMS, those were the sources consulted.

23 Q Nothing else?

24 A During the drafting of the report, nothing
25 else.

1 Q What about after?

2 A Afterwards, more out of intellectual
3 curiosity, I did want to try to see what else was out
4 there, but that was more for personal intellectual
5 curiosity than it was for professional purposes.

6 Q Okay. What were those things that you
7 reviewed?

8 A Articles by Jack Turban.

9 Q Can you spell his last name?

10 A T-U-R-B-A-N.

11 Q I'm not familiar.

12 A Well, it's -- he is cited in our report, but
13 he also is -- he's frequently quoted a lot, so I was
14 curious to see what other in print articles he had
15 produced.

16 Q Quoted in what?

17 A He's often cited in, like, news stories,
18 media.

19 MS. DEBRIERE: Simone just got a note that
20 folks are having trouble hearing me.

21 BY MS. DEBRIERE::

22 Q All right. When you were considering whether
23 the services listed at 59-G-1.050(7) were experimental,
24 did you evaluate whether excluding those services would
25 be budget neutral?

1 A No, we did not.

2 Q Did you consider whether private insurance
3 covers the services excluded by 59-G-1.050(7)?

4 A For this one we didn't, but primarily when we
5 do GAPMS, we really aren't interested in public and
6 private insurers. We're primarily interested in state
7 Medicaid programs and Medicare since, like, Florida
8 Medicaid, they're public payers. So primarily, we
9 really want to know what the public payers say.
10 Usually, our lowest priority for GAPMS is to provide
11 analyses of what private payers pay. And generally,
12 often we need those to supplement if we're unable to get
13 that many policies from Medicaid programs across the
14 nation, but since it's -- for this GAPMS, we actually
15 surveyed all 50 states, then we had adequate information
16 from that. Most GAPMS reports, usually we get maybe 10
17 or 12 when it comes down to coverage policies, it's --
18 it's pretty much what we can find in a certain amount of
19 time. But for this one, we've -- since Dede Pickle was
20 working on it independent, she was able to survey all
21 50.

22 Q And why is it covered under private insurance
23 informative of whether or not a service is experimental?

24 A Can you repeat that?

25 Q Uh-huh. Why don't you rely on -- why don't

1 you consider private insurance coverage to be
2 something -- I'm having trouble formulating what should
3 be a simple question.

4 Why don't you look at private insurance
5 coverage when you're determining whether or not a
6 service is experimental?

7 A Well, private insurance works differently. I
8 mean, Florida Medicaid, like Medicare, is a
9 taxpayer-funded health care system. Private insurers,
10 since they're privately funded, there's a great deal
11 more latitude, what they can cover and what they don't
12 have to cover, and they're more subject to the
13 competition of the market, as opposed to Medicaid
14 programs. So we -- while we do -- some often will look,
15 but often it's -- we often try to find what private
16 payers pay for following what we get from Medicare and
17 Medicaid. So, I mean, when it comes down to it, we can,
18 but it's not an absolute requirement, and we really do
19 want to find out what the Medicaid programs are paying
20 for. That's our first and foremost criteria for looking
21 at the coverage of -- other payers coverage.

22 Q So it's not apples to apples, because in
23 Medicaid and Medicare, you've got state taxpayer dollars
24 to consider, correct?

25 A That's correct.

1 Q Okay. But when you undertook the June 2022
2 GAPMS, you did not evaluate whether or not excluding
3 those services would be budget neutral?

4 A No, we didn't for this one, but we -- but
5 that's also not necessarily unique to this, as well.

6 Q So in other GAPMS, you've not evaluated the
7 budget neutrality of the service, whether or not you're
8 going to cover it?

9 A That's correct. In the GAPMS I did in 2017,
10 for, I think, like the nitrous oxide of -- pretty much
11 like an adjuvant to this, kind of jumped-up asthma test,
12 we didn't do a cost budget analysis because, like, we
13 weren't going to cover, it's not going to affect
14 anything.

15 Q So then you did evaluate whether it was budget
16 neutral. You won't be covering it, so, therefore, it
17 was neutral?

18 A Well, we just -- we just don't -- we just
19 don't do one, because, I mean, we're not covering it.
20 So it comes down to if we were going to make a coverage
21 determination, that's when you do a fiscal analysis. So
22 a coverage determination is definitely turned into a
23 fiscal -- it needs -- it needs a fiscal analysis,
24 because we're -- need to find out whether or not we're
25 going to be able to stay within our budget.

1 Q I see. I see. So in this instance, because
2 we are talking about the only GAPMS that excluded a
3 service previously covered, did you do anything to
4 determine whether or not that would cost or save the
5 state money?

6 A No.

7 Q I think you have -- you brought information
8 with you today about this. How did you collect state
9 Medicaid program coverage data?

10 A So on that spreadsheet, so Dede Pickle, she
11 went across the -- yeah. So she --

12 MR. JAZIL: Do you want to mark it as an
13 exhibit?

14 (Whereupon, Exhibit No. 13 was marked for
15 identification.)

16 THE WITNESS: She surveyed 50 states and I
17 think territories -- even up in the territories --
18 and was looking to see what their stances were on
19 gender-affirming care, to see whether or not they
20 had statements saying that they will cover it or
21 policy saying that they wouldn't. And then
22 there -- those that just didn't have a policy
23 available, or had no policy in place.

24 BY MS. DEBRIERE::

25 Q So Dede Pickle was the one who put together

1 the spreadsheet?

2 A Yes.

3 Q Okay. And where did she look to find this
4 information in each state?

5 A Well, she went to their state Medicaid web
6 pages, looked at their -- like, their coverage guides or
7 materials in each state Medicaid -- Medicaid programs.
8 There can likely be idiosyncrasies. I mean, some
9 have -- some are like ours, have a ton of coverage
10 policies, others are like Texas, Texas has one gigantic
11 coverage policy, which actually does -- despite the fact
12 it's huge, it's actually kind of more efficient.
13 It's -- you can get everything from there. But
14 that's -- that's what they do in Texas. Everything's
15 bigger in Texas. But she went and looked at all of the
16 different state -- various state Medicaid programs and
17 saw what their policies were and saw what was available.
18 And, of course, put the findings in the GAPMS report.

19 Q Did she only do an online search?

20 A Yeah, it was only an online search.

21 Q Did she contact any of the Medicaid programs?

22 A No.

23 Q Did she look at any of the policy reporters?

24 A No, we -- no, we didn't use policy reporter
25 for this GAPMS.

1 Q So just looking at the state's Medicaid Agency
2 websites?

3 A For the Medicaid, yes. But, generally,
4 without having worked in Medicaid, one of our research
5 criteria for across all kinds of reports and projects is
6 that we do want to see what other states do. And so
7 that gives us a great deal of familiarity of how to
8 navigate other states' programs. And one of our side
9 projects is the statewide Medicaid managed care program.
10 And, of course, we're always looking to see what other
11 states are doing. So we get a great deal familiar with
12 how to navigate the web pages of other states.

13 Q So at least half the states' Medicaid programs
14 explicitly cover pubertal suppression treatment for
15 gender dysphoria, is that correct?

16 A Based on -- based on the findings of the map.
17 So what -- so I will defer to the findings on the map.

18 Q Only ten exclude?

19 A Defer to the findings as stated in the map.

20 Q Okay. How about we do this: Based on the
21 findings in the map, only 10 states explicitly exclude
22 pubertal suppression therapy. How did you take that
23 into account when you reached the conclusions that you
24 did about the services being experimental, that
25 particular service being experimental?

1 A As far as that goes, it's informational, but
2 there was -- there was a divide between states that do
3 cover and states that don't. Primarily when making the
4 determination we focus -- we really focused on the
5 evidence and what the evidence said about treatments for
6 gender dysphoria since the Medicaid program -- since
7 there is -- seems like there's an absence of policies
8 for a lot of states. There are some states that come
9 out and say yes, and then there are some states that say
10 no. There is a -- there's a divide and you can even
11 potentially say like there could be a debate between
12 amongst the 50 states plus territories of whether or not
13 coverage is appropriate.

14 Q But you did say earlier on that you -- whether
15 a service is covered under the other state Medicaid
16 programs is usually a factor that you weigh heavily in
17 determining whether a service is experimental.

18 MR. JAZIL: Object to form.

19 THE WITNESS: So when it comes down to it --
20 it's like, so often, it's not just other Medicaid
21 programs, but also Medicaid programs are similar to
22 Florida. There are some Medicaid programs -- I'll
23 name two -- New York and California that are --
24 that cover things very, very liberally, as far as
25 services. Like, these added everything in their

1 fee schedules, where Florida Medicaid -- and
2 Florida Medicaid prides itself on being a very
3 fiscally responsible Medicaid program. So often we
4 try to see what states that are similar to our
5 Medicaid program, what they do. But we also do
6 see, we see overwhelming amounts of coverage from
7 states like us and states across the union, then
8 that does factor in our decision, but for in this
9 circumstance, because there is a split, if we were
10 going to have to more -- rely more so on the
11 evidence, than the notion that all these states
12 cover services, there -- it's not -- it's not
13 unanimous at all.

14 BY MS. DEBRIERE::

15 Q Did you ever contact the states that
16 explicitly exclude and ask them why they explicitly
17 exclude?

18 A We did not.

19 Q Did you ever call those states that have no
20 coverage statement one way or another and ask them?

21 A We didn't reach out to states. I mean, their
22 policy's online. I mean, that -- I mean, their
23 published policy is sufficient to give us the responses
24 we need to look at -- to look at it. Even for other
25 GAPMS, we don't contact other states.

1 Q Did you analyze how much Florida Medicaid
2 spends on -- spent on treatment for gender dysphoria
3 prior to the categorical exclusion?

4 A No, we did not.

5 Q Do you have any plans to reevaluate your
6 findings in the GAPMS report based on the September 2022
7 release of the WPS standards of care version eight?

8 A So in the immediate term, well, we don't,
9 so -- but, I mean, we can reopen the GAPMS later on,
10 there is -- there is a process for that. But generally,
11 I mean, these standards of care, I mean, based on the
12 release of one set of new standards of care, I mean, for
13 the time being we don't have any immediate plans, not
14 based on the release of one new update.

15 Q Okay. How long did you personally work on
16 that initial draft of the June 2022 GAPMS report?

17 A Oh, I was working on it pretty much until the
18 day it came out.

19 Q And you started that second week in May?

20 A Well, no, that was after I had the very first
21 initial draft done.

22 Q Okay. So tell me when you first started
23 working on it.

24 A April 20th.

25 Q Okay. So from April 20th until when it came

1 out. Published on what -- well, we know that it was
2 first reviewed by your higher-ups on June 1st. So April
3 20th to June 1st?

4 A Yeah, that's sufficient.

5 Q Okay. And you worked with Nai Chen and Dede
6 Pickle.

7 A Uh-huh.

8 Q Did you read all of the articles in the
9 work-cited section?

10 A I read every single document in that works
11 cited section.

12 Q 88 articles?

13 A All of them.

14 Q Okay. Were you able to read everything,
15 understand it, and draft a report in --

16 A Yes.

17 Q How often during that time period did you
18 communicate with the consultants?

19 A Oh, I think between four and five times.

20 Q And four or five times over that entire time
21 period?

22 A Yeah, during those time periods, yes, we
23 have -- periodically have, like, a one-hour discussion
24 with them.

25 Q So you talked to them about five hours total

1 over that time period?

2 A I think that's a valid estimate, yes.

3 Q Okay. Do you think it's more than that, like
4 more like 10 hours?

5 A No.

6 Q Okay. Turning back really quickly to the
7 amount of -- the cost of treatment for gender dysphoria.
8 How much was spent on the coverage of gender dysphoria
9 versus how much was spent -- strike that.

10 Do you know how much, prior to the adoption of
11 the categorical exclusion, how much annually AHCA spent
12 on the coverage of gender dysphoria?

13 A We did not.

14 Q Are you able to obtain that information?

15 A Our data analytics between managed care plans
16 paid per claim, and anything in fee-for-service, our
17 data bureau could probably muster that up.

18 Q Is there a way that we should ask for that
19 information to make the question clearer?

20 A You'd want to -- you would -- to put in a
21 request we would need diagnosis code, we'd need NDC, and
22 we would need CPT codes.

23 Q And what's NDC?

24 A National Drug Code.

25 Q Okay. And then for surgery, what would you

1 need?

2 A You would need the corresponding CPT code.

3 Q Okay. So you need the diagnostic code, the
4 NDC for drug coverage, and the CPT code?

5 A And the time -- the date ranges.

6 Q And the date ranges. Okay. And then you
7 could tell us how much AHCA -- or the Florida Medicaid
8 program paid in coverage of -- treatment for gender
9 dysphoria over a given period of time. Okay. When you
10 were communicating with the consultants about drafting
11 the June 2022 GAPMS report, what kinds of questions did
12 you ask?

13 A Generally, questions about -- mostly just
14 questions about, like, articles, like studies, making
15 sure we have our bases covered, things like that. We
16 wanted to make sure we didn't miss anything, or there's
17 anything glaring we -- because it isn't a piece of
18 academic work it is, it is -- mainly it's like a thesis
19 or a dissertation, because we make a case, we have to
20 support that case. So we want to make sure we have our
21 bases covered.

22 Q What were the consultants' positions on WPATH?

23 A Their positions were that -- I think they
24 identified -- all they did was identified it as an
25 advocacy group, like a combination of clinical

1 professionals, plus advocates, community activists can
2 join it. So that -- it's kind of a hybrid organization,
3 that they explained that to us. So that was pretty much
4 all the information they gave.

5 Q And you felt like that was an adequate
6 explanation of what WPATH was?

7 A Yes.

8 Q What about the Endocrine Society? What was
9 their position on?

10 A Their position was the Endocrine Society. I
11 mean, it is an established clinical organization. They
12 felt like the other guidelines, they had released
13 guidelines, but the Endocrine Society was transparent in
14 releasing their guidelines. They did clarify that their
15 recommendations were based on weak or very weak
16 evidence. They also clarified that their guidelines
17 were not a standard of care, that they were just
18 guidelines.

