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

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.

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

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

Whereupon,

MATTHEW BRACKETT

was called as a witness, having been first duly sworn to speak the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

THE WITNESS: I do.

COURT REPORTER: Thank you.

EXAMINATION

BY MS. DEBRIERE::

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

A That's fine.

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

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

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

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

BY MS. DEBRIERE::

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

A Yes.

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

A Yes.

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

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

A I do.

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

A Yes.

Q Have you ever been deposed before?

A Yes, I have.

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

A Okay.

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

A I'm fine with that.

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

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

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

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

A Okay.

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

A No.

Q And state your name for the record.

A So my full name is John Matthew Brackett.

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

A That's correct.

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

A Yes.

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

A Yes.

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

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

Q And who provided them to you?

A Those were provided to me by our outside counsel.

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

A Yes, I did.

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

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

Q Okay. Who did you speak to?

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

consulted my supervisor Devona Pickle.

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

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

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

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

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

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

BY MS. DEBRIERE::

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

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

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

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

Q The conferences, what were those about?

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

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

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

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

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

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

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

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

BY MS. DEBRIERE::

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

A Yeah, close enough.

Q What was your role at the Agency?

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

Q And how long did you do that for?

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

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

A Yes, I was.

Q And what was your role then?

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

completing the Generally Accepted Professional Medical Standards reports.

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

A Yes.

Q And what did you do then?

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

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

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

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

A Yes.

Q And that was in December of 2017 through --

A November 2017 through April of 2021.

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

A April 2021.

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

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

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

MS. CHRISS: Yes.

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

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

MR. JAZIL: Thank you.

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

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

BY MS. DEBRIERE::

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

A Okay.

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

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

Q What does AHCA use that medical necessity standard for?

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

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

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

Q Okay. Tell me why.

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

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

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

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

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

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

A No.

Q Okay. Why not?

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

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

A No, we wouldn't.

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

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

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

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

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

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

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

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

A No, they need to consult with us before

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

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

MS. CHRISS: May '22.

BY MS. DEBRIERE::

Q May 20th, 2022.

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

MS. DEBRIERE: Yes. Yes.

VIDEOGRAPHER: The one to your right. Thank you.

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

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

MS. DEBRIERE: Should I mark this as 3?

MS. CHRISS: Yes, the one for him.

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

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

committed to memory?

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

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

MS. DEBRIERE: Thanks.

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

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

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

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

BY MS. DEBRIERE::

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

A Yes.

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

A Okay.

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

A Okay.

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

A Yes, this is.

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

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

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

A One of our staff pharmacists probably would.

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

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

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

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

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

Q Do they compare it to coverage policies or guidelines?

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

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

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

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

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

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

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

A Well, so the thing about Medicaid coverage for

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

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

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

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

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

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

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

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

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

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

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

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

A Can you repeat that?

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

MR. JAZIL: Object to form.

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

BY MS. DEBRIERE::

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

authorization review?

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

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

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

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

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

Q Does that policy list every potential

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

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

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

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

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

A Yes.

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

A Oh, are we talking about estradiol.

Q Estradiol. Thank you.

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

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

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

Q Okay. How about micronized progesterone?

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

Q Okay, but not specifically named?

A We don't specifically name drugs.

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

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

Q Okay. Finasteride.

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

Q Dutasteride.

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

Q Okay. Testosterone.

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

Q Testosterone enanthate.

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

Q Okay. Two more. Testosterone undecanoate.

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

Q Gonadotropin-releasing hormone antagonists.

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

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

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

A Not promulgated into rule.

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

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

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

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

MS. CHRISS: This one?

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

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

THE WITNESS: I've seen it enough times.

BY MS. DEBRIERE::

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

A Yes.

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

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

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

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

medical necessity is made.

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

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

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

A That's correct.

Q And how do they do that?

A How do they do that?

Q Yeah.

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

Q Okay. MPI stands for --

A Medicaid Program Integrity.

Q So that's like a fraud investigation?

A Yes, there are two fraud investigation teams

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Do you know what a drug compendium is?

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

Q Which three are you aware of?

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

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

A That sounds correct.

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

A Yes.

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

A Okay, that's fine.

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

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

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

Q Do not require.

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

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

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

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

it?

A Yes, I recognize that.

Q What is the PDL?

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

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

Q Okay. Okay.

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

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

A And we do program our system with ICD-10

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

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

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

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

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

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

A That's correct.

Q Okay.

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

National Drug Codes.

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

A No, they were a little of everything.

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

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

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

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

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

BY MS. DEBRIERE::

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

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

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

A Yeah.

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

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

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

A Pharmacy Benefit Manager.

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

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

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

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

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

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

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

A Estradiol.

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

A That's correct.

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

A That's correct.

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

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

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

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

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

Q So that means no prior authorization is ever required?

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

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

A Right, not until the claim comes in.

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

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

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

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

A Okay.

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

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

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

A To program it to deny it?

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

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

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

A For estradiol?

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

A So we use ICD-10 for --

Q ICD. Okay.

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

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

A That's correct.

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

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

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

A Yes.

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

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

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

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

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

Q Okay. Would it also be governed by AHCA's drug criteria? And I'll just -- I'll pull that up. So when I say AHCA's drug criteria, I'm referring to that criteria listed at https://AHCA -- A-H-C-A --.myflorida.com/Medicaid/prescribed_ drug/drug _criteria.shtml.

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

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

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

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

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

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

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

Q How about for managed care?

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

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

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

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

A On the criteria?

Q Uh-huh?

A After --

Q Yes.

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

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

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

A I have trouble following that question.

MR. JAZIL: Object to form.

BY MS. DEBRIERE::

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

A Okay.

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

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

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

A That's correct.

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

A What ICD-10 codes?

Q Yes.

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

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

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

MS. DEBRIERE: Thank you. Okay.

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

(Brief recess.)

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

BY MS. DEBRIERE::

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

A I really don't know.

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

A Not on the PDL, no.

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

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

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

A That's correct.

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

A That's correct.

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

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

Q Because why?

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

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

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

policy, that claim would deny.

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

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

Q Right.

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

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

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

Q What is involved in a clean claim?

A No errors.

Q Errors of what?
A Someone might type in the wrong code by accident. Maybe they -- human error.
Q Okay. But you're -- but in that clean claim, there's no requirement to submit the indication for which it's being prescribed or AHCA undertaking a review of that?
A I mean, we do do retrospective review of claims.
Q At the time the coverage is being requested.
A Okay. Can we go back a little bit?
Q Yeah, yeah. Yeah. So looking at this formulation of testosterone cypionate, where no clinical prior authorization is required, when the claim is submitted and -- when the claim is submitted, AHCA is not doing a review of whether the indication it's being prescribed for -- sorry. Scratch that.
Looking at testosterone cypionate, in the formulation that we've been discussing where no clinical prior authorization was required, when the claim is submitted, AHCA -- neither AHCA nor its contractors does a review to determine for what indication the drug is being prescribed for?
A Right, there'd be no manual clinical review process or prior authorization process, if that's what

you're asking.

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

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

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

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

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

A Yes, we have a procedure for that.

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

FDA-approved?

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

Q Okay. And what is that process?

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

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

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

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

tried other drugs?

A That's correct, yeah.

Q Okay.

A It would be an individualized basis.

Q Okay. And then the second step was what?

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

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

A Plus support in the peer-reviewed literature.

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

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

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

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

BY MS. DEBRIERE::

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

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

Q Okay. And that starts with the criteria that

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

A Uh-huh.

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

A Yes.

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

A Okay.

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

MS. DUNN: Yes.

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

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

BY MS. DEBRIERE::

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

A I can give you more --

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

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

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

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

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

MR. JAZIL: Thank you.

BY MS. DEBRIERE::

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

A Okay.

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

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

Q Okay. And do we have that routing form?

MR. JAZIL: You should.

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

BY MS. DEBRIERE::

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

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

Q Please.

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

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

A She was one of our pharmacists.

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

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

BY MS. DEBRIERE::

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

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

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

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

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

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

Q Okay. And why did those questions arise?

A Those questions had arisen as part of the

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

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

A That's correct.

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

A Sarah Craig, I think, left in 2020.

Q Okay. Do you know where she went?

A I do not.

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

A Okay.

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

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

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

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

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

Q Uh-huh.

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

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

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

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

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

Q Okay. Who had access to this document?

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

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

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

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

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

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

Q Would it be Sheena Grantham?

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

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

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

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

A Yes.

MS. DEBRIERE: Let's flag that.

BY MS. DEBRIERE::

Q Was this report ever finalized?

A To my knowledge, and I did actually do some

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

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

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

Q Okay.

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

Q And GAPMS is generally low priority?

A It depends.

Q What does it depend on?

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

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

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

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

A The Capitol.

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

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

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

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

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

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

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

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

A Yes.

Q Prior to its adoption, prior to AHCA's

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

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

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

A Under -- so, well --

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

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

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

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

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

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

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

Q Fee-for-service only.

A We don't necessarily have that information available.

Q Why?

A Well, not offhand.

Q Why?

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

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

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

data.

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

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

Q In fee-for-service?

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

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

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

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

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

MS. DUNN: The one that was signed?

MS. DEBRIERE: Yeah.

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

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

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

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

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

BY MS. DEBRIERE::

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

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

Q Okay.

A And the one on the puberty suppression.

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

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

projects from 2016.

Q Okay. Okay.

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

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

Chelsea, should we mark it?

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

MS. DEBRIERE: Are we on 7? Okay.

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

BY MS. DEBRIERE::

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

A This would be the final report if he signed

it.