19 Q And that's the Endocrine Society. Who does
20 that -- or your consultancy, who did that?

21 A The Endocrine Society. So the Endocrine
22 Society, in the text of their guidelines, they do
23 identify each line of the treatment model, like the
24 puberty suppression, the cross-sex hormones and
25 surgeries. Primarily the hormones is the Endocrine

1 Society, but they are very clear that it's either low-
2 or very-low-quality evidence that supports it, and they
3 also do put that disclaimer on there, this is not a
4 standard of care.

5 Q What was your -- what was the consultants'
6 position on the American Psychiatric Association's
7 recommendations for gender-affirming care?

8 A It didn't come up in the conversations.

9 Q Okay. How about the AAP?

10 A The AAP was that the evidence available to
11 support the AAP's positions wasn't sufficient.

12 Q Okay. What about the AMA?

13 A We didn't talk about the AMA.

14 MS. DEBRIERE: Okay. So I would like to -- do
15 you have the exhibit of the Medicaid policy routing
16 and tracking form for the June 2002 GAPMS?

17 MR. JAZIL: Can you re-mark on this --

18 MS. DEBRIERE: Yes, please. I think -- I need
19 a bigger one.

20 (Whereupon, Exhibit No. 14 was marked for
21 identification.)

22 THE WITNESS: Yeah, that new formulation makes
23 it taste just like the real thing.

24 VIDEOGRAPHER: It's pretty good.

25 MR. JAZIL: See, we're finding common ground.

1 THE WITNESS: Wasn't, like, Coca-Cola and all
2 their peace commercials, they were holding hands
3 around the world? That was from the '70s, I think.

4 BY MS. DEBRIERE::

5 Q Okay. So I'm handing you what's been marked
6 as Plaintiff's Exhibit 14. It's the Medicaid policy
7 Routing and Tracking Form for the June 2022 GAPMS.
8 There's a start date column there. What's that mean?

9 A That's a start with the routing process. So
10 generally, for this, usually -- usually they try to
11 provide like a window. We always have, like, a window
12 of review. So for this, we enter the dates in the
13 system. The GAPMS is routed to first -- well, actually,
14 since my supervisor Dede was out, I was her delegate, so
15 I did sign on her behalf. Then it went to Ann Dalton
16 who signed. And, of course, Secretary Weida, of course,
17 signed in his role, and then went to Deputy Secretary
18 Wallace.

19 Q Okay. So start date's when the document hits
20 their desk?

21 A Yes.

22 Q Okay. And then end date's when they've
23 reviewed it and passed it on?

24 A Yes.

25 Q Okay. Date received is going to measure the

1 date that it hit their desk, but they didn't necessarily
2 pick it up and start reviewing it? I'm trying to
3 understand what's the difference between --

4 A Date received should be when they got it.

5 Q Okay. And the start date's when they start
6 reviewing it? What's the difference there?

7 A Start date, end date -- yeah, that should be.

8 Q And the approval column means that the GAPMS
9 was approved by each person that checked the box and
10 initial by it?

11 A That's correct.

12 Q Okay. So the June 2022 GAPMS report, which is
13 46-pages long and contains five separate reports from
14 AHCA consultants, it was reviewed and approved by each
15 person on this list in one day?

16 A Yes.

17 Q And all four people on this list reviewed and
18 approved the June 2022 GAPMS report in the span of two
19 days?

20 A Uh-huh, that's correct.

21 Q Oh, I see there MB for DVP.

22 A Yeah.

23 Q Why choose to adopt the 2022 GAPMS report into
24 rule?

25 A Because -- so since we had determined it to be

1 experimental and investigational, so we decided that we
2 didn't need to make the -- based on the evidence, based
3 on what the GAPMS said, the categorical exclusion
4 promulgating the rule is necessary.

5 Q Okay. So you adopted into rule because it was
6 a categorical exclusion?

7 A It was going to be, yes.

8 Q When was that decision made?

9 A The decision that was made -- the decision to
10 make -- to make a new categorical exclusion, of course,
11 that was not going to be made until after we had
12 completed the GAPMS report and signed off on, because
13 obviously, had either the experts had they disagreed
14 with one another, or if I'd come up with a different
15 conclusion, can't make a categorical exclusion unless
16 everyone was in sync. So it was one of those things
17 where had -- had the expert opinions disagreed with each
18 other, had I come up with a contradictory conclusion,
19 there -- you had -- we had to wait until after the
20 report was done before we'd sign whether or not to
21 proceed with the categorical exclusion.

22 Q And when was the decision made to adopt it
23 into rule? Was that at the same time that you decided
24 to make it a categorical exclusion?

25 A That was made after we had had the report

1 signed and done.

2 Q Okay. Sorry. I need to be more specific.
3 What date was that decision made?

4 A Well, I think it was probably made June 2nd.

5 Q Okay. And who made that decision?

6 A That would have probably have come down from
7 Secretary Marstiller, that would have come down from
8 now-Secretary Weida, and it would have come from our
9 General Counsel, Josephina Tamayo?

10 Q Why would it have come from those people?

11 A So -- because, of course, with our General
12 Counsel, with our Secretary, I mean, they do make the
13 decisions for the Agency. It's not out of the -- I
14 mean, it is typical in their role to make a decision to
15 promulgate something into rule.

16 Q Would that generally, though, be handled by
17 the Bureau of Medicaid policy?

18 A Sometimes. It depends on -- depends on the
19 nature of the rule change. Depends on where -- where
20 it's originating from.

21 Q How often has that decision come from the
22 Medicaid Secretary?

23 A So let's -- so to talk about the rulemaking
24 process a little bit.

25 Q Yeah.

1 A So rule -- proposes for rule changes come from
2 all different directions and --

3 Q Let's back up. Instead of talking generally
4 about rule changes, let's talk about changes to coverage
5 policies.

6 A Those can be made by our Deputy Secretary.
7 Those can come from the Secretary. I mean, anyone
8 who --

9 Q How often does that happen?

10 A We can't speak to how often it happens. I
11 mean, it does happen.

12 Q Had it happened more with the Bureau of
13 Medicaid policy?

14 A You mean, those in Medicaid policy who
15 initiated these changes?

16 Q More often than not?

17 A I actually would probably say not.

18 Q Oh, okay. I'm just -- I'm surprised because
19 we learned from Ms. Dalton that the -- both the
20 rulemaking process and the coverage policy units are
21 housed within the Bureau of Medicaid policy.

22 A Well, that's correct, they are, but often
23 they're responding to directives given to them from
24 either senior leadership or legislative changes.

25 Q Okay.

1 A So, yeah, while they are the ones that
2 implement and write and craft the new policies or update
3 the policies, they're often not the ones that are
4 piloting these new policies.

5 Q Or initiating the decision as to whether or
6 not --

7 A Precisely.

8 Q -- or adopt them into rule?

9 A Correct.

10 Q So you said that it was the decision to adopt
11 into rule was made on June 2nd, is that correct?

12 A That's correct.

13 Q Okay. And the notice of rule development,
14 that was issued on June 3rd, correct?

15 A Yeah.

16 Q I swear.

17 A Yeah, I'm deferring to the record on that.

18 Q Sure.

19 A The rulemaking process is highly documents, so
20 I'm going to be deferring to the documentation for the
21 rulemaking process.

22 Q Okay. So it took less than 24 hours for AHCA
23 to decide to adopt the conclusion in the 2022 GAPMS
24 report into a rule? And even less than that, because
25 you made it the same day that the report was released,

1 correct?

2 A Yes.

3 Q And at that time, you also knew which section
4 of 59-G it was going to go into?

5 A Yes, we did.

6 Q And who had to sign off on that decision?

7 A So all of our -- so whenever we adopt a rule,
8 it does go through a lengthy routing process. So it
9 does start -- the process starts in the Bureau of
10 Medicaid Policy, starts with the rules -- we have a
11 rules unit. That gets signed off on, then it goes to
12 the AHCA administrator authorities section, they have to
13 sign off. Then after that it goes to the Bureau Chief
14 of Medicaid Policy. Of course, likewise, they have to
15 review and sign off. Then it goes to the Assistant
16 Deputy Secretary of Policy and Quality. They have to
17 sign. Then, of course, the Deputy Secretary for
18 Medicaid has to sign. General Counsel's Office has to
19 sign. And then the Secretary is privy to all the
20 changes. And if Secretary decides like, wait, wait, we
21 can't do this or, no, there's a problem, yeah, that
22 sometimes can result in a frustrating headache, because
23 it takes a lot of work to get something that far.

24 Q Well, so the decision to adopt a categorical
25 exclusion to rule was made on June 2nd and the Notice of

1 Proposed Rule was made on June 3rd. So it was routed
2 through that entire process in less than 24 hours?

3 A Are we talking about the GAPMS or the rule?

4 Q The rule?

5 A Yes. And that -- and that's not unusual
6 sometimes for -- for the process to move very quickly.

7 Q Okay. Because you just made it sound like it
8 was a very lengthy process.

9 A It is with the number of people, but it's --
10 the rule content is very -- it's a very small addition.
11 It's not like a brand new coverage policy, because
12 often -- it depends on the nature of the rules. Like
13 one addition, that can move fast. Sometimes with --
14 like, for instance, in my experience as a program
15 administrator, we completely overhauled the community
16 behavioral health policies. That was five new coverage
17 policies. So that, of course, is going to require a
18 much lengthier review process rather than a quick
19 amendment to a rule. So it really depends on the nature
20 of the rule. If it's a very lengthy coverage policy,
21 yeah, that can take some more time if it's -- but if
22 it's like adding a few bullets or amending a line, that
23 can -- that can move along much faster because the
24 review time's just not -- a lengthy review process is
25 not necessary.

1 Q Or deciding to eliminate three types of
2 services that were previously covered by Florida
3 Medicaid?

4 A Correct. And, of course, but -- and, of
5 course, we have the GAPMS memo to substantiate that.

6 Q Okay. Okay. So speaking to the rule, it bans
7 Medicaid coverage for -- puberty blockers or cross-sex
8 hormone therapy and surgery if done so to treat gender
9 dysphoria, correct?

10 A That's correct.

11 Q But not to treat other diagnoses?

12 A Not to treat other diagnoses. Only for the
13 diagnosis of gender dysphoria.

14 Q Okay. Is this the only time that GAPMS has
15 been used to categorically eliminate coverage of
16 treatment for a particular diagnosis?

17 A For the one -- I think pretty much since the
18 institution of the GAPMS process, I think this was a
19 first.

20 Q Once the decision was made to adopt the
21 conclusions of the 2022 GAPMS report into rule, who was
22 in charge of that process?

23 A So our rule promulgation process, Cole
24 Gerring, he oversees the rule promulgation process for
25 our coverage policies and administrative rules for

1 Medicaid.

2 Q Does he head the Rules Unit under the Bureau
3 of Medicaid policy?

4 A Yes, he does.

5 Q Who drafted the actual language for the rule?

6 A I believe -- I believe he drafted the
7 language.

8 Q Did anybody revise it or have any input
9 that --

10 A There was input. So I mean, there were some
11 discussions. I remember we did have a meeting with
12 everyone to -- between, I think, like, Sheena Grantham,
13 myself, I think Dede Pickle, I think Secretary Weida, I
14 think like Sheena Grantham from General Counsel's
15 office, since rules are her area. I think there were
16 there was a -- there was a discussion on making sure
17 this was the finalized content we wanted.

18 Q And how long did that discussion take?

19 A About an hour.

20 Q Okay. And what kinds of topics were discussed
21 during that?

22 A Just determining how granular we should get,
23 mostly.

24 Q Okay. Okay. Was there any conversation about
25 whether adopting this categorical exclusion might

1 violate comparability under the Federal Medicaid Act?

2 A No.

3 Q What about EPSDT?

4 A No, because since we already have the -- we've
5 already had the GAPMS report to substantiate the
6 overriding EPSDT guideline -- guidance and requirements.

7 Q Because Florida Medicaid does not have to
8 cover a service under EPSDT if it's experimental?

9 A That's correct.

10 Q I had another question. Talking about how
11 granular to get with the language, was there any
12 conversation about what the Federal Medicaid Act
13 requires in terms of prescription drug coverage?

14 A I don't think so. Not during that
15 conversation.

16 Q Any other conversations had about that?

17 A As far as the federal requirements for
18 prescription drug coverage? No, I don't think we had
19 any conversations like that.

20 Q Okay. Any other conversations about
21 comparability under the Federal Medicaid Act?

22 A No.

23 Q So comparability under the Federal Medicaid
24 Act was not taken into consideration when adopting the
25 categorical exclusion?

1 A No.

2 Q Who planned the public hearing regarding the
3 proposed language in 59G-1.050(7)?

4 A So for the public hearing, since we did
5 anticipate a larger than normal crowd, we -- so I think
6 that was a joint effort between Cole Gerring I think,
7 Chief -- now Chief of Staff Brock Juarez, then Chief of
8 Staff Cody Farrell, and I think -- I think Secretary
9 Weida also had a little bit of input when it came down
10 to selecting the venue and making sure that we had
11 adequate staff and then also arranging for security as
12 well.

13 Q Why did you feel a need for security?

14 A Because of this -- the controversial nature of
15 the change and how those with opinions on it -- those
16 with feelings about it, I mean, they are deep-seated. I
17 mean, there's -- so because of the sensitivities
18 involved, we just felt that it would be best in the
19 event -- and we did think it was unlikely, but in the
20 event that someone might get upset or unruly, to have
21 security.

22 Q Why did you pick the venue you picked?

23 A Size and location.

24 Q What factors did you take into consideration
25 for size and location?

1 A That we would have adequate seating. That, of
2 course -- of course, location where it was, being
3 downtown, so --

4 Q Downtown being an easier location to get to?

5 A Yes.

6 Q Why did the location need to be easy to get
7 to?

8 A Because, I mean, since -- I mean, you know, we
9 do government in the Sunshine, we wanted the hearing to
10 be accessible to as many people as possible, so we
11 wanted to be able to fill as many seats as we could.
12 The facilities here at AHCA weren't going to be
13 sufficient for that. The Department of Transportation
14 auditorium was a very, very good venue, not just -- not
15 just to be able to provide those of us who were on the
16 panel visibility to the audience, but also just because
17 of the seating capacity. So it just was an ideal venue
18 compared to what we had available at the Agency.

19 Q Where do you normally hold rule hearings?

20 A We usually hold them here.

21 Q Why were you concerned about adequacy of
22 seating?

23 A Because we did expect a large turnout.

24 Q Why did you expect a large turnout?

25 A Because of the amount of coverage that the

1 GAPMS report had received, because of everything that
2 we'd been seeing, as far as -- per previous news stories
3 prior to the release, we just knew that this was a
4 sensitive subject. A lot of people have a deep-seated
5 conviction about it one way or the other, and we just
6 anticipated a large turnout.

7 Q In the planning of the public hearing, did
8 AHCA communicate with the Governor's office at all?

9 A No.

10 Q Did AHCA communicate with Department of Health
11 at all?

12 A No.

13 Q Who participated in the public hearing from
14 AHCA?

15 A So the participants from AHCA were myself,
16 Sheena Grantham, whose General Counsel's office,
17 Secretary Weida. Those are the -- those are the three
18 of us who were on the panel for AHCA. And, of course, I
19 think Cole Gerring handled the administrative procedures
20 and then I think to help -- help with crowd control, we
21 had, I think, Brock Juarez and some of the staff from
22 communications also helped arrange in making sure that
23 there's adequate seating, and just kind of serve -- just
24 helping out in any way, or any capacity that was
25 necessary, as needed.

1 Q Did anybody at AHCA help facilitate the
2 attendance at the hearing?

3 A There -- I think there's a speaker sign-in
4 sheet at the entrance. I think that -- like, I think
5 one of the Agency staff under Brock at the time was --
6 was allowing people to sign in.

7 Q Were there any particular people that were
8 encouraged to be at the hearing?

9 A No.

10 Q Are you aware of the Governor's office
11 encouraging anybody to attend the hearing, anybody in
12 particular?

13 A No. No.

14 Q Did anybody pay someone to attend the hearing?

15 A So for our -- for our experts, Dr. Grossman,
16 Dr. Van Meter and Dr. Van Mol, they were compensated for
17 their time spent at the hearing, or their time
18 traveling -- for Dr. Van Mol and Dr. Van Meter, their
19 time traveling and their travel expenses. So we did
20 reimburse them, but that was it.

21 Q Did that include the same agreement with the
22 \$35,000 cap or was that a separate agreement?

23 A I don't think it was a separate agreement,
24 because the three of them had not come anywhere close to
25 exhausting their caps.

1 Q Did AHCA provide any materials to those
2 consultants prior to the hearing to review for the
3 hearing?

4 A On the day of the hearing we gave -- we gave
5 them each bound copies of the report, but those
6 materials were already available online, so -- but we
7 just -- we just gave him paper copies or to reference
8 but nothing -- no other additional materials.

9 Q You didn't provide them any other materials
10 other than the GAPMS -- the June 2022 GAPMS?

11 A That's correct.

12 Q To review prior to the hearing?

13 A Correct.

14 Q Did you have any meetings with the consultants
15 prior to the hearing to prepare for the hearing?

16 A We had a couple -- there were a couple Zoom
17 calls.

18 Q How long did those last?

19 A About an hour?

20 Q What kind of things were discussed during
21 those meetings?

22 A Mostly the format. You know, we were talking
23 about, like, of course, Dr. Grossman, who was not going
24 to be able to travel. So we were talking about
25 technological arrangements. I think with Doctors Van

1 Meter and Van Mol, we were mostly talking about travel
2 arrangements and, like, where they'd sit and so forth,
3 so I mean --

4 Q Did you offer any questions that they might
5 anticipate from the audience and how they should
6 respond?

7 A To our experts? We didn't.

8 Q And why was it necessary to have the
9 consultants there?

10 A So -- well, since -- because we were actually
11 anticipating a crowd that was going to be largely
12 opposed to the challenge exclusion, we wanted to be able
13 to respond promptly and articulately to any comments
14 that were provided.

15 Q If you wanted to respond promptly and
16 articulately to any comments that were provided, what
17 was the purpose of having a public hearing?

18 A So the public hearing is to, of course, gather
19 feedback, but we also knew that we were likely going to
20 have either some type maybe medical professionals or
21 advocacy groups, or other advocates, and we did want to
22 be able to provide them with a little bit of engagement
23 to show that we do take their comments into
24 consideration, that we do think about them, that we do
25 engage with them.

1 Q Did the consultants respond to any comments by
2 a supporter of the rule?

3 A I don't think they did, actually.

4 Q How about those that were opposed to the rule?

5 A There was really -- I think Dr. Van Meter
6 responded once. I think Dr. Van Mol responded once.
7 And Dr. Grossman didn't respond to anything.

8 Q And that was -- both of those responses were
9 in response to individuals who were speaking in
10 opposition to the rule?

11 A Yes.

12 Q Have you ever participated in another rule
13 hearing where there is direct and prompt response to
14 public comment?

15 A Yes. Yeah, we do. Yeah, I mean, I've
16 participated in numerous rule hearings here at the
17 Agency. We do respond to comments.

18 Q When you say we, do you mean the office staff?

19 A Office staff, yes.

20 Q What about consultants with which AHCA has
21 contracted?

22 A We -- we generally don't -- we generally
23 don't. It's a -- it was a unique experience for this
24 case, but we generally don't have contracted consultants
25 at our hearings.

1 Q And where did the slogan, Let Kids Be Kids
2 come from?

3 A So that came from within, I think, our own
4 Agency, our Communications Department or the Chief of
5 Staff's office.

6 Q Was there any input in developing that from
7 outside entities?

8 A No.

9 Q So AHCA is wholly responsible for that slogan?

10 A Yes.

11 Q Was AHCA responsible for the printing off of
12 the stickers that had the slogan contained on it that
13 were being passed out at the hearing?

14 A No.

15 Q Do you know who was responsible for that?

16 A We do not know where those came from.

17 Q Is it normal to have slogans of an Agency
18 passed out at a rule hearing? Have you ever seen that
19 before?

20 A I have not seen that before, so -- but we --
21 that was not something that the Agency had anticipated,
22 and we certainly were not responsible for the passing
23 out of stickers with a slogan on it.

24 Q Did outside counsel appear at the public
25 hearing? Did AHCA outside counsel appear at the --

1 A Yes, they did.

2 Q Why?

3 A Because, of course, sensitive nature. I mean,
4 there were -- there were attorneys also -- there was --
5 because there was counsel that -- you know, who are
6 representing the plaintiffs who were also there. We do
7 anticipate litigation, so it was -- we did see to it
8 that we had outside counsel there to gather information
9 and be able to observe the procedures.

10 Q So AHCA had -- at the point of the public
11 hearing, AHCA had retained outside counsel to defend
12 against any potential litigation that the rule invited?

13 A Yes.

14 Q What was outside counsel's role at the
15 hearing?

16 A Outside counsel's role, I think -- I think
17 just calling up the speakers as they came. I think they
18 actually -- we had them helping out with the -- with the
19 hearing process and procedures.

20 Q What kind of -- well, okay. Did AHCA give the
21 consultants any instructions to prepare for the hearing?

22 A Basic ones. Most of -- I think, you know,
23 like to when responding that, you know, we would prompt
24 them to respond. Basic -- very basic instructions.

25 Q And so the instruction was that when AHCA

1 wanted someone to -- one of the consultants to respond,
2 you would prompt them to?

3 A So, yes. And during the hearing, Secretary
4 Weida would defer either to Dr. Van Meter or he would
5 defer to Dr. Van Mol when he needed -- when a response
6 was needed from one of them.

7 Q Okay. Just going back to the slogan really
8 quick, who in AHCA came up with that Let Kids Be Kids
9 slogan?

10 A I think -- I think it was a -- I think it was
11 a team effort. I think, like, it was Cody Farrell and,
12 I think, Brock Juarez. I think they worked on the Let
13 Kids be Kids slogan.

14 Q Anybody else?

15 A No, it would have been primarily them.

16 Q Who directed them to develop the slogan, or
17 was it their idea?

18 A So the orders would have been given verbally.
19 We don't know, like, exactly how they were told to do
20 that specific slogan.

21 Q When was the -- when was the slogan developed?

22 A It was developed, I think, in the days
23 preceding the release of the report.

24 Q When was the final draft of your report done?

25 A So the final draft -- so the final draft as

1 far as -- so the very, very final draft, like the last
2 finishing touches, as much as copy edits, was done that
3 week of the 2nd, but as far as the substantive
4 components of the report, that was done probably a few
5 weeks prior to the release.

6 Q So when was the slogan developed?

7 A Slogan was developed -- I think they did --
8 were working on it, like, the week before the release.

9 Q Is it normal for AHCA to develop a slogan for
10 the conclusions found in a GAPMS report?

11 A No, this is -- this was a first.

12 Q Why develop a slogan?

13 A Well, we do develop slogans for whenever we do
14 have -- do releases, or whenever we have new programs.
15 For instance, Canadian Prescription Drug Importation, we
16 do have a slogan for that. We do have a web page
17 dedicated to prescription drug transparency pricing. So
18 we do have -- often to correspond with our press
19 releases, we often will do a logo.

20 Q But you just said it's not normal for a slogan
21 to be developed for GAPMS. So why do it in this
22 instance?

23 A So because HHS had already -- had made
24 announcements with the publication of their documents,
25 Department of Health had done theirs, we, of course,

1 likewise, because we were publishing this document, was
2 to, of course, create the website and to, of course,
3 create some graphics along with that website.

4 Q So was the slogan meant to draw attention to a
5 particular message that the Agency was trying to send?

6 A No, I mean, other than that, we did the report
7 and we did was evidence-based and concluded these
8 treatments were experimental and investigational.

9 Q For children and adults, right?

10 A For children and adults.

11 Q And why was it Let Kids be Kids?

12 A Because -- so for adults with -- when it comes
13 to Medicaid, states -- because you don't have the EPSDT
14 consideration, states can be much more -- have much more
15 discretion in denying coverage. They have a lot more
16 latitude to be able to deny coverage, so -- but for
17 services that are intended for pediatrics, or are under
18 EPSDT considerations, that's partially -- partially why
19 not -- like one of the services that we evaluated was
20 puberty suppression, adults aren't going to use that.

21 Q But the conclusion of the GAPMS report was
22 that all treatment for gender dysphoria was experimental
23 for kids and adults?

24 A That's correct.

25 Q The slogan's just targeted at kids?

1 A Yes, that's correct.

2 Q Why?

3 A So it comes back down to the EPSDT
4 considerations. Because like -- well, for starters, I
5 mean, when it comes to adult coverage, that's a totally
6 different category. But for kids, especially with
7 puberty suppression and especially with the cross-sex
8 hormones, because of the experimental and
9 investigational nature, that's probably why we -- why
10 the Agency embarked on a, I guess, child-based kind of
11 graphic for its web page.

12 Q What does it mean Let Kids be Kids?

13 A I think, well, as far as semantics go, I think
14 that could mean something different to everybody.

15 Q What did AHCA by it?

16 A Let kids be free to explore their own
17 identities and figure out who they are.

18 Q What are some examples of other slogans AHCA's
19 used for its programs?

20 A Well, lower prescription drug costs.

21 Q That's a slogan that we can find?

22 A Yeah. I mean, that's one we've been using for
23 a while. I was using as -- under my signature on my
24 email, so things -- yeah, but, I mean, there are
25 slogans. I think like prescription drug transparency.

1 I mean, that's part of, you know, the state's mission is
2 when it's coming up with new programs -- and obviously
3 it's not isolated to AHCA, I mean, every agency's going
4 to have slogans and graphics for their new programs. I
5 mean, if you look at the Department of Children and
6 Families, they're promoting Hope Florida in a big
7 capacity. So for a lot of these -- so for a lot of
8 these programs that they want to have -- they want them
9 to be now such high profile, of course there's going to
10 be graphics and slogans.

11 Q Prescription Drug Transparency is not very
12 catchy, I'll say. Why create a web page dedicated to
13 supposedly fact-checking Health and Human Services? Is
14 that normal?

15 A No, it's not, but following -- but the thing
16 is following the review of the evidence and how our
17 findings really did contradict what was in HHS
18 documents, because we really wanted to demonstrate --
19 because we do understand, it's a GAPMS report, it's 46
20 pages. Not many people are going to take the time to
21 read it. So we wanted to kind of put it -- we wanted to
22 put the case in more simplistic layman's terms and make
23 it accessible to the audience to show that, hey, yeah,
24 this is a sensitive report. Yeah, if you got an hour
25 and a half and you understand medical terminology and

1 literature, you might have fun reading it, but for quick
2 information, we wanted to provide a resource, because
3 HHS had made all these claims regarding gender dysphoria
4 treatment, we want to make it accessible to everybody
5 that they could look at it and five minutes later
6 understand the gist of what we were saying in the GAPMS
7 report.

8 Q Prior to the July 8th public hearing, did AHCA
9 communicate with anyone from the Christian Family
10 Coalition?

11 A No.

12 Q Anyone from Florida Citizens Alliance?

13 A No.

14 Q Including Pastor Rick Stevens?

15 A No.

16 Q Anyone from Warriors of Faith, the Florida
17 Chapter?

18 A No.

19 Q Including Troy Peterson?

20 A No.

21 Q Anyone from Protect our Children Project?

22 A No.

23 Q That includes Pastor Ernie Rivera?

24 A That's correct.

25 Q Okay. Anyone from Florida Prayer Network?

1 A No.

2 Q And that includes Pam Olsen?

3 A Correct.

4 Q Anyone from Partners for Ethical Care?

5 A No.

6 Q What about Chloe Cole?

7 A No.

8 Q Sophia Galvin.

9 A No.

10 Q Anyone from the Rainbow Redemption Project?

11 A No.

12 Q How many comments did AHCA receive in response
13 to the proposed changes to 59G-1.050?

14 A 600 or so.

15 Q Oh, that's all? Did AHCA read them all?

16 A We did.

17 Q Who at AHCA reviewed them?

18 A It was a combination. So, like, I think Cole
19 Gerring, Nai Chen, myself, I remember we did sit down
20 once and we started going through all the emails. Most
21 of them were very brief, maybe like one or two lines,
22 not substantive whatsoever. For the more substantive
23 ones, those I did careful reviews of.