Q Okay. So it was adopted by the Agency?

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

Q Who authored this report?

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

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

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

Q Why would she then look at puberty suppression therapy?

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

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

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

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

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

A I think she was an RN.

Q Okay.

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

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

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

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

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

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

BY MS. DEBRIERE::

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

A You mean the criteria?

Q Yes. Yes. Exhibit 4.

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

Q The dates say six days.

A The dates say six days?

Q Yeah.

A I'll defer to that.

Q Okay. Are these two documents related?

A Can you provide some context on what related means?

Q Is one based off another?

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

Q Okay. So was the special services criteria at

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

MR. JAZIL: Exhibit 4?

MS. DEBRIERE: Did I say 3? I'm sorry. Exhibit 4. Thank you, Mo.

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

MS. DEBRIERE: Okay.

THE WITNESS: Based on the EPSDT consideration portion.

BY MS. DEBRIERE::

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

A Yes.

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

A Yes, correct.

Q Okay. Between the time this policy was

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

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

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

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

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

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

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

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

A I do not have those numbers.

Q Okay. Can we get those numbers?

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

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

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

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

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

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

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

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

BY MS. DEBRIERE::

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

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

information.

Q And you will provide us that information?

A We will obtain that information.

Q Okay.

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

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

MS. DEBRIERE: Okay.

BY MS. DEBRIERE::

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

confirmation surgery.

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

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

BY MS. DEBRIERE::

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

A So this report is authored by Rebecca Buceo.

Q Okay. When?

A This was authored in the summer of 2017.

Q How do you know who was authored by?

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

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

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

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

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

A That's correct.

Q Okay. Whose office was it found in?

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

Q Okay. And what else was in that binder?

A I think some of the research articles she used.

Q Is that it?

A That was it.

Q Okay. Is Rebecca Buceo still with AHCA?

A No, she's not.

Q When did she leave?

A I believe she left in 2019.

Q Okay. And what was her subject matter expertise?

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

Q Did she have any expertise in surgery?

A Not professionally, no.
Q What about not professionally?
A In other words, she's never worked as a surgeon or anything like that. But, I mean -- but I mean -- or in the formal education in that area.
Q Okay. But did she have any experience with surgery that would help her inform the drafting of this GAPMS?
A I couldn't speak to that.
Q Did AHCA ever rely on the conclusions in this report?
A So this report did not get past her immediate supervisor, so, no.
Q Okay. Prior to its adoption of the categorical exclusion of treatment for gender dysphoria, did Florida Medicaid ever cover gender confirmation surgery for the treatment of gender dysphoria?
A Under fee-for-service, to the best of my knowledge, we didn't. In managed care, there were a few instances where the managed care plan did approve the procedure.
MS. DEBRIERE: Okay. Can we look at those exhibits now? The -- I forget what they're called. They're a weird name. ATTB, ATTA. It's a weird name. It wouldn't come to me.

BY MS. DEBRIERE::

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

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

BY MS. DEBRIERE::

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

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

BY MS. DEBRIERE::

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

A Yes, that would mean it was approved.

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

A Uh-huh.

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

A That's correct.

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

A That's gender dysphoria.

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

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

Q Yeah.

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

Q Okay. And how do you know that?

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

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

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

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

A Each Medicaid recipient has a unique Medicaid

ID assigned to them. That's correct.

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

A Yeah, that's correct.

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

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

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

A That would be correct.

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

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

BY MS. DEBRIERE::

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

June 2022 GAPMS.

A That's fine.

Q When was the request to initiate this GAPMS made?

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

Q Were there any informal requests prior to that time?

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

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

A Our Agency leadership.

Q And who is that comprised of?

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

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

A Yes.
Q Okay. Who else in leadership was aware that this would be coming to AHCA prior to April 20th, 2022?
A At the time, Secretary Weida was serving as Assistant Deputy Secretary. He did have knowledge.
Q Okay. Anybody else?
A To my --to my knowledge, those two were the ones with the knowledge of this project.
Q Okay. When did you have knowledge of the project?
A Just probably a few days before we were given the letter.
Q Okay. So, like, April 17th?
A Something around there. Yeah, I don't remember the exact date.
Q Okay. Who did you gain the knowledge -- who did AHCA leadership gain the knowledge from?
A As far as the project goes, the decision to do a GAPMS to my -- so that was to do a GAPMS report, that was determined by our legal as the best route to evaluate the medical necessity for treatments for gender dysphoria. It was that -- it was subjected to the GAPMS process.
Q Okay. And which counsel was that?
A Andrew Sheeran, who's now our General Counsel.

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

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

Q Who would have been the first point of contact?

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

Q And that was?

A Josephina Tamayo.

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

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

Q No.

A -- or about requesting a Medicaid review?

Q Requesting a Medicaid review.

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

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

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

Newman and Maureen Farino.

Q Okay. What other agencies were involved?

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

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

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

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

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

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

A I can't name them with any specificity.

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

A So in regards specifically to this project?

Q Are there other projects we should be aware of?

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

Q Regarding what project?

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

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

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

Q No. Centers for Medicare. Great question.

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

Q Excuse me, HHS.

A It was in regard to that guidance.

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

A Right.

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

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

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

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

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

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

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

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

A No.

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

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

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

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

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

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

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

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

MR. JAZIL: Object to form.

MS. DEBRIERE: I can strike that.

BY MS. DEBRIERE::

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

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

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

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

MR. JAZIL: Object to form.

THE WITNESS: No.

BY MS. DEBRIERE::

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

MR. JAZIL: Object to form.

THE WITNESS: Can you rephrase that question?

BY MS. DEBRIERE::

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

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

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

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

Q So why did AHCA general counsel decide that

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

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

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

A To my knowledge, there was not.

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

A To my knowledge, yes.

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

A Are you talking about the Florida Department

of Health folks?

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

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

Q So AHCA did not reach out to HHS either?

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

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

A Uh-huh.

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

A State Medicaid Director, Deputy Secretary.

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

A Yes.

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

A Because the DOH guidance had just been published.

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

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

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

A Yes.

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

A To the knowledge of the Agency, yes.

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

A We started work on April 20th.

Q You didn't do anything prior to that?

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

do anything like that.

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

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

Q Who worked on the 2022 GAPMS at the Agency?

A You mean the June 2022 GAPMS?

Q Yes.

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

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

A Worked on the maps for Western Europe.

Q Okay. And what did Dede Pickle do?

A The maps for the State Medicaid programs.

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

A That's correct.

Q Okay. And did you have any assistance?

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

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

A Yes.

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

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

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

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

A Nobody assisted me with the drafting.

Q Inside or outside the Agency?

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

Q Were they a verbal consultations?

A They were verbal.

Q Only verbal?

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

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

A They did not write any of the main report.

Q Or outline it or anything?

A No.

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

after-the-fact request form under 35k.

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

BY MS. DEBRIERE::

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

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

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

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

Q Okay. So you wanted to make sure that there

would be a quick response to the HHS guidance?

A Yes.

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

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

Q Yes.

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

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

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

Q What -- How did you know that?

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

clinical indication.

Q Okay.

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

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

A Not necessarily.

Q Why?

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

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

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

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

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

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

A Uh-huh.

Q Okay. After the checklist was developed, for

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

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

Q What was your mental checklist?

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

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

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

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

A Went to a GAPMS.

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

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

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

A Prior to the request being made.

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

A No.

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

A No.

Q What about HHS?

A No.
Q And what about Alliance Defending Freedom?
A No.
Q Liberty Counsel?
A No.
Q Okay. What consultants were used by AHCA in the development of the GAPMS.
A So during the development, we have a few verbal conversations with Doctors Miriam Grossman and Andre Van Mol.
Q Okay. And what did those conversations entail?
A Well, Dr. Van Mol, he just offered suggestions for articles and research for us to look at. He did provide us with a bibliography for our consideration, as far as -- mostly just leads on research to help save time in finding resources. And Dr. Grossman, of course, she provide us with some history of gender dysphoria treatments, and gave us more reviews of some scientific techniques.
Q How did you get connected with Dr. Van Mol?
A So Dr. Van Mol, like all of our experts, who also provide published reports, so the process for those was that we did get a name at the very outset of the process, which was Michelle Cretella. And by contacting

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

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

A Yeah.

Q Okay. And who Michelle?

A Michelle -- Dr. Michelle Cretella?

Q Uh-huh.

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

Q How did you find her?

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

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

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

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

A Yes.
Q You didn't do any outside research on whether you should seek out other consultants?
A Well, we were vouching for our -- for the consultants. I mean and so we did want individuals who had expertise in their respective fields of medicine, and who also were going to take an evidence-based approach.
Q Okay. Who at Department of Health recommended Dr. Cretella?
A Don't -- we don't have the name of the individual.
Q Because it was sent in an anonymous email? Why don't you have the name?
A We can get that information for you.
Q So you don't have the name, but the Agency has the name, correct?
A The Agency might have a name. We need to confirm that.
Q And who at the Agency was this communication sent to? I mean, how was it communicated?
A To my knowledge, it was verbal. It was a verbal exchange.
Q Okay. So who at AHCA was part of that conversation?

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

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

A Yes.

Q Could it have been anybody else at the Agency?

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

Q It seems like you have a name in mind.

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

Q Who was the chief of staff?

A Cody Farrell.

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

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

Q And she recommended everyone, is that correct?