24 Q So it's three people. You, Nai Chen and Cole
25 Gerring?

1 A Uh-huh.

2 Q Okay. And you split them up amongst each
3 other?

4 A We read them together.

5 Q What process did you use to decide whether or
6 not to incorporate the input into the final rule?

7 A We wanted to look at the -- we looked at the
8 content of every -- of every single comment. A lot of
9 the comments were just saying don't do this, or
10 something -- or something very sensationalist. So a lot
11 of the comments we really couldn't take into
12 consideration because there wasn't -- there wasn't --
13 there was no substance behind them. So there were some
14 comments that were -- we did receive some feedback
15 from -- I think we got something -- we got -- we got a
16 lengthy comment from American Academy of Pediatrics. We
17 got a very lengthy one from Yale University. We got
18 feedback from the Endocrine Society. I think one of
19 UF's gender clinic physicians wrote us up, not a
20 terribly long comment, but wrote us a comment. So we
21 did want to take a look at the substantive ones. But
22 we did them into -- we did take into consideration every
23 comment submitted to us.

24 Q Did you receive any comments from the people
25 who had Medicaid coverage for treatment of gender

1 dysphoria?

2 A During the comment review, there wasn't any --
3 we didn't -- we didn't notice any comments from those
4 offhand, but, of course, that was over six months ago.
5 So we -- because of the volume of comments, we did have
6 to read them fairly quickly.

7 Q Had you received a comment from anyone who was
8 receiving Medicaid coverage for treatment of gender
9 dysphoria, how would you have factored that into your
10 ultimate determination?

11 A Well, we would -- we would have looked at it.
12 We would look at the content. We were wondering, like,
13 what kind of services they were receiving and so forth,
14 but it depends on what the comment was. If they
15 provided a case for why they were getting it, you know,
16 but we didn't -- we didn't receive anything like that.

17 Q For those people who lost Medicaid coverage
18 for treatment of gender dysphoria, or were going --
19 stood to lose based on the categorical exclusion, during
20 any of this process, was there any consideration given
21 to the inability to access that care?

22 A There was. We did have questions. We wanted
23 to make sure that if we were to discontinue individuals
24 who were receiving, particularly cross-sex hormones, we
25 wanted to -- we did have questions like, would there be

1 withdrawal? What would -- would they need some -- would
2 they be weaned off the medication? How would -- how
3 would the Agency take that into consideration? And we
4 actually kind of realized that if, say, if they do need
5 to discontinue testosterone because of the categorical
6 exclusion and their doctor deems, well, they're going to
7 need some small doses to wean themselves off, but we
8 also realized that necessarily wouldn't be for gender
9 dysphoria, that would be because of withdrawal symptoms,
10 and that would be a different diagnosis.

11 Q Did you give that guidance to any treating
12 professionals or Medicaid recipients?

13 A No, we didn't.

14 Q Okay. Why was it necessary to review the
15 comments quickly?

16 A It wasn't necessary to; it was just -- I mean,
17 most of the comments were because the nature, they
18 were -- most of them were sensationalist, a lot of them
19 just hurled insults at us, a lot of them ad hominem
20 attacks, things like that. We just kind of went through
21 a lot of them very fast.

22 Q So that wasn't quite my question. It sounds
23 like you were able to review them quickly.

24 A I think I want to rephrase as we were able to.
25 We weren't really in a hurry. Because, obviously, like,

1 we got a 47-page comment from Yale University. That was
2 not a five-minute skim, obviously. So there were those
3 we deemed to be substantive comments that warranted
4 in-depth attention, and then there were those we deemed
5 non-substantive comments and just read. They're like --
6 yeah, we received some ones that were using, I will say,
7 the colorful metaphors. And then we don't -- I mean,
8 obviously, not going to pay attention to those, so --
9 but the substantive ones that where they're putting
10 together, like, an argument or making points, being
11 something that we have to take back and think over, we
12 did invest time in those, yes.

13 Q Were there any discussions about the comments
14 between you and Cole and Mr. Chen?

15 A As far as the discussions go, no, most of
16 discussions were like, okay, let's move on to that one,
17 that one's just insulting us or that one's -- that one's
18 expletive-laden, let's move on. So when we got the
19 substantive ones, of course, those were -- those were
20 handled differently.

21 Q How were they handled differently?

22 A So those, because they were going to take
23 in-depth review is not something that's going to be a
24 group activity. Of course, we printed those out and
25 started reviewing with a fine-tooth comb.

1 Q Did AHCA review the underlying cases and
2 studies cited in those substantive comments?

3 A Yeah.

4 Q Okay. How did they factor those in to the
5 ultimate determination?

6 A So we did take a look. So we checked to see
7 what studies that Yale University and the AAP brought
8 into it. And we looked at two responses from the Yale
9 University, not just the response that they made to us,
10 because Yale University frequently cited their response
11 to Texas and Arkansas, we pulled that up as well and
12 did -- and analyzed that. So we looked to see what
13 articles they were citing and we were -- so we checked
14 to see whether our GAPMS report or any of the expert
15 reports also did evaluations of those studies to see
16 that -- make sure that we were in alignment.

17 Q Okay. Do you remember any particular
18 underlying cases or studies?

19 A There's -- I think there's one by Jack Turban
20 that they cited. I think there was one that we did cite
21 in GAPMS review. We didn't discuss it at length, this
22 was by Tordoff, et al. And we looked at that. And, of
23 course, but we also captured those in Dr.
24 Brignardello-Petersen's piece that they were evaluated
25 as, like, being very low-quality or in a critical risk

1 of bias.

2 Q Okay. How did you determine whether -- okay.
3 Turning to the implementation. Sorry.

4 A Okay.

5 Q Hold on. One second. Something breaking is
6 coming in. Did you review any comments that reference
7 court cases?

8 A We did see some comments that referenced, I
9 think, like *Bostock v. Clayton*. I mean, there were some
10 cases referenced in the comments, but, of course, I
11 mean, we were primarily interested in -- we were looking
12 for comments that were providing -- that were either
13 providing examples of literature or anything that was
14 going to contradict the GAPMS report. In other words,
15 we were looking -- we were looking for anything that, I
16 guess you could say, delivered, like, a mortal wound or
17 something like that, something that would foreseeably
18 cause us to have to go back and make revisions or cause
19 us to have to retract the rule, or something that -- or
20 a comment that we couldn't just dismiss or a comment
21 that we couldn't explain. So those were what we were
22 looking for.

23 Q What types of information provided by the
24 public would have mortally wounded your conclusion?

25 A So a mortal wound would have come from a

1 quality study, or a number of quality studies.

2 Q And define a quality study.

3 A So something that -- well, a quality study,
4 well, I mean, that -- that's a pretty broad definition
5 of what you're asking for, and there are different ways
6 a quality study can come about, but something that, of
7 course, lengthy longitudinal histories on participants,
8 either has adequate control groups. And this is not an
9 all-inclusive list. These are just examples. Also
10 follows participants for a lengthy period.

11 Q Well, what's the difference between that and a
12 lengthy longitudinal study?

13 A Long -- when it comes to a longitudinal
14 history, what we mean by longitudinal history, and this
15 is often for behavioral health, is that longitudinal
16 history is necessary to really ascertain the full
17 impacts of somebody's mental health conditions. Because
18 it's -- because mental health, it's not necessarily like
19 an acute illness or a chronic condition diagnosis. So,
20 like there's treatment histories, medications and --
21 like, in other words, and, of course, like activities of
22 daily living, how that all is affected. So it's usually
23 something that has to be obtained over a number of
24 years.

25 So, mental health longitudinal histories, but

1 we also were finding in the studies that we evaluate for
2 the GAPMS process that they lacked participants'
3 longitudinal histories. If they even -- if they even
4 did -- provided any histories or any -- identified the
5 recipients or the participants at all. I mean, there
6 were so many studies where they were -- I think there
7 was one that we came across, and this was during the
8 comment period, that was just a massive survey and they
9 were trying to give gift cards to participants. And, of
10 course, people were just completing it, but it was like
11 a one-time snapshot, and it's subjective self-reports.
12 So I mean, there are a myriad examples that we can say
13 for high-quality evidence, and not to mention RCT's, as
14 well. So --

15 Q What does that stand for?

16 A Randomized control trials. So there -- so,
17 yeah, so that was what we were looking for, evidence
18 that -- evidence that would hold up to questioning, and
19 that's not what we were finding.

20 Q So in undertaking the review of the comments,
21 the only thing you were looking for is anything that
22 would, in your definition, cause a mortal wound to your
23 conclusion in the GAPMS?

24 A That was among one of the things we were
25 looking for.

1 Q What else were you looking for?

2 A I mean, we were looking -- we were looking
3 for -- I mean, we, of course, we were looking to see if
4 there's anything that would directly conflict with the
5 GAPMS report. That was one thing, because the rule's
6 foundation was the GAPMS report. So that's the big
7 reason why we were looking for contradictory evidence or
8 evidence that would be like, well, wait a second, we say
9 it's all -- you know, because our primary argument is
10 it's low-quality evidence and therefore experimental,
11 experimental investigational. That basis doesn't
12 sustain itself if all of a sudden there's modern,
13 high-quality evidence out there. So we want to make
14 sure that we had not left any stones unturned. But we
15 were just -- you know, I mean, we -- this things we
16 weren't -- that was the primary thing we were looking
17 for.

18 Other things -- I mean, we also, I mean,
19 anything that spoke to the legality of it, but I mean,
20 of course, we wouldn't necessarily evaluate that. We'd
21 turn that over to legal, but anything that was
22 looking -- that was looking at the legality of what we
23 were doing. So I mean -- so, I mean, there were
24 different angles. I think when I was looking at it
25 through my personal lens, that was what I was looking

1 for.

2 Q Are you aware that similar exclusions have
3 been found unconstitutional in other federal districts?

4 A I am aware at the district level that there
5 have been some -- some exclusions that have been tossed,
6 yes.

7 Q All right. Turning to the implementation --

8 MR. JAZIL: We've been going for an hour and a
9 half. Could we do a five-minute break?

10 MS. DEBRIERE: Sure.

11 VIDEOGRAPHER: This concludes video three. The
12 time is 3:00 p.m.

13 (Brief recess.)

14 VIDEOGRAPHER: This is beginning of video four.
15 The time is 3:08 p.m. we're on the record.

16 BY MS. DEBRIERE::

17 Q Just after that break, and I should have asked
18 this earlier, just after that break, did you have any
19 conversations with anyone during that break?

20 A During --

21 Q Just this recent break? Did you have
22 conversations with anyone?

23 A I mean, talked about, like, personality types
24 on 16 personalities, just had a conversation, but as far
25 as the case goes, no.

1 Q Okay. What about at lunch?

2 A Just a quick touch-base with our attorneys.

3 Q Okay. How long did you talk?

4 A 15 minutes.

5 Q Okay. All right. Turning to implementation
6 of the rule with managed care plans. Did Florida
7 Medicaid managed care plans -- well, we've already
8 answered that. What's the purpose of Inter-Qual?

9 A Inter-Qual?

10 Q Uh-huh.

11 A I don't have the answer to that.

12 Q Okay. Are you familiar with it at all?

13 A I'm not familiar with Inter-Qual.

14 Q Did AHCA develop, or help develop language for
15 notices of adverse benefit determinations in order to
16 incorporate the categorical exclusion of treatment for
17 gender dysphoria?

18 A No.

19 Q AHCA didn't assist at all in developing the
20 language for those denials for terminations?

21 A No, managed care plans were -- handled those
22 themselves.

23 Q Okay. Did AHCA review any of the language
24 that managed care plans submitted to AHCA for review?

25 A No.

1 Q Same question for notices of outcome relied on
2 by EQ Health?

3 A No, AHCA wasn't directly involved in those.

4 Q Did they review the notices of outcome
5 language?

6 A No.

7 Q Okay. What about Magellan?

8 A Magellan? No.

9 Q Did AHCA develop or help develop language for
10 any other types of notices used to notify a Medicaid
11 recipient of a denial or termination of treatment for
12 gender dysphoria?

13 A No.

14 Q All right. Can I have the notice of adverse
15 benefit determination, and that's Bates-stamped
16 Defendant_ 000292335, I think. We'll check? Did I get
17 it right? I don't think I did. I'll read the correct
18 Bates-stamp on -- so this is going to be the Molina
19 Health Care Notice of Adverse Benefit Determination.
20 I'm not going to name the Medicaid recipient. And the
21 date stamp appears to be cut off, but it is dated
22 October 26th, 2022, and the initials for the recipient
23 are AS.

24 (Whereupon, Exhibit No. 15 was marked for
25 identification.)

1 MR. JAZIL: Counsel, can we agree that this
2 should be confidential, attorney's eyes only?

3 MS. DEBRIERE: Absolutely.

4 MR. JAZIL: Do you mind if I write that on top
5 of the --

6 MS. DEBRIERE: Not at all. Not at all. So the
7 previous Bates stamp I gave was not correct, but
8 the Bates stamp on this exhibit is cut off, so I
9 can't provide the actual number, but I think I've
10 sufficiently described it. And, of course, it will
11 be Exhibit 15.

12 BY MS. DEBRIERE::

13 Q All right. This particular notice of adverse
14 benefit determination is from Molina. In that second
15 page there, it runs through AHCA's medical necessity
16 definition, correct?

17 A Yes, that's consistent.

18 Q And that's consistent across notices of
19 adverse benefit determinations?

20 A So each health plan is a little idiosyncratic
21 in how they do NABD's. We'd have -- we'd have to verify
22 with managed care plans. I mean, the contracts does
23 provide specific requirements when it comes down NABD's
24 and sending them.

25 MS. DEBRIERE: Mo, do you know if you guys have

1 produced an NABD template to us?

2 MR. JAZIL: We've never --

3 MS. DEBRIERE: I know they exist. They should
4 be pretty easy to --

5 MR. JAZIL: I'll check. What's that stand for,
6 again?

7 THE WITNESS: Notice of Adverse Benefit
8 Determination. It's a long phrase for a denial.

9 BY MS. DEBRIERE::

10 Q Or termination or reduction?

11 A Or termination, or reduction.

12 Q Or partial reduction.

13 A It's --

14 Q Okay. So this particular notice of adverse
15 benefit determination is to an actual Medicaid
16 recipient, correct?

17 A Yes.

18 Q And it looks like it's been it's denying a
19 request for coverage of testosterone cypionate.

20 A That's correct.

21 Q Okay. And what is the reason for the denial?

22 A The box for other authority non-covered
23 benefits is checked off.

24 Q Why isn't the, request service is not a
25 covered benefit, checked off?

1 A We would have to ask that question of the
2 plans.

3 Q Okay. So you don't require some kind of
4 uniform response to not -- that plans must provide when
5 there's a non-covered benefit?

6 A We're not aware of one. There -- I don't
7 think there's one mentioned in the contract.

8 Q Okay, but I guess my other question is, would
9 it be equally sufficient, had they checked off, must
10 meet accepted medical standards and not be experimental?

11 A They could have checked that box. They could
12 have checked, the requested service is not a covered
13 benefit. They could have checked other boxes, as well.

14 Q Okay, but it is accurate to say that it is not
15 a covered benefit?

16 A Yeah, that is accurate.

17 Q Is any plan allowed to currently cover
18 treatment for gender dysphoria of the services listed
19 and 59G-1.050(7)?

20 A For any plan right now currently?

21 Q Yes.

22 A No. No plan can cover them.

23 Q Since the adoption of the categorical
24 exclusion of treatment for gender dysphoria, how many
25 notices of adverse benefit determination have been sent

1 to Medicaid beneficiaries that denied coverage for
2 services on the basis of --

3 A So for MMA plans, so we did a little looking
4 into this -- so for managed medical assistance, which
5 most of these recipients, given their ages, are going to
6 be on MMA, we do not actually require the MMA plans to
7 submit reports regarding how many NABD's that they
8 actually mail out to their enrollees. Long-term care,
9 that process is different. We do require them for
10 long-term care to mail those to report to the Agency how
11 many NABD's they are sending out, but for MMA we
12 currently don't have that as a requirement.

13 Q Okay. So is that -- does the same hold true
14 for notice of appeal plan -- plan appeal resolutions?

15 A As far as that goes, I don't think -- I don't
16 think we're collecting information from the plans on
17 those.

18 Q Okay. So generally, not just as related to
19 treatment of gender dysphoria?

20 A Generally.

21 Q What about notice of outcomes?

22 A Notice of outcomes, I don't think we're
23 collecting them from those informations either.

24 Q Okay. Just generally, do any of those notices
25 include reference to the variance in waiver process

1 described at Florida Statute 120.542?

2 A No. I mean, we definitely -- I mean, so
3 looking at this, this is in compliance with what we do,
4 we require them to have, which is an appeals process.
5 So, no, we don't -- we do not require the plans to
6 include the procedures for variances.

7 Q Okay. So those procedures are not listed in
8 notices of denial?

9 A That would be correct.

10 Q Okay. How many grievances have been submitted
11 to AHCA regarding a claim related to AHCA's adoption of
12 the categorical exclusion of treatment for gender
13 dysphoria?

14 A So that information, we do have a complaint
15 hub for recipients and providers who'd like to submit
16 complaints, be given the -- when the questions came in,
17 we, of course, have to reach out because our complaint
18 hub is actually down in Fort Myers, so it's not -- it's
19 not here locally, so that's information we're still in
20 the process of obtaining.

21 Q And once you obtain that, you'll provide it to
22 us?

23 MR. JAZIL: Yes.

24 MS. DEBRIERE: Can you put that as a follow-up?

25 BY MS. DEBRIERE::

1 Q How many -- how many appeals of Notice of
2 Adverse Benefit Determination denying care on the basis
3 of the exclusion have there been?

4 A As far as appeals going up to the fair hearing
5 level, I think that's zero.

6 Q Okay. What about -- yeah, so that would
7 include both notice of plan appeal resolutions as well
8 as notice of outcome?

9 A Yeah.

10 Q Okay. Prior to August 21st, 2022, did AHCA
11 ever reverse a decision made by AHCA or by a plan to
12 deny pubertal suppression therapy for the treatment of
13 gender dysphoria?

14 A We did not.

15 Q You never reversed a decision to deny?

16 A To deny?

17 Q Yeah.

18 A No, we never did. Sorry. I misunderstood the
19 question.

20 Q Okay. I just want to make sure you're
21 understanding. So prior to the adoption of the
22 categorical exclusion, did AHCA ever reverse a decision
23 to deny puberty suppression therapy for the treatment of
24 gender dysphoria?

25 A So if a plan reviewed for medical necessity

1 criteria decided, no, it didn't meet the criteria and
2 issued denial, no, we never reversed it.

3 Q What about upon a fair hearing review?

4 A Are we talking about, like, since 2015?

5 Q Well, I'm asking ever, but if 2015 is a
6 helpful marker.

7 A I don't have that information offhand.

8 Q Is that information you can obtain?

9 A I think we can.

10 Q Prior to August 21st, 2022, did AHCA ever
11 reverse a decision to deny cross-sex hormone therapy for
12 the treatment of gender dysphoria? And by reverse I
13 include at the fair hearing level.

14 A That's information that we would have to
15 obtain.

16 Q Same question for surgery in furtherance of
17 the treatment for gender dysphoria.

18 A At the fair hearing level, we would have to
19 obtain that.

20 Q So you will tell us the number of times, if
21 ever, that AHCA reversed a decision at the fair hearing
22 level to provide treatment in furtherance of -- services
23 and treatment for gender dysphoria?

24 A We can confirm it. It's probably zero.

25 Q Okay.

1 A As far as overturning a decision that was
2 already a denial, it's probably going to be zero, but we
3 just want to confirm.

4 Q Okay. I'll tell you, we have different
5 information.

6 A Okay.

7 Q How many AHCA fair hearings have been provided
8 where the categorical exclusion of treatment for gender
9 dysphoria was an issue?

10 A Well, can you repeat that?

11 Q How many AHCA fair hearings have occurred
12 where the subject at issue was the categorical exclusion
13 of treatment for gender dysphoria? So where the rule
14 exclusion --

15 A We'll have to obtain those numbers.

16 Q Did any -- do final orders in general
17 reference the variance and waiver process described at
18 Florida Statute 120.542?

19 A You'll have to slow down and ask the question
20 a little bit --

21 Q Sure. Sure. The final orders that are issued
22 at the end of any AHCA Medicaid fair hearing, do those
23 written final orders contain any reference to the
24 variance and waiver process at Florida Statute 120.542?

25 A I don't think the final orders do. I don't

1 think they do.

2 Q Okay. Is there any way you can get
3 confirmation of that answer?

4 A I mean, we could obviously pull up a copy of
5 the final order and see if that information is included.

6 Q If we had a copy of an AHCA final order, would
7 that be sufficient to determine, and it did not list it,
8 would that --

9 A I'll defer to our attorneys, if that's
10 sufficient.

11 MR. JAZIL: That'd be sufficient. If you have
12 one, you can show it to him.

13 MS. DEBRIERE: Well, we can pull one up, can't
14 we?

15 MS. CHRISS: Just one?

16 MS. DEBRIERE: Yeah. Yeah. Why not. Yeah, as
17 long as their name's blocked out, which really
18 shouldn't matter here because we're dealing with an
19 AHCA employee.

20 THE WITNESS: Yeah. I mean, I'm cleared to
21 review PHI and recipient information. It shouldn't
22 be a problem.

23 MS. DEBRIERE: Do you want another one? I can
24 send you another one. Bear with me one second.

25 I'm going to forward you this email. And

1 it's -- I can tell you what the name of the
2 document is. It's the last document, 23. That
3 should be the last one. Chelsea's copied on that
4 one, too.

5 THE WITNESS: Okay.

6 MS. DEBRIERE: Okay. Okay. So feel free to
7 just scroll through it and see if you see any
8 reference -- oh I'm sorry, it isn't a touchscreen?

9 THE WITNESS: I don't know where the scroll
10 bar.

11 MS. CHRISS: It's just -- just use two fingers
12 and just go like that.

13 MS. DEBRIERE: Oh, it's a Mac.

14 MS. CHRISS: I'm sorry.

15 THE WITNESS: Okay. There it goes. Yeah.
16 Ipads and iPhones I'm good with, Mac's I never got
17 comfortable with.

18 MS. DEBRIERE: The next exhibit I'm going to do
19 is emails related to the policy transmittal and the
20 policy transmittal itself, if that helps.

21 MS. DUNN: Yep.

22 THE WITNESS: So are we talking about the --
23 that last paragraph on the final page that's, like,
24 notice of judicial review?

25 BY MS. DEBRIERE::

1 Q Yes. So does that relate to the variance
2 waiver process?

3 A I mean, it doesn't point out the variance
4 processes as described in section -- or Chapter 120. I
5 think that's more if they want to appeal to the next
6 level -- next court level. I don't think that's in
7 response to the variance process. That's a different
8 process.

9 Q Okay. Thank you. So it does not mention the
10 variance waiver process --

11 MR. JAZIL: Would it be possible just to read
12 off the --

13 MS. DEBRIERE: Yes, absolutely. So it says at
14 the bottom: Notice of a right to judicial review.
15 A party who is adversely affected by this final
16 order is entitled to judicial review, shall be
17 instituted by filing the original notice of appeal
18 with the Agency clerk of AHCA, and a copy along
19 with the filing fee prescribed by law with the
20 District Court of Appeal and appellate district
21 where the Agency maintains its headquarters or
22 where a party resides. Review proceedings shall be
23 conducted in accordance with the Florida appellate
24 rules. The Notice of Appeal must be filed within
25 30 days at the rendition of the order to be

1 reviewed.

2 THE WITNESS: Our various processes doesn't
3 involve appellate courts, so it would not be an
4 appellate case, so it's a different affair.

5 BY MS. DEBRIERE::

6 Q Thank you. Okay. Did AHCA work with Florida
7 Medicaid managed care plans to implement the exclusion
8 set forth in 59G-1.050(7) in any way?

9 A No. I mean, the publication's in the Florida
10 Administrative Register, that was to provide ample
11 notice -- public notice that the rule's changing, the
12 managed care plans are responsible for keeping up with
13 changes to manage -- to AHCA's coverage policies and
14 administrative policies.

15 Q What about plan transmittal? Are you maybe
16 forgetting those?

17 A We do not do a plan transmittal for this. Are
18 you referring to a policy transmittal?

19 Q Yes.

20 A We did not send out a policy transmittal.

21 Q Okay. Okay. So we have what's marked as
22 Exhibit 16 and Exhibit 17. Exhibit 16 is some emails
23 from Dede Pickle to Jason Weida, cc'ing Ann Dalton. And
24 those are dated August 22, 2022. I believe that's where
25 they start. Also involved are you, Matt, and Ashley

1 Peterson. Also, I just want to note that Exhibit 17 is
2 an SMMC policy transmittal dated August 22nd, 2022.

3 (Whereupon, Exhibit Nos. 16 - 17 were marked
4 for identification.)

5 BY MS. DEBRIERE::

6 Q Getting back to the list of questions. So did
7 AHCA not send the plan policy transmittal out, Exhibit
8 17?

9 A We did not send them out.

10 Q Why?

11 A Pretty much because all it's doing is
12 reproducing what was already stated in the rule. The
13 rules -- the rule -- the policy changes already in rule,
14 that was announced through the FAR. Policy
15 transmittal's a little superfluous at this point.

16 Q Why draft an entire plan transmittal and then
17 not send it out?

18 A Which this happens frequently. Sometimes we
19 will draft something and later decide not to -- not to
20 use it, or not to utilize that content in favor of
21 different strategy. So, in this case, since the rule --
22 since the rule change itself was pretty self-explanatory
23 and pretty direct, just we later deemed wasn't
24 necessary.

25 Q Who made the decision not to send out the

1 policy transmittal?

2 A I think that would have been -- that would
3 have been Secretary Weida.

4 Q Only Secretary Weida? Is it Weida or Weida?

5 A Weida. I mean, as Assistant Deputy Secretary,
6 he would be within his purview to decide whether or not
7 to send something out -- or to send something out, but
8 given that the rule itself was self-explanatory, and we
9 just decided that a policy transmittal wasn't necessary.

10 Q All right. In the email exchanges -- I think
11 it's on the second page -- oh, and Jason Weida, at this
12 time that he made this decision, was not the
13 Secretary -- AHCA's Secretary, correct? At the time
14 this was sent, Mr. Weida was not the AHCA Secretary,
15 correct?

16 A Right, he was Assistant Deputy Secretary for
17 Policy and Quality.

18 Q On the last page, it looks like you were the
19 person who drafted the first policy transmittal, is that
20 correct?

21 A Yes. Yeah, I mean, Dede and I, it was a
22 collaborative effort between the two of us. We were, of
23 course, working on each other's language.

24 Q Why did you think Dede -- why did you and Dede
25 think it was important to draft a policy transmittal?

1 A We were asked to.

2 Q By who?

3 A I think Ann Dalton asked Dede to work on it.

4 Q Okay. And later -- well, let's look to --

5 Ashley Peterson says on August 22, 2022 at 10:35 a.m.:

6 I added one thing to help clarify that these drugs will
7 still be provided, just not for gender dysphoria.

8 Please let me know if you think this is unnecessary or
9 adds confusion.

10 So at least Ashley thought there was some
11 clarity that could be provided to plans on the
12 implementation of the exclusion.

13 MR. JAZIL: Object to form.

14 THE WITNESS: Okay. There's several emails.

15 Which one are you --

16 BY MS. DEBRIERE::

17 Q This one is from Ashley to Dede, copying you.

18 A August 22nd, 11:04 a.m. That's Dede --

19 Q 10:35 a.m.

20 A Okay.

21 Q It's DEF_0002587.

22 A Okay. I think it was just a minor, minor
23 technical catch. I mean, when we worked on this, I
24 mean, we were just fine tuning the drafts.

25 Q And further up Ann wants to include the 60-day

1 language in the alert, which has been later included.

2 What is the 60-day language?

3 A That would be the bottom paragraph of the
4 policy transmittal.

5 Q Okay. And that you're referring to starts
6 with: To ensure the safe discontinuation of puberty
7 blockers or hormone and hormone antagonists for the
8 treatment of gender dysphoria?

9 A Uh-huh.

10 Q Then the managed care plan must notify its
11 subcontractors, providers, enrollees receiving active
12 treatment and changes in coverage, and they must honor
13 any current prior authorization of prescribed outpatient
14 drugs for the treatment of gender dysphoria through 60
15 days after the date of this policy transmittal. So that
16 means that under the 60-day rule for continuity of care,
17 the managed care plans were to continue coverage of the
18 prescribed outpatient drugs for the treatment of gender
19 dysphoria, correct?