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

with. So there were some that we did turn down.
Q Who did you turn down?
A We can get that -- we can get that -- we can get those names for you.
Q With Dr. Cretella, was there any consideration given to the associations, the medical associations of which she was a member?
A No.
Q Okay. So you didn't look to see if she was associated with any particular medical association?
A No.
Q You just went off the recommendation of Department of Health?
A Yes.
Q Was Dr. Cretella paid for her assistance with -- to AHCA?
A No.
Q So DOH didn't pay her or anything?
A Well, I don't know at DOH, that's a question for the Department of Health. AHCA did not -- we did not establish a financial arrangement with her.
Q Okay. Are you -- are you personally aware of any financial arrangement between Dr. Cretella and Department of Health?
A No.

Q Okay. I'm sorry. Who did you turn down?
A We would have to get those for you.
Q Okay. And so Dr. Grossman and Dr. Van Mol just gave you some article leads, and that's all?
A Gave some article leads, some background information. Yeah, it was -- I mean, as far as providing us with content to include in the report, they did not.
Q Why not?
A Because it was an independent assessment by the Agency.
Q Okay. Did -- but they didn't write any of the reports that were in the attachments to the June 2022 GAPMS either?
A Right?
Q Why not?
A I think because we had experts. We already had a psych -- one psychologist who was writing one. We already had -- we, of course, we had physicians for, like, plastic surgery. We had a bioethicist, as well. Since those bases were covered, we felt they would best benefit us by helping provide guide -- guidance with research.
Q Were they ever given the option of writing a report for one of the attachments?

A No, we didn't ask them to write a report.
Q Okay. Did they ask if they could write a report?
A No, they did not.
Q How did you identify Dr. Romina Brignardello-Petersen?
A So through the contacts we were making, her name was passed on to us as someone at McMaster University who had some experience in doing evidence evaluation.
Q Did Dr. Cretella pass on that name?
A As far as the actual contact that gave us that name?
Q Uh-huh.
A Dr. Cretella was kind of the head of the tree of the contacts. We would have to go back and get that information on who gave us the exact name for Dr. Brignardello-Petersen.
Q Okay. But Dr. Cretella was the one who -- so what -- if Dr. Cretella didn't recommend Dr. Brignardello-Petersen, who would have?
A We would have to get that information for you.
Q Would it have been another physician?
A Yes, it likely -- yes, it would have probably been another physician.

Q What other physicians provided recommendations for consultants?

A We would have to get that information.

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

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

Q Okay. So who recommended Dr. Cantor?

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

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

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

BY MS. DEBRIERE::

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

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

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

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

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

MS. DEBRIERE: Yes.

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

what he's talked about, well --

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

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

MS. DEBRIERE: Thank you.

BY MS. DEBRIERE::

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

A That's information we would have to --

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

A Right.

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

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

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

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

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

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

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

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

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

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

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

Q Any other federal standards?

A No.

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

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

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

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

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

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

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

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

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

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

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

A That was one element of many elements.

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

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

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

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

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

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

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

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

Q What about the American Academy of Family Physicians?

A No, we didn't use theirs.

Q What about the American Academy of Pediatrics?

A We did do an evaluation of theirs.

Q Did you rely on them, their conclusions?

A So what do you mean by --

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

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

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

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

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

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

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

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

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

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

Q And ultimately you disagreed with their standards?

A Ultimately, yes.

Q What about the American Psychiatric Association?

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

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

A No, we did not.

Q What about the American Psychological Association?

A No, we did not.

Q American Medical Association?

A We did not.

Q When you say we, you mean --

A The Agency.

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

MS. DEBRIERE: Oh, yes.

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

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

VIDEOGRAPHER: Okay. This concludes video two. The time is 12:42 p.m.

(Whereupon, the deposition resumes in Volume 2.)

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

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

Gary V. Perko, Esq.
gperko@holtzmanvogel.com

February 21, 2023

RE: August Dekker, et al. vs. Jason Weida, et al.
February 8, 2023/Matthew Brackett/5696545

The above-referenced transcript is available for review. The witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason on the attached Errata Sheet. The witness should, please, date and sign the Errata Sheet and email to the deposing attorney as well as to Veritext at Transcripts-fl@veritext.com and copies will be emailed to all ordering parties. It is suggested that the completed errata be returned 30 days from receipt of testimony, as considered reasonable under Federal rules*, however, there is no Florida statute to this regard. If the witness fail(s) to do so, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions
*Federal Civil Procedure Rule 30(e)/Florida Civil Procedure Rule 1.310(e).

August Dekker, et al. vs. Jason Weida, et al.

February 8, 2023/Matthew Brackett

E R R A T A S H E E T

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Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

_____ _____

Matthew Brackett DATE

p

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.

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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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REPRESENTING THE DEFENDANT:

MOHAMMAD O. JAZIL, ESQ.
GARY V. PERKO, ESQ.
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Tallahassee, Florida 32301

ALSO PRESENT:
RL Minnich, Videographer

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

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.

Q And turning back to the individuals who wrote reports for the June 2022 GAPMS, who made the decision to contract with them to prepare those reports?

A So after establishing each one, we wanted to -- their backgrounds and their suitability to provide reports, that decision was made by, I think, now Secretary Weida.

Q And who was involved in determining whether they had the appropriate backgrounds to write the reports?

A So I think those individuals who were working with the experts, I think that was, of course, now Secretary Weida, I think at our time, General Counsel Josephina Tamayo.

Q Okay. Anybody else?

A I don't --

Q Were you involved?

A I was not.

Q Was Nai Chen involved?

A He was not.

Q Was Dede Pickle involved?

A She was not.

Q Okay. So now Secretary Weida and Josephina Tamayo were the two people who decided whether the consultants who read the reports were qualified to do

so?

MR. JAZIL: Object to form.

THE WITNESS: So are you asking that whether or not those two only assessed their credentials?

BY MS. DEBRIERE::

Q Yes.

A I mean, yeah. I mean, they assessed their credentials and looked at their background and experience and knowledge.

Q Were those the only two people that assessed their credentials before deciding whether to engage them?

A In regarding the Agency, I mean, the -- Andrew Sheeran may have been involved. So it's possible a couple others with the principal decision to rely on those experts was theirs.

Q Okay. And so just to be clear, you were not involved in that decision?

A I was not involved in that decision.

Q And Nai Chen was not involved in that decision?

A That's correct.

Q And Dede Pickle was not involved in that decision?

A Correct.

Q When making that decision, did AHCA investigate whether any of the consultants had a stance related to the treatment of gender dysphoria?

A We, of course, were looking for those that had -- were knowledgeable about the existing literature of gender dysphoria, and those who would, for the supplemental reports, would take an evidence-based approach.

Q Did it -- so those were the only two criteria that you used to determine which consultants you would engage with?

A Correct.

Q And so opposition to gender-affirming care was not a factor in who you chose?

A We were specifically looking -- I think we might be talking semantics on what we consider opposition, but we were looking for individuals who were going to make reports and recommendations based on the existing evidence.

Q Okay. Was whether the vendor had experienced treating -- I'm sorry. Was whether the consultant had experienced treating gender dysphoria a factor?

A Not so much a factor that would outweigh the knowledge of the existing literature and the evidence, since this was going to be a -- the GAPMS process really

takes into account peer-reviewed literature. It takes into account evidence-based clinical guidelines, et cetera, so those are our primary -- our primary factors in evaluating the experts and their ability to contribute to this report.

Q Would people who actually provide treatment in gender dysphoria be most familiar with peer-reviewed literature as it relates to their practice?

A Well, that is a complicated question. They don't necessarily have to be. It's possible to -- I mean, it is possible -- I mean, it is hypothetically speaking, someone could engage in treatment of these individuals and run and follow anecdotes.

Q So it's not important to AHCA that the consultants with whom you engaged had actual experience treating gender dysphoria?

A So based on how the GAPMS rule is written, the needs of the report, we really -- the primary ask was for individuals who were steeped in the evidence.

Q But didn't necessarily have actual real life experience treating gender dysphoria?

A Right, that wasn't a primary consideration.

Q Okay. For -- was AHCA aware that all the consultants with which you engaged took a stance to oppose mainstream medical organizations' stance on

gender-affirming care?

MR. JAZIL: Object to form.

THE WITNESS: So are you talking about in opposition or in contradiction?

BY MS. DEBRIERE::

Q Contradiction.

A We -- whether contradiction or alignment really was irrelevant, it really was taking a look and making evidence-based conclusions.

Q Speaking to Dr. Brignardello-Petersen -- I'm sorry. I'll start here actually. In deciding on whether to use these consultants, was any input provided from the Alliance Defending Freedom?

A No.

Q What about the Heritage Foundation?

A No.

Q Liberty Council?

A No.

Q Society for Evidence-Based Gender Medicine?

A We may have gotten Romina's name from that organization.

Q Okay. And what about the Family Christian Coalition?

A No.

Q Did you get anybody else's name from the

Society for Evidence-Based Gender Medicine?

A Because the -- because it was verbal conversations, so don't -- don't think so, but the kind of details -- because there's a lot of verbal conversations and no written record, so --

Q Maybe?

A It could be a maybe at best.

Q And did the Family Christian Coalition recommend any of -- or play any role in the recommendation of the consultants --

A No.

Q -- with AHCA engaged? What about the Florida Citizens Alliance?

A No.

Q The Florida Department of Health?

A Well, the Florida Department of Health passed along to the name of Dr. Michelle Cretella. So, yes.

Q What about the Governor's office?

A No.

Q The Surgeon General Ladapo?

A Well, he would be acting in his capacity as, of course, the agency head for the Department of Health. So the Department of Health, cumulatively, gave us that name.

Q Did he personally?

A There was a conversation, like, once with our general counsel Tamayo at the time with Dr. Ladapo, but we don't recall whether or not the name was given during that conversation.

Q I think you touched on this a bit earlier, so I apologize for circling back around, but did AHCA consider using any other consultants in the development of the June 2022 GAPMS?

A By any other --

Q Other than those that wrote the reports or Grossman or Dr. Van Mol?

A There were those who were contacted. Of course, there was -- it was all verbal conversations, but not necessarily -- not necessarily considered to write a report either.

Q And do you remember who you were -- who you contacted?

A Since it was all through verbal conversations, it was eight months ago, it wasn't through written correspondence, the -- we're not really aware of all those details.

Q And who was the one who did the contacting?

A The contacting was done, I think -- I think by Andrew Sheeran. He's now our General Counsel. I think Josephina Tamayo -- Tamayo. Sorry. I think she also

was involved in contacting them.

Q Okay. And those were all phone calls?

A These were verbal conversations, yes.

Q So no communication by email?

A No.

Q Did you use the folks who ended up not offering the reports -- aside from Dr. Van Mol and Dr. Grossman and the individuals who authored the reports, did you use the people that you contacted in any other capacity?

A No.

Q And what was the scope of the agreement between AHCA and each consultant?

A So each consultant, of course, they provide us their hourly rate. We wrote up purchase agreements that those amounts cannot exceed $35,000 because of the nature of the procurement.

Q Can you speak a little bit more to that? I'm not -- I'm unfamiliar with the way that -- the regulations that govern that.

A So if it were to exceed $35,000, it would have to be a competitive procurement, and that's why -- so the -- so we, of course, we enter in agreements with each of these experts. The amounts paid to them cannot exceed 35,000.

Q Okay. What was each vendor -- in procurement of consultants, was this the usual procedure? I'm sorry. In contracting.

A Yeah, this is the procedure that we can follow.

Q That you can follow, but is it the usual procedure?

A Well, I mean, what is defined by a usual procedure? I mean --

Q How many times in prior GAPMS have you contracted with a consultant to develop the GAPMS?

A Well, we haven't, but then there are instances -- I know with coverage determinations, et cetera, that sometimes we will actually send stuff for a physician review, like over at EQ Health Solutions. So it's not unusual for us to ask for medical experts or clinical expertise on a prospectus.

Q Had you ever previously contracted and paid the person for that clinical expertise?

A No, we had not.

Q What was the total budget allocated to the development of the GAPMS?

A You know, 35,000 times seven. That'd be 210 -- 245,000.

Q So each consultant is capped at --

A That was the cap of the budget.
Q And is that 34,999, or 35 straight?
A I'm leaning towards 34,999, so we can subtract $7 from that amount.
Q Okay. Has each consultant been paid in full for that work?
A Each consultant has been paid in full for the work they completed.
Q Okay. Some of those consultants now, though, are acting as experts in this case and being reimbursed for that, as well?
A Those would be under separate agreements.
Q Okay. In the example you just gave about using outside physician consultants for the other GAPMS, did AHCA pay those other consultants?
A For other GAPMS? Those consultants are usually salaried or have hourly rates from our subcontractors.
Q Okay. Okay. But you didn't enter into any kind of vendor agreement with them?
A No, they're already employed by one of our subcontractors.
Q Okay. Did all of the $35,000 paid to the vendor -- paid to the consultants come directly from AHCA?

A Yes.
Q Was AHCA reimbursed by anyone else for those consultant payments?
A No.
Q Other than through its subcontractors, has AHCA ever previously retained outside consultants to undertake a review of the evidence-based clinical practice guidelines for GAPMS?
A Well, previously, we did actually have -- of course, we discontinued it, but we did have PAYS, which was back -- and we had it throughout 2017 -- which was a course and evidence review guide program that I had to subscribed to. We did have that and often referenced that in the early days, but after the amount of time, and because it was an expensive subscription, we discontinue it.
Q So that was a subscription service. Do you -- can you recall any time that you engaged with an outside consultant, other than those employed by your subcontractors?
A No.
Q What about to undertake a review of professional literature?
A No.
Q To actively participate by making a

recommendation or assessment as to the experimental or investigational nature of the service?

A No.

Q Why didn't you use the subcontractors -- AHCA subcontractors, why didn't you rely on their expertise in developing the June 2022 GAPMS?

A Because of this GAPMS and because of the nature of the subject. We did anticipate litigation after -- once the report was done and once we were working on it. So because of that anticipation, we needed to have experts that were -- that did have a degree of expertise in this field. Our subcontractors, their practices are more like general practitioners, or may be specialized in other areas, and they wouldn't be able to adapt quickly enough to the learning curve to provide a valuable assessment.

Q So you were concerned about attacks litigation might have on the integrity of that report itself?

A Can you repeat that?

Q Well, you said that because you anticipated litigation, that's why you engaged with consultants who had expertise, in particular --

A The Agency needed as robust a report as possible. So because we needed such a robust report, and because of the HHS guidance, the Department of

Health, so the fact that there were published documents out there, the Agency did need to come up with a response that we needed to disseminate as robust as possible, and that's why we engaged with the outside experts.

Q Why is gender-affirming care different from any other Medicaid service?

A Well, I'm going to defer to GAPMS process and our GAPMS report. For -- for the response to that is that gender-affirming care, of course, we are looking at, like, a treatment model that has very weak and low-quality evidence supporting it. And because we did a review and assessment of the literature, because there are a lot of claims made, especially by HHS, in particular, about its efficacy, because of its nature, because of -- and because of the low-quality evidence, that's how we deemed it. I mean, it is a different sort of care than we can consider traditional.

Q The GAPMS process is used to determine whether a Medicaid service is experimental, right?

A Yes.

Q So then that question is presented in any Medicaid service you're evaluating under GAPMS?

A That's right.

Q So why is gender-affirming care different?

A I'm going to defer to the conclusions we drew in the GAPMS report.

Q Why did you anticipate litigation before you even reached a decision?

A Well, I think that's because, I mean, this is often a very touchy subject. It's something that's frequently seen in the mainstream media. And, of course -- of course, the documents from HHS. It is a high-profile issue. It's considered by many to be controversial. So that should -- that's kind of why we did anticipate potential litigation resulting from whatever determination we made.

Q Why didn't you need gender dysphoria experts from the prior gender dysphoria GAPMS?

A For the prior ones?

Q Uh-huh.

A So for the prior ones, I think at the time -- I mean, we have to take it in context at the time, and, of course, these were done piecemeal, these were all separate reports, not one large one. So in the course -- at the time because this wasn't viewed as far as a potential hot topic, there wasn't the HHS guidance at the time, that's -- I think the best explanation as far as to why we decided not to engage with consultants.

Q HHS releases guidance all the time, though,

about coverage?

A Uh-huh. That's correct. It does.

Q Did you anticipate litigation for the 2016 GAPMS memo on puberty suppression therapy?

A The staff of the Agency who were present for that determination are no longer with the Agency, so we, in our current capacity, can't speak to that.

Q Did you undertake any research to derive an answer for that question?

A No, we didn't.

Q Did you look at any past memos related to whether or not the GAPMS might have litigation initiated?

A It's always a concern with every coverage determination and every GAPMS we do because inevitably, if we do say no to a service, there's going to be disappointed party. So it is a consideration we always have in place that there might be litigation.

Q Well, then that brings me back to the question as to why gender-affirming -- why this GAPMS is different?

A Well, this brings us back to the present circumstances behind how much attention the subject's been drawing in the media. The -- and it goes back also to the HHS guidance, which was making claims based on

evidence that we determined was insufficient.

Q So I only listen to NPR, I'll be honest. I don't watch any news. What media? Where's this a hot topic in the media?

A Oh, I mean, let's see here. I mean, we can name a lot of sources. I also -- I do listen to NPR myself. So NPR actually does periodically have an article on it. Then, of course, let's see here, there's quite a few other sources of things listed here. CNN, MSNBC, ABC, NBC. Your major outlets. New York Times. The Guardian.

Q How long has the media coverage been going on for?

A So as far as media coverage goes, well, the media coverage, there's always been smatterings of it here and there, but I think when -- as far as it becoming a consistent theme probably the past year. But that's not me speaking on behalf of the Agency, that's me speaking from personal observation.

Q Okay. Fair enough. Did AHCA share any of the draft consultant reports with external entities?

A We did not.

Q The Governor's office?

A We did not.

Q Department of Health?

A We did not.
Q No one?
A No, they stayed internal.
Q Did AHCA provide any material to the consultants to review in drafting their reports?
A No, we did not.
Q Did AHCA edit the reports of the consultants?
A There was some copy editing for style and grammar. Other than that, no, we did not make edits to the content.
Q So no substantive edits?
A No substantive edits.
Q And that includes Lappert's report?
A That includes Dr. Lappert's report.
Q And Dr. Donovan's report?
A And that's for Dr. Donovan.
Q And did any of the consultants provide edits to the AHCA GAPMS report?
A So after we finished the draft, we did send drafts to Doctors Grossman and Dr. Van Wol and they provided some feedback, but none of the feedback met -- were made -- resulted in drastic changes. I think -- I think Dr. Van Mol suggested we -- there's one more article we could discuss, and we added some content in there regarding that. They did help us correct some

terminology errors. There are some -- so there are some technical edits that were made. But as far as anything substantive, my first draft, I mean, was largely intact by -- from the first draft process to when we had the final draft.

Q Okay. And you were the only person involved in making the first draft?

A I can articulate a little bit more on how that went. So while the experts -- while the experts were composing their reports, I was composing mine. And once we had their reports, then that was -- then we did add -- we added some snippets from their reports in our report to make it more, I guess you could say, cumulative.