20 A Only for those existing prior authorizations
21 had already been approved.

22 Q Okay. So that meant that AHCA was -- or that
23 Florida Medicaid was covering this drugs?

24 A Yeah, just for the sake of honoring existing
25 PA's.

1 Q Was it not important that the plans know that
2 they should maintain continuity of care?

3 A It's actually in the contract. I mean, when
4 you refer to continuity of care, can you clarify what
5 you mean by continuity of care?

6 Q In this instance, I'm talking about the
7 continued coverage for 60 days of those prescribed
8 outpatient drugs for the treatment of gender dysphoria.

9 A As far as the continuity of care went, I mean,
10 there -- as far as medically necessary services,
11 enrollees are always going to have access to those. So
12 when it comes to the continuity of care, whether or --

13 Q They're not going to have access to services
14 that have been previously covered, but now are excluded,
15 correct?

16 A That'd be correct.

17 Q Okay. So the 60-day continuity of care
18 ensures that after that categorical exclusion is
19 adopted, those individuals continue to access that care
20 for 60 days?

21 A This, of course, was a draft. It was never
22 sent out.

23 Q At some point, AHCA thought that the 60-day
24 period of continuity of care should apply in this
25 situation, correct?

1 A Since this was a draft and it was not -- not
2 officially sent out, this is not -- since it is draft
3 language, it is not an official transmittal, we sent out
4 to the health plan, so this does not formally represent
5 the views of the Agency. This is a -- this is a draft
6 that we created, deliberated upon and decided not to
7 send out.

8 Q Who decided?

9 A That would, of course, been leadership. That
10 would have been -- would have gone to Assistant Deputy
11 Secretary Weida.

12 Q And he was the only one who was involved in
13 that decision, correct?

14 A I mean, since he oversees the bureau policy,
15 that's -- which means policy transmittal, yes, he had --
16 is within his -- is within his job description and his
17 responsibilities and rights to veto sending out a policy
18 transmittal.

19 Q Okay. Since the policy transmittal was not
20 sent out, then is it AHCA's position that those who had
21 a current prior authorization at the time that
22 categorical exclusion was adopted, was not entitled to
23 the 60-day continuity of care period -- were not
24 entitled?

25 A So once the rule went into effect, that was,

1 of course, the notice of the plans that the coverage for
2 these services has to stop.

3 Q Immediately?

4 A Well, I mean, that's based on what the rules
5 say, yeah.

6 Q Okay. So they -- that means that the plans
7 were not to implement this 60-day period of continuity
8 of care as described in this transmittal?

9 A Right, we didn't provide notice of -- them of
10 this.

11 Q Okay. And it was AHCA's position that
12 Medicaid beneficiaries were not entitled to that?

13 A That's correct.

14 Q Okay. You previously noted how people on
15 hormones may go through withdrawal, there was something
16 as part of your 2022 GAPMS request. Why wasn't that
17 important to communicate to the plans?

18 A Well, because withdrawal is not gender
19 dysphoria. It's a different -- that's a different --
20 it'd be a different diagnosis altogether.

21 Q But in the decision to no longer cover drugs
22 that may cause withdrawal, was it important to
23 communicate to the plans or providers that they may need
24 to help facilitate transition off those drugs that would
25 no longer be covered?

1 A We were leaving that to the health plans to
2 manage independently, as well as the providers of these
3 services.

4 MS. DEBRIERE: Do we have a document titled
5 Florida Medicaid health alert? You just -- under
6 DEF_000258815. I feel like I've had the same Bates
7 stamp number. So we're marking as Exhibit 18, the
8 Florida Medicaid health care alert sign-off form.

9 (Whereupon, Exhibit No. 18 was marked for
10 identification.)

11 THE WITNESS: I'm familiar with that. I
12 drafted it.

13 BY MS. DEBRIERE::

14 Q That would definitely have been one of my
15 questions.

16 A No, I'm listed on there as the analyst who
17 drafted it.

18 Q And there's Dede and Ann.

19 A Yeah.

20 Q Okay. Did this healthcare alert go out to all
21 providers?

22 A That provider alert did not go out.

23 Q And the provider alert on the back, it lists
24 that same language to ensure the safe discontinuation of
25 puberty blockers or hormones and hormone antagonists for

1 the treatment of gender dysphoria, or allow transition
2 to payment to non-Medicaid funding sources. You
3 incorporated the reference to the 60-day continuity of
4 care period. You drafted that one. Did you include
5 that 60-day language?

6 A Yeah. I -- yeah, I did include that.

7 Q Why did you think it was important to include?

8 A Because at the time we were -- we were
9 creating a provider alert in sync with -- in sync with
10 the policy transmittal, so we wanted to make sure that
11 they used the same language and addressed the same
12 things.

13 Q And why wasn't this sent out?

14 A Because -- because, well, we've deemed that
15 the notice of the rule is sufficient, and that once the
16 rule had said that AHCA will no longer cover these
17 services, we could no longer cover those services. I
18 mean, the rule was clear-cut. It's very -- I mean,
19 language is pretty -- pretty straight to the point and
20 direct.

21 Q Who made the decision not to send this out?

22 A That would have come from Assistant Deputy
23 Secretary Weida at the time.

24 Q Did you agree with that decision?

25 A I thought it was sufficient. I actually

1 thought given that we put the rule out there, the rule
2 is very straightforward, noticing, like, we had the
3 providers, health plans, adequate notice was given.

4 Q Did Ms. Dalton agree with the decision not to
5 send any of this out?

6 A I can't speak to Ms. Dalton. She and I didn't
7 confer on our opinions of whether to -- we didn't confer
8 on how we felt about it.

9 Q Was there any stated opposition to not sending
10 these out?

11 A Not that I'm aware of, no.

12 Q So in managing withdraw, how would a plan or
13 provider know how to navigate that if AHCA wasn't -- if
14 AHCA notified them that they weren't going to cover the
15 service that was needed to help titrate individuals off
16 of their hormones or puberty suppression therapy?

17 A So it comes back down to practitioners
18 delivering treatment to their -- to their patients.
19 Once again, it comes down to how, like -- you know, when
20 they know that they can't treat for gender dysphoria
21 anymore, and they know that the individual might
22 suffer -- might suffer withdrawal symptoms from
23 testosterone. We, of course, did see some conflicting
24 information on that one, whether they would experience
25 symptoms or not, or estrogen, or if there were

1 withdrawal symptoms, you'd be treating the withdrawal.
2 And, of course practitioners, we do trust the medical
3 professionals to know what condition they're treating,
4 when the -- because they do so every day when their
5 course -- when they're, of course, diagnoses. And, of
6 course, when the medical coders come in there to do the
7 billing, it's --

8 Q If transition involved smaller dosages of
9 hormones over time to treat gender dysphoria, how was
10 the provider and the plan to know that they could
11 continue to prescribe that?

12 A It would be coming through a different
13 diagnosis code. And since we only said that for -- we
14 only said in the rule only for the diagnosis of gender
15 dysphoria. So if they're -- so if they're taking on
16 some small doesn't testosterone because of withdrawal,
17 that's a different -- that's a different diagnosis
18 altogether.

19 Q How would they know what diagnosis code to
20 use?

21 A So, practitioners and providers often don't --
22 aren't that familiar with the coding system. That's
23 where their coders do to figure out. So their coders,
24 of course, review the medical records and, of course,
25 put in the CPT codes, they put in the ICD-10 codes, the

1 place of service. So usually the claims process is
2 usually done either by often, like, a clearing house or
3 individual coders that sometimes just rotate like a
4 circuit through different physicians offices and so
5 forth.

6 Q So when we're talking about the safe
7 discontinuation of a medication, wouldn't the prudent
8 thing to do would be to notify providers and plans of
9 the options they had to ensure that individuals who
10 could no longer access this treatment could at least
11 come off of it as safely as possible?

12 A Given that physicians deal with that kind of
13 situation, for other diagnoses and medical services, we
14 just didn't feel it was necessary. That's one area we
15 were going to, like, leave it. Practitioner discretion
16 was how to withdraw their patients from testosterone or
17 estrogen, if it was even necessary at all.

18 Q Did any managed care plan ask questions about
19 how to implement the categorical exclusion of
20 gender-affirming care?

21 A I don't think we received any questions for
22 managed care plans.

23 Q What about from providers?

24 A I don't think we received any provider
25 questions either.

1 Q Did any plan communicate that they will
2 continue coverage in spite of the categorical exclusion?

3 A Definitely no.

4 Q Could a plan do that?

5 A Well, they hypothetically can --

6 Q Would Florida Medicaid allow them to do that?

7 A No, we would not.

8 Q I'm showing you what's marked as -- well, I
9 will be in a second -- what is marked as DEF_ 000169125.
10 It's the template member handbook -- actually, let's
11 skip that one. I'm sorry. I'm sorry.

12 MS. DUNN: Oh, I'm sorry, we have numbers that
13 aren't lining up with --

14 MS. DEBRIERE: Yeah, let's actually -- let's
15 move to the emails from Susan Williams between her
16 and Magellan. I'm not sure what the Bates stamp
17 is. Okay. Thank you.

18 (Whereupon, Exhibit No. 19 was marked for
19 identification.)

20 BY MS. DEBRIERE::

21 Q And that's marked as 19 and it's a series of
22 emails between Susan Williams, Jessica Forbes at AHCA,
23 Ashley Peterson, and the first date on the document is
24 June 3rd, 2022. The subject is for treatment of gender
25 dysphoria for children and adolescents.

1 A Well, this was -- well, we received this prior
2 to the promulgation of the challenge exclusion.

3 Q You did. So, Stephanie McGriff over at
4 Magellan says, Hi, Ashley and Susan, attached are the
5 internal criteria not publicly posted. CCM that the
6 implemented all meds with the gender code equals B, both
7 in the subsequent updated denial letter that includes
8 the non-discriminatory verbiage. What are the internal
9 criteria she's referring to?

10 A So it looks like the email chain started on
11 April 20th, following the release of the Department of
12 Health's guidelines. So there were 14 impressions to
13 AHCA at that time. We had just initiated the GAPMS
14 process for these treatments.

15 Q Yeah. In fact -- so looking at the email from
16 Alicia King Wilson dated April 20th -- so that would be
17 the day that the Florida Department of Health released
18 its guidance, right?

19 A Yes.

20 Q And Secretary Marstiller directed Tom Wallace
21 just to start the GAPMS process.

22 A Yes.

23 Q It says: Leslie noted MMA does have an
24 internal gender dysphoria criteria, which is attached.
25 This internal document serves for a GnRH analog used to

1 delay puberty in adolescence with gender dysphoria, but
2 it does not speak to use of hormone therapy. This
3 document was provided by the Agency due to a fear of
4 hearing requests received from Lupron for recipient with
5 this diagnosis. All requests for use of the drug at
6 that time to delay puberty were to be vetted by AHCA
7 before a final determination is made. Can you explain
8 that a little bit more? What does it mean that AHCA had
9 to vet all determinations? What determinations was AHCA
10 vetting?

11 A I don't -- I mean, it's tough to fully
12 understand the context of this email. I mean, the
13 context level is light throughout the chain, because I
14 mean, Magellan does handle the prior authorization of
15 clinical reviews for drugs in the fee-for-service
16 system.

17 Q Okay, but it says that this document was
18 provided the Agency due to a fair hearing request
19 received from Lupron first, recipient with this
20 diagnosis, all requests required vetting by AHCA before
21 a final determination was made. So, I mean, I interpret
22 that to mean that anytime Magellan received a request
23 for Lupron to treat gender dysphoria, AHCA had to vet it
24 before a decision as to coverage would be reached. Am I
25 wrong?

1 A No, that's what it sounds like. The
2 pharmacy -- the pharmacy processes may involve -- as far
3 as like the pharmacist job descriptions go -- I mean, as
4 far as like vetting, that's the kind of the questions
5 like, are they -- because we don't do in-house prior
6 authorizations or clinical determinations anymore. We
7 haven't done those since SMC went into a fact.

8 Q Was a special exception made for the coverage
9 of hormone therapy to treat gender -- I'm sorry -- for
10 the treatment of puberty suppressant?

11 A No. No. Yeah.

12 Q So not to your knowledge --

13 A I'm just trying to figure out what they mean
14 by vetting. Like, in other words, does this mean --
15 like, is Magellan sending the determination back to AHCA
16 for yes or no approval?

17 Q Yeah.

18 A So they could be doing that.

19 Q But you don't know?

20 A Don't know.

21 Q Can we find that information out?

22 A We might be able to, because like -- because
23 it's only a few emails, and we're trying to go over the
24 process. I mean, it is possible that we could ask
25 people who do oversee this area. I mean, they might

1 give us some information, but they may not be able to
2 describe the exact context of the email because, I mean,
3 sometimes things get lost in translation.

4 Q Does Susan Williams still work here?

5 A Yes, she does.

6 Q Does Ashley Peterson still work here?

7 A Ashley Peterson recently left us.

8 Q What's recent?

9 A Last week.

10 Q Find another opportunity?

11 A Yeah.

12 Q How about Kelly Reuben?

13 A Kelly Reuben's still here.

14 Q Jessica Forbes.

15 A Jessica Forbes is still with the Agency.

16 Q Shantice Green.

17 A No, she's not here anymore.

18 Q She find another opportunity?

19 A I believe so, yes.

20 Q All right. So, as a reminder, all gender
21 codes were removed from programming as directed by the
22 Agency in 2017. What does that mean?

23 A I'm not sure because I'm not sure what they
24 mean by CCM. Generally, when we do -- when we make
25 systems updates, it's either done through a file

1 maintenance or a customer service request to Gainwell
2 Technologies oversees the FMMIS, so --

3 Q You were familiar with the programming of the
4 ICD-10 codes, but you're not familiar with programming
5 of the gender codes?

6 A Well, no, I'm familiar with the -- how
7 diagnosis codes are programmed in the system, but this
8 CCM acronym I'm not familiar with.

9 Q What is a gender code?

10 A You mean a gender code? Well, what they mean
11 by gender codes, I'm assuming that means the ICD-10 Code
12 F64. That's -- that's assuming that's what that means.