Q Okay. So only after the consultants who wrote a report, those reports were done, then you pulled some of that information into your --

A Correct. So my section was complete when we started receiving their reports.

Q Okay. Okay. What was the date of your first draft?

A I think the date of my first draft -- let's see here -- want to say early to mid May.

Q Okay. So, like, second week of May-ish?

A Somewhere around there, yeah.

Q Going back to the edits that the consultants provided to your report, what terminology had to be corrected?

A What was it? I mean, it was some medical terminology. I don't remember the specifics. I mean, it was very, like, miniscule changes.

Q Where they red lines in, like, a Word document?

A No, the edits were given to me verbally and I made them -- sometimes I made them right there when we were talking to them.

Q Okay. You stated in your declaration filed with the court on January 25th, 2023, that the only sources you relied on for the June 2022 GAPMS, were those cited in the works cited section of the report; is that a correct statement?

A That's correct.

Q So that means that the only sources that you consulted or considered -- or cited in the June 2022 GAPMS report?

A During the -- yeah, during the writing of the GAPMS, those were the sources consulted.

Q Nothing else?

A During the drafting of the report, nothing else.

Q What about after?

A Afterwards, more out of intellectual curiosity, I did want to try to see what else was out there, but that was more for personal intellectual curiosity than it was for professional purposes.

Q Okay. What were those things that you reviewed?

A Articles by Jack Turban.

Q Can you spell his last name?

A T-U-R-B-A-N.

Q I'm not familiar.

A Well, it's -- he is cited in our report, but he also is -- he's frequently quoted a lot, so I was curious to see what other in print articles he had produced.

Q Quoted in what?

A He's often cited in, like, news stories, media.

MS. DEBRIERE: Simone just got a note that folks are having trouble hearing me.

BY MS. DEBRIERE::

Q All right. When you were considering whether the services listed at 59-G-1.050(7) were experimental, did you evaluate whether excluding those services would be budget neutral?

A No, we did not.

Q Did you consider whether private insurance covers the services excluded by 59-G-1.050(7)?

A For this one we didn't, but primarily when we do GAPMS, we really aren't interested in public and private insurers. We're primarily interested in state Medicaid programs and Medicare since, like, Florida Medicaid, they're public payers. So primarily, we really want to know what the public payers say. Usually, our lowest priority for GAPMS is to provide analyses of what private payers pay. And generally, often we need those to supplement if we're unable to get that many policies from Medicaid programs across the nation, but since it's -- for this GAPMS, we actually surveyed all 50 states, then we had adequate information from that. Most GAPMS reports, usually we get maybe 10 or 12 when it comes down to coverage policies, it's -- it's pretty much what we can find in a certain amount of time. But for this one, we've -- since Dede Pickle was working on it independent, she was able to survey all 50.

Q And why is it covered under private insurance informative of whether or not a service is experimental?

A Can you repeat that?

Q Uh-huh. Why don't you rely on -- why don't

you consider private insurance coverage to be something -- I'm having trouble formulating what should be a simple question.

Why don't you look at private insurance coverage when you're determining whether or not a service is experimental?

A Well, private insurance works differently. I mean, Florida Medicaid, like Medicare, is a taxpayer-funded health care system. Private insurers, since they're privately funded, there's a great deal more latitude, what they can cover and what they don't have to cover, and they're more subject to the competition of the market, as opposed to Medicaid programs. So we -- while we do -- some often will look, but often it's -- we often try to find what private payers pay for following what we get from Medicare and Medicaid. So, I mean, when it comes down to it, we can, but it's not an absolute requirement, and we really do want to find out what the Medicaid programs are paying for. That's our first and foremost criteria for looking at the coverage of -- other payers coverage.

Q So it's not apples to apples, because in Medicaid and Medicare, you've got state taxpayer dollars to consider, correct?

A That's correct.

Q Okay. But when you undertook the June 2022 GAPMS, you did not evaluate whether or not excluding those services would be budget neutral?

A No, we didn't for this one, but we -- but that's also not necessarily unique to this, as well.

Q So in other GAPMS, you've not evaluated the budget neutrality of the service, whether or not you're going to cover it?

A That's correct. In the GAPMS I did in 2017, for, I think, like the nitrous oxide of -- pretty much like an adjuvant to this, kind of jumped-up asthma test, we didn't do a cost budget analysis because, like, we weren't going to cover, it's not going to affect anything.

Q So then you did evaluate whether it was budget neutral. You won't be covering it, so, therefore, it was neutral?

A Well, we just -- we just don't -- we just don't do one, because, I mean, we're not covering it. So it comes down to if we were going to make a coverage determination, that's when you do a fiscal analysis. So a coverage determination is definitely turned into a fiscal -- it needs -- it needs a fiscal analysis, because we're -- need to find out whether or not we're going to be able to stay within our budget.

Q I see. I see. So in this instance, because we are talking about the only GAPMS that excluded a service previously covered, did you do anything to determine whether or not that would cost or save the state money?

A No.

Q I think you have -- you brought information with you today about this. How did you collect state Medicaid program coverage data?

A So on that spreadsheet, so Dede Pickle, she went across the -- yeah. So she --

MR. JAZIL: Do you want to mark it as an exhibit?

(Whereupon, Exhibit No. 13 was marked for identification.)

THE WITNESS: She surveyed 50 states and I think territories -- even up in the territories -- and was looking to see what their stances were on gender-affirming care, to see whether or not they had statements saying that they will cover it or policy saying that they wouldn't. And then there -- those that just didn't have a policy available, or had no policy in place.

BY MS. DEBRIERE::

Q So Dede Pickle was the one who put together

the spreadsheet?

A Yes.

Q Okay. And where did she look to find this information in each state?

A Well, she went to their state Medicaid web pages, looked at their -- like, their coverage guides or materials in each state Medicaid -- Medicaid programs. There can likely be idiosyncrasies. I mean, some have -- some are like ours, have a ton of coverage policies, others are like Texas, Texas has one gigantic coverage policy, which actually does -- despite the fact it's huge, it's actually kind of more efficient. It's -- you can get everything from there. But that's -- that's what they do in Texas. Everything's bigger in Texas. But she went and looked at all of the different state -- various state Medicaid programs and saw what their policies were and saw what was available. And, of course, put the findings in the GAPMS report.

Q Did she only do an online search?

A Yeah, it was only an online search.

Q Did she contact any of the Medicaid programs?

A No.

Q Did she look at any of the policy reporters?

A No, we -- no, we didn't use policy reporter for this GAPMS.

Q So just looking at the state's Medicaid Agency websites?

A For the Medicaid, yes. But, generally, without having worked in Medicaid, one of our research criteria for across all kinds of reports and projects is that we do want to see what other states do. And so that gives us a great deal of familiarity of how to navigate other states' programs. And one of our side projects is the statewide Medicaid managed care program. And, of course, we're always looking to see what other states are doing. So we get a great deal familiar with how to navigate the web pages of other states.

Q So at least half the states' Medicaid programs explicitly cover pubertal suppression treatment for gender dysphoria, is that correct?

A Based on -- based on the findings of the map. So what -- so I will defer to the findings on the map.

Q Only ten exclude?

A Defer to the findings as stated in the map.

Q Okay. How about we do this: Based on the findings in the map, only 10 states explicitly exclude pubertal suppression therapy. How did you take that into account when you reached the conclusions that you did about the services being experimental, that particular service being experimental?

A As far as that goes, it's informational, but there was -- there was a divide between states that do cover and states that don't. Primarily when making the determination we focus -- we really focused on the evidence and what the evidence said about treatments for gender dysphoria since the Medicaid program -- since there is -- seems like there's an absence of policies for a lot of states. There are some states that come out and say yes, and then there are some states that say no. There is a -- there's a divide and you can even potentially say like there could be a debate between amongst the 50 states plus territories of whether or not coverage is appropriate.

Q But you did say earlier on that you -- whether a service is covered under the other state Medicaid programs is usually a factor that you weigh heavily in determining whether a service is experimental.

MR. JAZIL: Object to form.

THE WITNESS: So when it comes down to it -- it's like, so often, it's not just other Medicaid programs, but also Medicaid programs are similar to Florida. There are some Medicaid programs -- I'll name two -- New York and California that are -- that cover things very, very liberally, as far as services. Like, these added everything in their

fee schedules, where Florida Medicaid -- and Florida Medicaid prides itself on being a very fiscally responsible Medicaid program. So often we try to see what states that are similar to our Medicaid program, what they do. But we also do see, we see overwhelming amounts of coverage from states like us and states across the union, then that does factor in our decision, but for in this circumstance, because there is a split, if we were going to have to more -- rely more so on the evidence, than the notion that all these states cover services, there -- it's not -- it's not unanimous at all.

BY MS. DEBRIERE::

Q Did you ever contact the states that explicitly exclude and ask them why they explicitly exclude?

A We did not.

Q Did you ever call those states that have no coverage statement one way or another and ask them?

A We didn't reach out to states. I mean, their policy's online. I mean, that -- I mean, their published policy is sufficient to give us the responses we need to look at -- to look at it. Even for other GAPMS, we don't contact other states.

Q Did you analyze how much Florida Medicaid spends on -- spent on treatment for gender dysphoria prior to the categorical exclusion?

A No, we did not.

Q Do you have any plans to reevaluate your findings in the GAPMS report based on the September 2022 release of the WPS standards of care version eight?

A So in the immediate term, well, we don't, so -- but, I mean, we can reopen the GAPMS later on, there is -- there is a process for that. But generally, I mean, these standards of care, I mean, based on the release of one set of new standards of care, I mean, for the time being we don't have any immediate plans, not based on the release of one new update.

Q Okay. How long did you personally work on that initial draft of the June 2022 GAPMS report?

A Oh, I was working on it pretty much until the day it came out.

Q And you started that second week in May?

A Well, no, that was after I had the very first initial draft done.

Q Okay. So tell me when you first started working on it.

A April 20th.

Q Okay. So from April 20th until when it came

out. Published on what -- well, we know that it was first reviewed by your higher-ups on June 1st. So April 20th to June 1st?

A Yeah, that's sufficient.

Q Okay. And you worked with Nai Chen and Dede Pickle.

A Uh-huh.

Q Did you read all of the articles in the work-cited section?

A I read every single document in that works cited section.

Q 88 articles?

A All of them.

Q Okay. Were you able to read everything, understand it, and draft a report in --

A Yes.

Q How often during that time period did you communicate with the consultants?

A Oh, I think between four and five times.

Q And four or five times over that entire time period?

A Yeah, during those time periods, yes, we have -- periodically have, like, a one-hour discussion with them.

Q So you talked to them about five hours total

over that time period?

A I think that's a valid estimate, yes.

Q Okay. Do you think it's more than that, like more like 10 hours?

A No.

Q Okay. Turning back really quickly to the amount of -- the cost of treatment for gender dysphoria. How much was spent on the coverage of gender dysphoria versus how much was spent -- strike that.

Do you know how much, prior to the adoption of the categorical exclusion, how much annually AHCA spent on the coverage of gender dysphoria?

A We did not.

Q Are you able to obtain that information?

A Our data analytics between managed care plans paid per claim, and anything in fee-for-service, our data bureau could probably muster that up.

Q Is there a way that we should ask for that information to make the question clearer?

A You'd want to -- you would -- to put in a request we would need diagnosis code, we'd need NDC, and we would need CPT codes.

Q And what's NDC?

A National Drug Code.

Q Okay. And then for surgery, what would you

need?

A You would need the corresponding CPT code.

Q Okay. So you need the diagnostic code, the NDC for drug coverage, and the CPT code?

A And the time -- the date ranges.

Q And the date ranges. Okay. And then you could tell us how much AHCA -- or the Florida Medicaid program paid in coverage of -- treatment for gender dysphoria over a given period of time. Okay. When you were communicating with the consultants about drafting the June 2022 GAPMS report, what kinds of questions did you ask?

A Generally, questions about -- mostly just questions about, like, articles, like studies, making sure we have our bases covered, things like that. We wanted to make sure we didn't miss anything, or there's anything glaring we -- because it isn't a piece of academic work it is, it is -- mainly it's like a thesis or a dissertation, because we make a case, we have to support that case. So we want to make sure we have our bases covered.

Q What were the consultants' positions on WPATH?

A Their positions were that -- I think they identified -- all they did was identified it as an advocacy group, like a combination of clinical

professionals, plus advocates, community activists can join it. So that -- it's kind of a hybrid organization, that they explained that to us. So that was pretty much all the information they gave.

Q And you felt like that was an adequate explanation of what WPATH was?

A Yes.

Q What about the Endocrine Society? What was their position on?

A Their position was the Endocrine Society. I mean, it is an established clinical organization. They felt like the other guidelines, they had released guidelines, but the Endocrine Society was transparent in releasing their guidelines. They did clarify that their recommendations were based on weak or very weak evidence. They also clarified that their guidelines were not a standard of care, that they were just guidelines.

Q And that's the Endocrine Society. Who does that -- or your consultancy, who did that?

A The Endocrine Society. So the Endocrine Society, in the text of their guidelines, they do identify each line of the treatment model, like the puberty suppression, the cross-sex hormones and surgeries. Primarily the hormones is the Endocrine

Society, but they are very clear that it's either low- or very-low-quality evidence that supports it, and they also do put that disclaimer on there, this is not a standard of care.

Q What was your -- what was the consultants' position on the American Psychiatric Association's recommendations for gender-affirming care?

A It didn't come up in the conversations.

Q Okay. How about the AAP?

A The AAP was that the evidence available to support the AAP's positions wasn't sufficient.

Q Okay. What about the AMA?

A We didn't talk about the AMA.

MS. DEBRIERE: Okay. So I would like to -- do you have the exhibit of the Medicaid policy routing and tracking form for the June 2002 GAPMS?

MR. JAZIL: Can you re-mark on this --

MS. DEBRIERE: Yes, please. I think -- I need a bigger one.

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

THE WITNESS: Yeah, that new formulation makes it taste just like the real thing.

VIDEOGRAPHER: It's pretty good.

MR. JAZIL: See, we're finding common ground.

THE WITNESS: Wasn't, like, Coca-Cola and all their peace commercials, they were holding hands around the world? That was from the '70s, I think.

BY MS. DEBRIERE::

Q Okay. So I'm handing you what's been marked as Plaintiff's Exhibit 14. It's the Medicaid policy Routing and Tracking Form for the June 2022 GAPMS. There's a start date column there. What's that mean?

A That's a start with the routing process. So generally, for this, usually -- usually they try to provide like a window. We always have, like, a window of review. So for this, we enter the dates in the system. The GAPMS is routed to first -- well, actually, since my supervisor Dede was out, I was her delegate, so I did sign on her behalf. Then it went to Ann Dalton who signed. And, of course, Secretary Weida, of course, signed in his role, and then went to Deputy Secretary Wallace.

Q Okay. So start date's when the document hits their desk?

A Yes.

Q Okay. And then end date's when they've reviewed it and passed it on?

A Yes.

Q Okay. Date received is going to measure the

date that it hit their desk, but they didn't necessarily pick it up and start reviewing it? I'm trying to understand what's the difference between --

A Date received should be when they got it.

Q Okay. And the start date's when they start reviewing it? What's the difference there?

A Start date, end date -- yeah, that should be.

Q And the approval column means that the GAPMS was approved by each person that checked the box and initial by it?

A That's correct.

Q Okay. So the June 2022 GAPMS report, which is 46-pages long and contains five separate reports from AHCA consultants, it was reviewed and approved by each person on this list in one day?

A Yes.

Q And all four people on this list reviewed and approved the June 2022 GAPMS report in the span of two days?

A Uh-huh, that's correct.

Q Oh, I see there MB for DVP.

A Yeah.

Q Why choose to adopt the 2022 GAPMS report into rule?

A Because -- so since we had determined it to be

experimental and investigational, so we decided that we didn't need to make the -- based on the evidence, based on what the GAPMS said, the categorical exclusion promulgating the rule is necessary.

Q Okay. So you adopted into rule because it was a categorical exclusion?

A It was going to be, yes.

Q When was that decision made?

A The decision that was made -- the decision to make -- to make a new categorical exclusion, of course, that was not going to be made until after we had completed the GAPMS report and signed off on, because obviously, had either the experts had they disagreed with one another, or if I'd come up with a different conclusion, can't make a categorical exclusion unless everyone was in sync. So it was one of those things where had -- had the expert opinions disagreed with each other, had I come up with a contradictory conclusion, there -- you had -- we had to wait until after the report was done before we'd sign whether or not to proceed with the categorical exclusion.

Q And when was the decision made to adopt it into rule? Was that at the same time that you decided to make it a categorical exclusion?

A That was made after we had had the report

signed and done.

Q Okay. Sorry. I need to be more specific. What date was that decision made?

A Well, I think it was probably made June 2nd.

Q Okay. And who made that decision?

A That would have probably have come down from Secretary Marstiller, that would have come down from now-Secretary Weida, and it would have come from our General Counsel, Josephina Tamayo?

Q Why would it have come from those people?

A So -- because, of course, with our General Counsel, with our Secretary, I mean, they do make the decisions for the Agency. It's not out of the -- I mean, it is typical in their role to make a decision to promulgate something into rule.

Q Would that generally, though, be handled by the Bureau of Medicaid policy?

A Sometimes. It depends on -- depends on the nature of the rule change. Depends on where -- where it's originating from.

Q How often has that decision come from the Medicaid Secretary?

A So let's -- so to talk about the rulemaking process a little bit.

Q Yeah.

A So rule -- proposes for rule changes come from all different directions and --

Q Let's back up. Instead of talking generally about rule changes, let's talk about changes to coverage policies.

A Those can be made by our Deputy Secretary. Those can come from the Secretary. I mean, anyone who --

Q How often does that happen?

A We can't speak to how often it happens. I mean, it does happen.

Q Had it happened more with the Bureau of Medicaid policy?

A You mean, those in Medicaid policy who initiated these changes?

Q More often than not?

A I actually would probably say not.

Q Oh, okay. I'm just -- I'm surprised because we learned from Ms. Dalton that the -- both the rulemaking process and the coverage policy units are housed within the Bureau of Medicaid policy.

A Well, that's correct, they are, but often they're responding to directives given to them from either senior leadership or legislative changes.

Q Okay.

A So, yeah, while they are the ones that implement and write and craft the new policies or update the policies, they're often not the ones that are piloting these new policies.

Q Or initiating the decision as to whether or not --

A Precisely.

Q -- or adopt them into rule?

A Correct.

Q So you said that it was the decision to adopt into rule was made on June 2nd, is that correct?

A That's correct.

Q Okay. And the notice of rule development, that was issued on June 3rd, correct?

A Yeah.

Q I swear.

A Yeah, I'm deferring to the record on that.

Q Sure.

A The rulemaking process is highly documents, so I'm going to be deferring to the documentation for the rulemaking process.

Q Okay. So it took less than 24 hours for AHCA to decide to adopt the conclusion in the 2022 GAPMS report into a rule? And even less than that, because you made it the same day that the report was released,

correct?