13 Q What's a B for both?

14 A Maybe that's written reference to male and
15 female.

16 Q What is the significance of that? Why does it
17 matter if it's -- what are the options? B for both and
18 then, what, M for male, F for female?

19 A That could -- I mean, that's what I'm assuming
20 based on -- based on this email chain. I mean, it's a
21 little difficult because -- I mean, there's a lot of
22 extrapolation and it's -- much of it's open to
23 interpretation, so --

24 Q Sorry, I lost my place. Please prepare a CCM
25 to remove gender code from all the NDC's. What are

1 NDC's? You said that?

2 A National drug codes. So that's almost like --
3 kind of like a procedure code, because each drug has a
4 corresponding NDC. So the system doesn't recognize drug
5 names or recognize national drug codes.

6 Q Okay. And that was actually -- that
7 instruction was provided to someone -- Arlene Elliot
8 sent that instruction to someone back in 2017, to remove
9 the gender code. Do you have any idea why Magellan and
10 AHCA were talking about this on June 3rd?

11 A No. We hadn't announced that we were going to
12 do a categorical exclusion yet.

13 Q Okay. I think this is just a place where
14 we're going to need to reserve some time for deposition
15 after you're able to do some adequate research on what
16 the information this email contains, and then we can do
17 some follow-up questioning. Okay.

18 You mentioned earlier, were there any
19 communications from the plans about the exclusion prior
20 to its adoption?

21 A What do you mean? Do the plans have any -- do
22 we discuss with the plans prior? No.

23 Q All right. Turning to waivers and variances
24 under Chapter 120, are you familiar with that process?

25 A Oh, yes, I am.

1 Q Okay. I'm going to hand you a copy of the
2 statute, Section 120.542. We'll mark that as Exhibit
3 20.

4 (Whereupon, Exhibit No. 20 was marked for
5 identification.)

6 BY MS. DEBRIERE::

7 Q Are you familiar with the statute?

8 A Yes, I'm familiar with it.

9 Q Based on your understanding, what is the
10 purpose?

11 A So the purpose of this is because, of course,
12 agencies are granted rulemaking authority. And because
13 agencies now -- and, of course, the rulemaking process,
14 I mean, it's public, transparent, but there are times
15 that there may be an exception that's required, so it's
16 kind of like the check and balances that if a variance
17 is required on a rule that -- like a party could apply
18 to that agency that administers that rule for
19 consideration of a variance.

20 Q Does the purpose of the underlying rule have
21 to -- the spirit of it have to be met in granting the
22 variance or waiver?

23 A What's meant by the spirit?

24 Q I'm trying to look for the specific language.
25 So under subpart two, variance and waiver shall be

1 granted when the person subject to this rule
2 demonstrates the purpose of the underlying statute -- I
3 guess in this case it would be a rule -- or what statute
4 will we be referencing?

5 A Well, in legal terminology, I mean,
6 differences between rule and statute, I mean, statutes,
7 of course, are approved by the legislature, goes to the
8 Governor, and the rules are done under the authority of
9 the statutes. So, I mean, like agencies are authorized
10 to grant variances and waivers to requirements of the
11 rules consistent with the section and with rules adopted
12 under the authority of the section. So, I mean, they do
13 call out rules, specific. Then, of course, this applies
14 to all state agencies, so --

15 Q Who makes a determination at AHCA whether a
16 petitioner has established a substantial hardship under
17 the statute?

18 A Those come through our General Counsel's
19 office. So if somebody wants to request a variance,
20 they do so through our agency clerk.

21 Q And how is the determination itself made?

22 A So the agency clerk will reach out to
23 individuals to, of course, who have pertinent knowledge
24 about the -- about the circumstances of the request of
25 the variance, will ask for input. And, of course, the

1 determination's made. It rides up to the Secretary.
2 The Secretary has to do the final approval for a
3 variance.

4 Q So same question as to determining whether
5 principle -- principles of fairness are violated, who
6 makes that determination?

7 A So when it comes to waivers and variances,
8 that's same process. Goes to the agency clerk. Then,
9 of course, does an investigation, consults with
10 individuals who are knowledgeable about the pertinent
11 subject, and then it goes up to the Secretary.

12 Q Has AHCA developed any criteria to guide its
13 determination of whether to grant a variance or waiver
14 from the categorical exclusion of gender-affirming care?

15 A No. No, we haven't. Variances are determined
16 on a very individualized basis.

17 Q So, again, turning back to the -- ensuring the
18 purpose of the underlying statute, 120.542 specifically
19 states that variance and waivers shall be granted when
20 the person subject to the rule demonstrates that the
21 purpose of the underlying statute will be or has been
22 achieved by other means for the person. So that means
23 the granting of the variance or waiver shows that the
24 purpose of the underlying statute will be or has been
25 achieved by granting it. What statute -- in reviewing

1 any request for a variance or waiver from 159G-1.050(7),
2 how would you demonstrate that the purpose -- well, what
3 statute will be at issue, first of all?

4 A Well, for the statute -- I mean, would be
5 Chapter 409. Those are the Florida Medicaid -- that
6 consists of the Florida Medicaid statute, so --

7 Q What specific -- what specific provision of
8 409 would you be looking at?

9 A I mean, we'd be looking at -- well, for the
10 variance, we'd probably be looking at, like, I mean,
11 somewhere under 409.9, probably under covered services
12 or optional services.

13 Q Okay. So how -- if someone requested a waiver
14 or variance from 59G-1.050(7), under what circumstances
15 would AHCA authorize coverage of the services listed in
16 that rule?

17 A Well, we can't speak to those because I don't
18 think -- we haven't gotten a request for variances on
19 this yet. So like it says, a highly individualized
20 process. We will be looking at in-depth at the
21 recipient, looking at all the records available, and, of
22 course, discussing things with various experts and so
23 forth. But each request is individualized. So because
24 each request is individualized and focuses on the
25 specific individual, we can't project on what grounds we

1 would grant a variance under.

2 Q Well, so the June -- the categorical exclusion
3 of treatment for gender dysphoria was adopted because
4 the certain -- AHCA found that those services were
5 experimental, correct? And Florida Medicaid cannot
6 cover services that are experimental?

7 A That's correct.

8 Q So in what situation could AHCA grant a waiver
9 or variance covering services that AHCA has found to be
10 experimental?

11 A Well, I mean, based on the rule we wouldn't.
12 I mean, based on the rule, we would deny the variance,
13 but because each variance, it's individualized requests,
14 we would have to go through and evaluate each one
15 individually.

16 Q Would the person have to establish that the
17 service they're requesting is not experimental?

18 A We will not be placing the burden on the
19 recipient.

20 Q Who would the burden be on?

21 A Well, that would be on -- it'd be an
22 individualized process, evaluating all the -- all --
23 whatever medical records that we can get a hold of.
24 That's -- that's process that we use in the past, but
25 based on the rule, I mean, yeah, we say that these

1 would -- you have a categorical exclusion. While we --
2 while the variance process is available, but because we
3 have a categorical exclusion, we do declare the services
4 to be experimental, investigational due to
5 very-low-quality evidence that -- yeah, I mean, we would
6 deny variance, but because variance reviews are
7 individualized, we don't want to speak in absolute terms
8 on the variance process. But for -- because, I mean,
9 there's all kinds of questions that could come up in the
10 review of the medical records. Maybe it was a -- maybe
11 it was a misdiagnosis. Maybe something else could come
12 up. That's pretty much why. So --

13 Q Okay.

14 A Everything is different and --

15 Q If a person sought a waiver of the application
16 of 59G-1.050(7) so they can receive Medicaid coverage
17 for a mastectomy that is specifically to treat their
18 gender dysphoria, under what circumstances would that
19 waiver be granted?

20 A For -- under what circumstances?

21 Q Yeah.

22 A Well, I mean, we did declare this service to
23 be experimental investigational.

24 Q So they could not get a waiver, correct? The
25 waiver would be denied?

1 A Based on the very general, hypothetical
2 situation that you provided, straight out just for
3 gender dysphoria, they got denied by their insured so
4 they request a variance.

5 Q Yeah.

6 A Based on our rule language, yeah, it'd be
7 denial.

8 Q And someone is entitled to a fair hearing when
9 Medicaid coverage is denied, correct?

10 A Yes, they are.

11 Q Given that the Agency has found the services
12 in 1.057 -- 59G-1.050(7) to be experimental, and
13 therefore never medically necessary, correct?

14 A Correct.

15 Q Could someone ever prevail at a fair hearing
16 where they sought coverage of the services for gender
17 dysphoria?

18 A Well, based on our rule, based on our
19 findings, no.

20 Q Could someone use the variance or waiver
21 process to get around the final decision issued after
22 the fair hearing?

23 A Well, I mean, they can request a variance, but
24 then they would go through the process, but based on our
25 rule and our findings, no.

1 Q How often do Medicaid beneficiaries file
2 variance requests?

3 A So in the research for this case, we found 10
4 requests, and that's since going back to about 2015,
5 2016.

6 Q Okay. So between 2015, 2016 to present, there
7 has been 10 requests?

8 A That's correct.

9 Q Okay. These variances -- and I have copies of
10 all of them, if you'd like to reference them. They
11 request that a service that AHCA affirmatively covers.
12 So there's -- there's a few types of variances we found
13 in our review. There's situations in which AHCA
14 affirmatively covers the service, but the individual
15 wants an amount greater -- in a greater amount or
16 duration.

17 A Yeah, I'm familiar with that one. It's --
18 there was a variance request -- and it was actually
19 several various requests, because they were granted for
20 six months at a time. We're talking about our recipient
21 under our I-budget waiver. So, of course, our I-budget
22 waiver -- and no, it isn't, it's codified in rule. So,
23 of course, there was a service limit on these behavior
24 assistance services at the time. They were requesting
25 additional behavior assistance services. So while -- so

1 because we already covered the service, and they're just
2 looking for additional services, you know, and that
3 that's -- that's flexibility that we can grant because
4 we haven't actually gone through -- the service they are
5 requesting, we have not codified as a categorical
6 exclusion, and we've not deemed that service be
7 experimental investigational.

8 Q Okay. And that's true for all the services
9 that are contained in the variances --

10 A Yeah, from what I could tell, they're pretty
11 much all I-budget.

12 Q Okay. And they -- none of the services that
13 they were requesting some kind of variance on had been
14 categorically excluded, correct?

15 A Correct.

16 Q Okay. And none of them have been determined
17 experimental?

18 A Right.

19 Q Okay. Do you know of every Medicaid recipient
20 who made a request for a variance, if they were
21 represented by counsel?

22 A No, we don't know if they were all represented
23 by counsel or not.

24 Q Because I did notice that the recipients were
25 all listed.

1 A Yeah, the recipients were listed. The
2 information is referred to the agency clerk. Then the
3 Agency does its internal processes.

4 Q Do you know what pro se means?

5 A No.

6 Q So, in any of the requests for variances to
7 the Medicaid recipient, him or herself, do any of the
8 direct request for the variance, or did they need
9 assistance?

10 A Given the complexities of request and
11 legalities of it, I would -- I think it's safe to say
12 that they had some assistance, although it's not
13 required.

14 Q Okay. Between April of 2022 and August 21st
15 of 2022, did anyone at AHCA ever discuss the variance or
16 waiver process for use in challenging a denial based on
17 the categorical exclusion of treatment for gender
18 dysphoria?

19 A No.

20 Q All right. Turning to our specific clients,
21 at anytime prior to August 21st, 2022, did Florida
22 Medicaid cover any of the services listed at
23 59G-1.050(7) for the treatment of gender dysphoria and
24 that actually --

25 A You're talking about --

1 Q Everyone.

2 A You're talking about after the hard date when
3 the ruling took effect?

4 Q Anytime prior to that, did Florida Medicaid
5 cover any of the services listed at 59G-1.05 --

6 A Prior to the effective date, yes.

7 Q Okay. So they covered puberty blockers?

8 A Yes. Well, for that small handful of
9 recipients we pulled the data on, yes.

10 Q They cover cross-sex hormone therapy for the
11 treatment of gender dysphoria?

12 A Yeah. I mean, as far as data showed.

13 Q Did they cover surgery for the treatment of
14 gender dysphoria?

15 A From our data revealed, yes.

16 Q At any time prior to August 21st, 2022, did
17 Florida Medicaid cover any of the services listed at
18 59G-1.050(7) for August Dekker?

19 A We did go through our -- we did go through
20 there the recipient's histories, yeah.

21 Q Did Florida Medicaid cover puberty blockers
22 for August Dekker to treat gender dysphoria?

23 A For August Dekker?

24 Q Yes.

25 A Puberty blockers?

1 Q Yes.

2 A I don't believe so, no.

3 Q Did Florida Medicaid cover hormone therapy for
4 August Dekker in treatment of gender dysphoria?

5 A For August Dekker, yes. I think -- I think
6 his managed care plan, Humana was providing him those.

7 Q And he's still currently eligible for Florida
8 Medicaid?

9 A Last time we checked he was still Medicaid
10 eligible.

11 Q Okay. And he's still enrolled in Humana, or
12 did he switch to another plan?

13 A Well, we haven't -- we haven't verified
14 since -- we did have an enrollment period and recipients
15 are eligible to switch plans during that enrollment
16 period.

17 Q In the coverage of hormones for treatment of
18 August Dekker's gender dysphoria, how long -- for how
19 long did AHCA authorize that treatment? For how long
20 did Florida Medicaid cover that treatment?

21 A I don't know the exact length. We would have
22 to go back and take a look at the records we received
23 from Humana on the case.

24 Q More than six months?

25 A I think it was more than six months.

1 Q More than a year?

2 A That's where it gets hazy.

3 Q Was coverage for hormones to treat gender
4 dysphoria terminated for August Dekker after August
5 21st?

6 A According to rule, yes, it would be
7 terminated.

8 Q Did Florida Medicaid cover surgery for August
9 Dekker and treatment of gender dysphoria?

10 A Yes.

11 Q When?

12 A So that would have been prior to the -- that
13 would have been prior to the challenge exclusion being
14 implemented. Then to clarify, that was -- is -- the
15 managed care plan was covering that outside our state
16 plan benefits.

17 Q How do you know that?

18 A Because our state plan does not -- does not
19 specify the service as being -- as being mandated for
20 coverage. In other words, if Humana had denied the
21 service, well, it would have just been a denial because
22 it's not a -- Medicaid doesn't -- we don't have that in
23 our state plan. Managed care plans have to cover all
24 state plan services. Sex change operations are not a
25 state plan covered service.