A Yes.

Q And at that time, you also knew which section of 59-G it was going to go into?

A Yes, we did.

Q And who had to sign off on that decision?

A So all of our -- so whenever we adopt a rule, it does go through a lengthy routing process. So it does start -- the process starts in the Bureau of Medicaid Policy, starts with the rules -- we have a rules unit. That gets signed off on, then it goes to the AHCA administrator authorities section, they have to sign off. Then after that it goes to the Bureau Chief of Medicaid Policy. Of course, likewise, they have to review and sign off. Then it goes to the Assistant Deputy Secretary of Policy and Quality. They have to sign. Then, of course, the Deputy Secretary for Medicaid has to sign. General Counsel's Office has to sign. And then the Secretary is privy to all the changes. And if Secretary decides like, wait, wait, we can't do this or, no, there's a problem, yeah, that sometimes can result in a frustrating headache, because it takes a lot of work to get something that far.

Q Well, so the decision to adopt a categorical exclusion to rule was made on June 2nd and the Notice of

Proposed Rule was made on June 3rd. So it was routed through that entire process in less than 24 hours?

A Are we talking about the GAPMS or the rule?

Q The rule?

A Yes. And that -- and that's not unusual sometimes for -- for the process to move very quickly.

Q Okay. Because you just made it sound like it was a very lengthy process.

A It is with the number of people, but it's -- the rule content is very -- it's a very small addition. It's not like a brand new coverage policy, because often -- it depends on the nature of the rules. Like one addition, that can move fast. Sometimes with -- like, for instance, in my experience as a program administrator, we completely overhauled the community behavioral health policies. That was five new coverage policies. So that, of course, is going to require a much lengthier review process rather than a quick amendment to a rule. So it really depends on the nature of the rule. If it's a very lengthy coverage policy, yeah, that can take some more time if it's -- but if it's like adding a few bullets or amending a line, that can -- that can move along much faster because the review time's just not -- a lengthy review process is not necessary.

Q Or deciding to eliminate three types of services that were previously covered by Florida Medicaid?

A Correct. And, of course, but -- and, of course, we have the GAPMS memo to substantiate that.

Q Okay. Okay. So speaking to the rule, it bans Medicaid coverage for -- puberty blockers or cross-sex hormone therapy and surgery if done so to treat gender dysphoria, correct?

A That's correct.

Q But not to treat other diagnoses?

A Not to treat other diagnoses. Only for the diagnosis of gender dysphoria.

Q Okay. Is this the only time that GAPMS has been used to categorically eliminate coverage of treatment for a particular diagnosis?

A For the one -- I think pretty much since the institution of the GAPMS process, I think this was a first.

Q Once the decision was made to adopt the conclusions of the 2022 GAPMS report into rule, who was in charge of that process?

A So our rule promulgation process, Cole Gerring, he oversees the rule promulgation process for our coverage policies and administrative rules for

Medicaid.

Q Does he head the Rules Unit under the Bureau of Medicaid policy?

A Yes, he does.

Q Who drafted the actual language for the rule?

A I believe -- I believe he drafted the language.

Q Did anybody revise it or have any input that --

A There was input. So I mean, there were some discussions. I remember we did have a meeting with everyone to -- between, I think, like, Sheena Grantham, myself, I think Dede Pickle, I think Secretary Weida, I think like Sheena Grantham from General Counsel's office, since rules are her area. I think there were there was a -- there was a discussion on making sure this was the finalized content we wanted.

Q And how long did that discussion take?

A About an hour.

Q Okay. And what kinds of topics were discussed during that?

A Just determining how granular we should get, mostly.

Q Okay. Okay. Was there any conversation about whether adopting this categorical exclusion might

violate comparability under the Federal Medicaid Act?

A No.

Q What about EPSDT?

A No, because since we already have the -- we've already had the GAPMS report to substantiate the overriding EPSDT guideline -- guidance and requirements.

Q Because Florida Medicaid does not have to cover a service under EPSDT if it's experimental?

A That's correct.

Q I had another question. Talking about how granular to get with the language, was there any conversation about what the Federal Medicaid Act requires in terms of prescription drug coverage?

A I don't think so. Not during that conversation.

Q Any other conversations had about that?

A As far as the federal requirements for prescription drug coverage? No, I don't think we had any conversations like that.

Q Okay. Any other conversations about comparability under the Federal Medicaid Act?

A No.

Q So comparability under the Federal Medicaid Act was not taken into consideration when adopting the categorical exclusion?

A No.

Q Who planned the public hearing regarding the proposed language in 59G-1.050(7)?

A So for the public hearing, since we did anticipate a larger than normal crowd, we -- so I think that was a joint effort between Cole Gerring I think, Chief -- now Chief of Staff Brock Juarez, then Chief of Staff Cody Farrell, and I think -- I think Secretary Weida also had a little bit of input when it came down to selecting the venue and making sure that we had adequate staff and then also arranging for security as well.

Q Why did you feel a need for security?

A Because of this -- the controversial nature of the change and how those with opinions on it -- those with feelings about it, I mean, they are deep-seated. I mean, there's -- so because of the sensitivities involved, we just felt that it would be best in the event -- and we did think it was unlikely, but in the event that someone might get upset or unruly, to have security.

Q Why did you pick the venue you picked?

A Size and location.

Q What factors did you take into consideration for size and location?

A That we would have adequate seating. That, of course -- of course, location where it was, being downtown, so --

Q Downtown being an easier location to get to?

A Yes.

Q Why did the location need to be easy to get to?

A Because, I mean, since -- I mean, you know, we do government in the Sunshine, we wanted the hearing to be accessible to as many people as possible, so we wanted to be able to fill as many seats as we could. The facilities here at AHCA weren't going to be sufficient for that. The Department of Transportation auditorium was a very, very good venue, not just -- not just to be able to provide those of us who were on the panel visibility to the audience, but also just because of the seating capacity. So it just was an ideal venue compared to what we had available at the Agency.

Q Where do you normally hold rule hearings?

A We usually hold them here.

Q Why were you concerned about adequacy of seating?

A Because we did expect a large turnout.

Q Why did you expect a large turnout?

A Because of the amount of coverage that the

GAPMS report had received, because of everything that we'd been seeing, as far as -- per previous news stories prior to the release, we just knew that this was a sensitive subject. A lot of people have a deep-seated conviction about it one way or the other, and we just anticipated a large turnout.

Q In the planning of the public hearing, did AHCA communicate with the Governor's office at all?

A No.

Q Did AHCA communicate with Department of Health at all?

A No.

Q Who participated in the public hearing from AHCA?

A So the participants from AHCA were myself, Sheena Grantham, whose General Counsel's office, Secretary Weida. Those are the -- those are the three of us who were on the panel for AHCA. And, of course, I think Cole Gerring handled the administrative procedures and then I think to help -- help with crowd control, we had, I think, Brock Juarez and some of the staff from communications also helped arrange in making sure that there's adequate seating, and just kind of serve -- just helping out in any way, or any capacity that was necessary, as needed.

Q Did anybody at AHCA help facilitate the attendance at the hearing?

A There -- I think there's a speaker sign-in sheet at the entrance. I think that -- like, I think one of the Agency staff under Brock at the time was -- was allowing people to sign in.

Q Were there any particular people that were encouraged to be at the hearing?

A No.

Q Are you aware of the Governor's office encouraging anybody to attend the hearing, anybody in particular?

A No. No.

Q Did anybody pay someone to attend the hearing?

A So for our -- for our experts, Dr. Grossman, Dr. Van Meter and Dr. Van Mol, they were compensated for their time spent at the hearing, or their time traveling -- for Dr. Van Mol and Dr. Van Meter, their time traveling and their travel expenses. So we did reimburse them, but that was it.

Q Did that include the same agreement with the $35,000 cap or was that a separate agreement?

A I don't think it was a separate agreement, because the three of them had not come anywhere close to exhausting their caps.

Q Did AHCA provide any materials to those consultants prior to the hearing to review for the hearing?

A On the day of the hearing we gave -- we gave them each bound copies of the report, but those materials were already available online, so -- but we just -- we just gave him paper copies or to reference but nothing -- no other additional materials.

Q You didn't provide them any other materials other than the GAPMS -- the June 2022 GAPMS?

A That's correct.

Q To review prior to the hearing?

A Correct.

Q Did you have any meetings with the consultants prior to the hearing to prepare for the hearing?

A We had a couple -- there were a couple Zoom calls.

Q How long did those last?

A About an hour?

Q What kind of things were discussed during those meetings?

A Mostly the format. You know, we were talking about, like, of course, Dr. Grossman, who was not going to be able to travel. So we were talking about technological arrangements. I think with Doctors Van

Meter and Van Mol, we were mostly talking about travel arrangements and, like, where they'd sit and so forth, so I mean --

Q Did you offer any questions that they might anticipate from the audience and how they should respond?

A To our experts? We didn't.

Q And why was it necessary to have the consultants there?

A So -- well, since -- because we were actually anticipating a crowd that was going to be largely opposed to the challenge exclusion, we wanted to be able to respond promptly and articulately to any comments that were provided.

Q If you wanted to respond promptly and articulately to any comments that were provided, what was the purpose of having a public hearing?

A So the public hearing is to, of course, gather feedback, but we also knew that we were likely going to have either some type maybe medical professionals or advocacy groups, or other advocates, and we did want to be able to provide them with a little bit of engagement to show that we do take their comments into consideration, that we do think about them, that we do engage with them.

Q Did the consultants respond to any comments by a supporter of the rule?