1 Q Surgery is a state plan covered service?

2 A Surgery, yes, but for -- but not for this --
3 necessarily this condition.

4 Q Does the state plan specify for what
5 conditions services are provided?

6 A No, it doesn't break down the diagnosis codes,
7 but this was one -- was the plan's discretion. The plan
8 could have said yes. The plan could have said no. It
9 was up to the plan.

10 Q Were federal Medicaid match dollars used to
11 pay for August Dekker's surgery?

12 A So capitation rates that we pay to the plans
13 are per-member per-month rate. That is a combination of
14 federal matching dollars and state revenue.

15 Q Okay. At any time prior to August 21st, 2022,
16 did Florida Medicaid cover any of the services listed at
17 59G-1.050(7) for Brit Rothstein?

18 A Based on the -- based on the records that we
19 pulled, based on the recipient's individual histories
20 that we were -- we were able to locate, looked like,
21 yes, we did.

22 Q Okay. Did Florida Medicaid ever cover puberty
23 blockers for Mr. Rothstein?

24 A So for Mr. Rothstein -- so for Mr.
25 Rothstein -- I -- so. Sorry. I think he's one of the

1 adult plaintiffs?

2 Q Yes. Yes. And you said that he -- I'm
3 sorry -- pulled in a lot of directions.

4 A We did cover services that we did determine to
5 be experimental investigational prior to the challenge
6 exclusion.

7 Q And no longer cover them, correct?

8 A Yes, because of the challenge exclusion.

9 Q Same question for KF.

10 A Since -- with KF, we did have a hard time
11 since for the minors we didn't have, like, their full
12 identification information. Trying to locate their
13 records in the system, I think there were encounters,
14 based on information we had, that did show they were
15 receiving GnRH.

16 Q Okay. For the treatment of gender dysphoria?

17 A Yeah.

18 Q Okay. And that includes Susan Doe, as well?

19 A Based on what we could find, looked like
20 they -- that there had been some coverage.

21 Q And they're -- KF is still currently eligible
22 for Florida Medicaid, is that correct?

23 A We would have -- I think -- I think they would
24 be, because we haven't been doing these determinations
25 because of COVID. So, yes, they would still be

1 Medicaid-eligible. That would go for all the
2 plaintiffs.

3 MS. DEBRIERE: Okay. Let's -- can we take a
4 five-minute break?

5 MR. JAZIL: Sure.

6 VIDEOGRAPHER: Okay. This concludes video
7 four. The time is 4:15 p.m.

8 (Brief recess.)

9 VIDEOGRAPHER: This is the beginning of video
10 five. The time is 4:30 p.m. We're on the record.

11 BY MS. DEBRIERE::

12 Q All right. Turning back quickly to plaintiff
13 August Dekker, did Humana violate Florida Medicaid
14 policy by covering his surgery for treatment of gender
15 dysphoria?

16 A No, they did not at the time.

17 Q Okay. And then I just want to talk about a
18 few more exhibits. One labeled -- we've marked as
19 Exhibit 21, and that is the GAPMS queue that was
20 provided to us.

21 (Whereupon, Exhibit No. 21 was marked for
22 identification.)

23 BY MS. DEBRIERE::

24 Q And it looks like the most recent date on that
25 queue was maybe an update to one of the GAPMS in 2019.

1 That's as far as it goes. Are all -- are these the only
2 GAPMS that are currently pending?

3 A So the requests came in to pull the most
4 recent GAPMS queue.

5 Q Yeah.

6 A So at this -- when I went through our -- we
7 have a GAPMS folder that's on our shared drive. I did
8 look through to see what -- we have a folder for the
9 GAPMS queues. I did pull the most recent one. This was
10 the most recent one that had been updated that was in
11 there --

12 Q I'm sorry. Go ahead.

13 A This does -- this does consist of a lot of
14 GAPMS reports, which I do remember drafting some of
15 those as well, but this was our most recent one.

16 Q And have there been GAPMS reports created
17 after 2018?

18 A Yeah, I think there have been.

19 Q Why aren't they on this list?

20 A I'm not -- I'm not sure why they wouldn't be
21 included on this list. This list should be updated on
22 regular basis, so I'm not sure why they wouldn't be
23 included on this, or on the list on the share drive,
24 because the GAPMS queue is really is not so much for the
25 GAPMS analyst, because GAPMS analysts generally have a

1 pretty good idea of what's outstanding, what's pending,
2 and what's been turned in. It's more for leadership --
3 or their supervisor to pull and take a look at when
4 necessary, so I'm not sure why this hasn't been listed
5 to update in this current.

6 Q So whoever's working in GAPMS at the time has
7 a good understanding of which GAPMS are pending.

8 A When I was -- when I had the role, I could
9 tell you exactly where all my reports were, what their
10 status was and where they stood in the queue. So, yeah,
11 I kind of had all committed to memory.

12 Q Okay. Would that be true of anyone holding
13 that GAPMS position?

14 A As far as pulling it from memory, I couldn't
15 vouch for the other employees as to their memories, when
16 it came down to their reports that are outstanding.

17 Q But they should have a good sense?

18 A They should have a good sense of what's
19 pending and what's been turned in.

20 Q Can you provide us a list of what's pending
21 that's not listed on this queue?

22 A So I think -- so I think the ones that are
23 still pending aren't -- I think there were, like,
24 reopened reports. I think we had gotten requests from
25 the manufacturers of Atheno, was the asthma tests that I

1 discussed earlier. That was one I had to have
2 finalized. We've gotten a request for them to -- for us
3 to review it, provided that they don't send some more
4 evidence and more studies that have been done after our
5 original report. So I think that one was reopened.
6 That one should still be pending. Then there was
7 specially modified low-protein foods. That was another
8 one that I had written up. We had gotten requests to
9 reopen that one that, and to reevaluate that service. I
10 think there was another one, which was the -- which was
11 a bone growth stimulator called Exigent. I think that
12 one is still outstanding and pending. Now, those are
13 just some examples of ones I can think are still
14 pending.

15 Q Were there any new requests made after
16 December of 2018?

17 A Yeah. I mean, there have been some new
18 requests for either, like, expedited GAPMS or full
19 GAPMS. I mean, we do get the service requests in fairly
20 frequently, so --

21 Q Because it would be odd if any new requests
22 hadn't come in almost five years --

23 A Correct. Yeah.

24 Q Okay. But there's no way -- all right. And
25 then I just want to put into the record, because we've

1 been referring to it quite a bit, we'll Mark it as
2 Exhibit 22, and that is the document from Health and
3 Human Services that we've referenced multiple times
4 during the deposition. Is that the one you're referring
5 to?

6 A That's correct. This is it.

7 (Whereupon, Exhibit No. 22 was marked for
8 identification.)

9 BY MS. DEBRIERE::

10 Q Thank you. And then the guidance from the
11 Florida Department of Health regarding treatment of
12 gender dysphoria for children and adolescents dated
13 April 20th, 2022. That's Exhibit 23. Is that the
14 document that we've been referring to when we're talking
15 about DOH guidance?

16 A Yes, it is.

17 (Whereupon, Exhibit No. 23 was marked for
18 identification.)

19 MS. DEBRIERE: And then -- I think that's it
20 for my questions. The only thing I wanted to put
21 on the record, Mo, is we are at what time,
22 Videographer?

23 VIDEOGRAPHER: Do you mean the whole run time
24 or --

25 MS. DEBRIERE: Just the questioning time.

1 Yeah, the time that we've been live and active on
2 the record.

3 VIDEOGRAPHER: Five hours, eight minutes plus
4 five and a half minutes.

5 MS. DEBRIERE: Okay. So want to just say that
6 we have an hour and 45 minutes of questioning --

7 MR. JAZIL: Sure.

8 MS. DEBRIERE: -- to reserve?

9 MR. JAZIL: And so the depo is open. I'd like
10 to ask questions at the end. So I'll just reserve
11 that until after our second session, is that okay,
12 or would you like for me to --

13 MS. DEBRIERE: Can I confer with my team
14 quickly? Okay.

15 VIDEOGRAPHER: We will remain on the record?

16 MS. DEBRIERE: We'll go off the record.

17 VIDEOGRAPHER: Okay. Off the record at 4:36
18 p.m.

19 (Discussion off the record.)

20 VIDEOGRAPHER: We're back on the record. The
21 time is 4:37 p.m.

22 MS. DEBRIERE: And plaintiff's counsel is all
23 finished with their questioning.

24 EXAMINATION

25 BY MR. JAZIL::

1 Q This is Mohammed Jazil for the defense. I'll
2 try to be brief, recognizing we have time limitations
3 here. Mr. Brackett, I'd like to have you look at
4 Exhibit 3 again.

5 A Okay.

6 Q Exhibit 3 has a date on it, May 20th, 2022. I
7 want the record to be clear, why is that date not
8 accurate?

9 A This date isn't accurate because that date
10 is -- automatically sets to the date you print it out.

11 Q And what sets that date?

12 A The template is automatically set to enter in
13 this current date that you're viewing the document. So
14 it automatically updates the second you open it.

15 Q And that's the template in the AHCA document?

16 A That is our template, yeah.

17 Q And when was this GAPMS report created?

18 A This GAPMS was originally created in 2016.

19 Q Thank you. You discussed with my friend the
20 variance and waiver process. Do you recall that
21 testimony?

22 A Yes.

23 Q You testified that the variance and waiver
24 process is individualized. Do you recall that
25 testimony?

1 A Yes, I do.

2 Q Once a variance and waiver request comes in,
3 it goes to the clerk is what you testified to, if my
4 understanding is correct?

5 A Yes.

6 Q And then the clerk routes it to whom?

7 A The clerk gathers information and it has to be
8 routed up to the secretary.

9 Q Is it routed directly to the Secretary or is
10 there any other office that it goes through first?

11 A I'd have to take a look at the variances
12 again. It might be -- I think it probably have to route
13 through General Counsel before it goes to the Secretary.

14 Q Okay. And is the General Counsel's office
15 responsible for the formulating the Agency's position on
16 legal issues?

17 A Yes.

18 Q Does that include the variance and waiver
19 process?

20 A Yes.

21 MR. JAZIL: I have no further questions.

22 FURTHER EXAMINATION

23 BY MS. DEBRIERE::

24 Q Just one redirect. Very brief. On Exhibit 3,
25 which is the GAPMS memo dated May 20th, 2022, that was

1 the date it was printed out. It also appears changes
2 were made on that date, is that correct?

3 A Based on the comments in the edits, yeah, it
4 looks like somebody had made changes to that document on
5 that date.

6 Q But you don't know who that person is?

7 A SG, I'm -- I can't speak to who SG is.

8 Q But you will find that information out for us?

9 A We can -- we can figure out who, but we
10 would -- probably want to verify with IT.

11 MS. DEBRIERE: Okay. That's all.

12 MR. JAZIL: So, counsel, while we're still on
13 the record, he's still under oath, so I'm not going
14 to obviously talk to him about any issues that
15 might come up, but with your consent, I'd like to
16 at least work with him to gather the additional
17 information that's being sought. Is that
18 appropriate?

19 MS. DEBRIERE: I mean, I would assume that
20 would be your process.

21 MR. JAZIL: He is under oath, and so I'm
22 obviously not going to try to, you know --

23 MS. DEBRIERE: I see. I see.

24 MR. JAZIL: -- work with him while -- work with
25 him on his testimony, I say, as I try to gather

1 additional information, so I'll make that clear on
2 the record.

3 VIDEOGRAPHER: Anyone else? Anybody by Zoom?

4 MS. DEBRIERE: No.

5 VIDEOGRAPHER: Okay. This concludes the
6 February 8th, 2023 portion of the video-recorded
7 deposition of Corporate Representative for Agency
8 for Health Care Administration. The time is 4:40
9 p.m.

10 COURT REPORTER: Are you going to be ordering
11 this?

12 MS. DEBRIERE: Yes.

13 COURT REPORTER: All right. And Mo has
14 requested a rough draft. I told him I could get it
15 to him tomorrow. Do you guys -- would you guys
16 like one, as well?

17 MS. DEBRIERE: Yes, please.

18 (Whereupon, the deposition was concluded at
19 4:40 p.m., and the witness did not waive reading
20 and signing.)

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CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF LEON)

I, the undersigned authority, certify that the above-named witness personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 21st day of February, 2023.



DANA W. REEVES
NOTARY PUBLIC
COMMISSION #GG970595
EXPIRES MARCH 22, 2024

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CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, DANA W. REEVES, Professional Court Reporter, certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages, numbered 128 through 257, are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 21st day of February, 2023.



DANA W. REEVES
NOTARY PUBLIC
COMMISSION #GG970595
EXPIRES MARCH 22, 2024

1 Gary V. Perko, Esq.
gperko@holtzmanvogel.com

2
3 February 21, 2023
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5 RE: August Dekker, et al. vs. Jason Weida, et al.
6 February 8, 2023/Matthew Brackett/5696545
7

8 The above-referenced transcript is available for review.
9 The witness should read the testimony to verify its
10 accuracy. If there are any changes, the witness should
11 note those with the reason on the attached Errata Sheet.
12 The witness should, please, date and sign the Errata
13 Sheet and email to the deposing attorney as well as to
14 Veritext at Transcripts-fl@veritext.com and copies will
15 be emailed to all ordering parties. It is suggested
16 that the completed errata be returned 30 days from
17 receipt of testimony, as considered reasonable under
18 Federal rules*, however, there is no Florida statute to
19 this regard. If the witness fail(s) to do so, the
20 transcript may be used as if signed.
21

22 Yours,
23 Veritext Legal Solutions
24 *Federal Civil Procedure Rule 30(e)/Florida Civil
25 Procedure Rule 1.310(e).

1 August Dekker, et al. vs. Jason Weida, et al.

2 February 8, 2023/Matthew Brackett

3 E R R A T A S H E E T

4 PAGE _____ LINE _____ CHANGE _____

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18 REASON _____

19 Under penalties of perjury, I declare that I have read
20 the foregoing document and that the facts stated in it
21 are true.

22 _____

23 _____

24 Matthew Brackett

DATE

25 _____

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate.

The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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