A I don't think they did, actually.

Q How about those that were opposed to the rule?

A There was really -- I think Dr. Van Meter responded once. I think Dr. Van Mol responded once. And Dr. Grossman didn't respond to anything.

Q And that was -- both of those responses were in response to individuals who were speaking in opposition to the rule?

A Yes.

Q Have you ever participated in another rule hearing where there is direct and prompt response to public comment?

A Yes. Yeah, we do. Yeah, I mean, I've participated in numerous rule hearings here at the Agency. We do respond to comments.

Q When you say we, do you mean the office staff?

A Office staff, yes.

Q What about consultants with which AHCA has contracted?

A We -- we generally don't -- we generally don't. It's a -- it was a unique experience for this case, but we generally don't have contracted consultants at our hearings.

Q And where did the slogan, Let Kids Be Kids come from?

A So that came from within, I think, our own Agency, our Communications Department or the Chief of Staff's office.

Q Was there any input in developing that from outside entities?

A No.

Q So AHCA is wholly responsible for that slogan?

A Yes.

Q Was AHCA responsible for the printing off of the stickers that had the slogan contained on it that were being passed out at the hearing?

A No.

Q Do you know who was responsible for that?

A We do not know where those came from.

Q Is it normal to have slogans of an Agency passed out at a rule hearing? Have you ever seen that before?

A I have not seen that before, so -- but we -- that was not something that the Agency had anticipated, and we certainly were not responsible for the passing out of stickers with a slogan on it.

Q Did outside counsel appear at the public hearing? Did AHCA outside counsel appear at the --

A Yes, they did.
Q Why?
A Because, of course, sensitive nature. I mean, there were -- there were attorneys also -- there was -- because there was counsel that -- you know, who are representing the plaintiffs who were also there. We do anticipate litigation, so it was -- we did see to it that we had outside counsel there to gather information and be able to observe the procedures.
Q So AHCA had -- at the point of the public hearing, AHCA had retained outside counsel to defend against any potential litigation that the rule invited?
A Yes.
Q What was outside counsel's role at the hearing?
A Outside counsel's role, I think -- I think just calling up the speakers as they came. I think they actually -- we had them helping out with the -- with the hearing process and procedures.
Q What kind of -- well, okay. Did AHCA give the consultants any instructions to prepare for the hearing?
A Basic ones. Most of -- I think, you know, like to when responding that, you know, we would prompt them to respond. Basic -- very basic instructions.
Q And so the instruction was that when AHCA

wanted someone to -- one of the consultants to respond, you would prompt them to?

A So, yes. And during the hearing, Secretary Weida would defer either to Dr. Van Meter or he would defer to Dr. Van Mol when he needed -- when a response was needed from one of them.

Q Okay. Just going back to the slogan really quick, who in AHCA came up with that Let Kids Be Kids slogan?

A I think -- I think it was a -- I think it was a team effort. I think, like, it was Cody Farrell and, I think, Brock Juarez. I think they worked on the Let Kids be Kids slogan.

Q Anybody else?

A No, it would have been primarily them.

Q Who directed them to develop the slogan, or was it their idea?

A So the orders would have been given verbally. We don't know, like, exactly how they were told to do that specific slogan.

Q When was the -- when was the slogan developed?

A It was developed, I think, in the days preceding the release of the report.

Q When was the final draft of your report done?

A So the final draft -- so the final draft as

far as -- so the very, very final draft, like the last finishing touches, as much as copy edits, was done that week of the 2nd, but as far as the substantive components of the report, that was done probably a few weeks prior to the release.

Q So when was the slogan developed?

A Slogan was developed -- I think they did -- were working on it, like, the week before the release.

Q Is it normal for AHCA to develop a slogan for the conclusions found in a GAPMS report?

A No, this is -- this was a first.

Q Why develop a slogan?

A Well, we do develop slogans for whenever we do have -- do releases, or whenever we have new programs. For instance, Canadian Prescription Drug Importation, we do have a slogan for that. We do have a web page dedicated to prescription drug transparency pricing. So we do have -- often to correspond with our press releases, we often will do a logo.

Q But you just said it's not normal for a slogan to be developed for GAPMS. So why do it in this instance?

A So because HHS had already -- had made announcements with the publication of their documents, Department of Health had done theirs, we, of course,

likewise, because we were publishing this document, was to, of course, create the website and to, of course, create some graphics along with that website.

Q So was the slogan meant to draw attention to a particular message that the Agency was trying to send?

A No, I mean, other than that, we did the report and we did was evidence-based and concluded these treatments were experimental and investigational.

Q For children and adults, right?

A For children and adults.

Q And why was it Let Kids be Kids?

A Because -- so for adults with -- when it comes to Medicaid, states -- because you don't have the EPSDT consideration, states can be much more -- have much more discretion in denying coverage. They have a lot more latitude to be able to deny coverage, so -- but for services that are intended for pediatrics, or are under EPSDT considerations, that's partially -- partially why not -- like one of the services that we evaluated was puberty suppression, adults aren't going to use that.

Q But the conclusion of the GAPMS report was that all treatment for gender dysphoria was experimental for kids and adults?

A That's correct.

Q The slogan's just targeted at kids?

A Yes, that's correct.
Q Why?
A So it comes back down to the EPSDT considerations. Because like -- well, for starters, I mean, when it comes to adult coverage, that's a totally different category. But for kids, especially with puberty suppression and especially with the cross-sex hormones, because of the experimental and investigational nature, that's probably why we -- why the Agency embarked on a, I guess, child-based kind of graphic for its web page.
Q What does it mean Let Kids be Kids?
A I think, well, as far as semantics go, I think that could mean something different to everybody.
Q What did AHCA by it?
A Let kids be free to explore their own identities and figure out who they are.
Q What are some examples of other slogans AHCA's used for its programs?
A Well, lower prescription drug costs.
Q That's a slogan that we can find?
A Yeah. I mean, that's one we've been using for a while. I was using as -- under my signature on my email, so things -- yeah, but, I mean, there are slogans. I think like prescription drug transparency.

I mean, that's part of, you know, the state's mission is when it's coming up with new programs -- and obviously it's not isolated to AHCA, I mean, every agency's going to have slogans and graphics for their new programs. I mean, if you look at the Department of Children and Families, they're promoting Hope Florida in a big capacity. So for a lot of these -- so for a lot of these programs that they want to have -- they want them to be now such high profile, of course there's going to be graphics and slogans.

Q Prescription Drug Transparency is not very catchy, I'll say. Why create a web page dedicated to supposedly fact-checking Health and Human Services? Is that normal?

A No, it's not, but following -- but the thing is following the review of the evidence and how our findings really did contradict what was in HHS documents, because we really wanted to demonstrate -- because we do understand, it's a GAPMS report, it's 46 pages. Not many people are going to take the time to read it. So we wanted to kind of put it -- we wanted to put the case in more simplistic layman's terms and make it accessible to the audience to show that, hey, yeah, this is a sensitive report. Yeah, if you got an hour and a half and you understand medical terminology and

literature, you might have fun reading it, but for quick information, we wanted to provide a resource, because HHS had made all these claims regarding gender dysphoria treatment, we want to make it accessible to everybody that they could look at it and five minutes later understand the gist of what we were saying in the GAPMS report.

Q Prior to the July 8th public hearing, did AHCA communicate with anyone from the Christian Family Coalition?

A No.

Q Anyone from Florida Citizens Alliance?

A No.

Q Including Pastor Rick Stevens?

A No.

Q Anyone from Warriors of Faith, the Florida Chapter?

A No.

Q Including Troy Peterson?

A No.

Q Anyone from Protect our Children Project?

A No.

Q That includes Pastor Ernie Rivera?

A That's correct.

Q Okay. Anyone from Florida Prayer Network?

A No.
Q And that includes Pam Olsen?
A Correct.
Q Anyone from Partners for Ethical Care?
A No.
Q What about Chloe Cole?
A No.
Q Sophia Galvin.
A No.
Q Anyone from the Rainbow Redemption Project?
A No.
Q How many comments did AHCA receive in response to the proposed changes to 59G-1.050?
A 600 or so.
Q Oh, that's all? Did AHCA read them all?
A We did.
Q Who at AHCA reviewed them?
A It was a combination. So, like, I think Cole Gerring, Nai Chen, myself, I remember we did sit down once and we started going through all the emails. Most of them were very brief, maybe like one or two lines, not substantive whatsoever. For the more substantive ones, those I did careful reviews of.
Q So it's three people. You, Nai Chen and Cole Gerring?

A Uh-huh.

Q Okay. And you split them up amongst each other?

A We read them together.

Q What process did you use to decide whether or not to incorporate the input into the final rule?

A We wanted to look at the -- we looked at the content of every -- of every single comment. A lot of the comments were just saying don't do this, or something -- or something very sensationalist. So a lot of the comments we really couldn't take into consideration because there wasn't -- there wasn't -- there was no substance behind them. So there were some comments that were -- we did receive some feedback from -- I think we got something -- we got -- we got a lengthy comment from American Academy of Pediatrics. We got a very lengthy one from Yale University. We got feedback from the Endocrine Society. I think one of UF's gender clinic physicians wrote us up, not a terribly long comment, but wrote us a comment. So we did want to take a look at the substantive onces. But we did them into -- we did take into consideration every comment submitted to us.

Q Did you receive any comments from the people who had Medicaid coverage for treatment of gender

dysphoria?

A During the comment review, there wasn't any -- we didn't -- we didn't notice any comments from those offhand, but, of course, that was over six months ago. So we -- because of the volume of comments, we did have to read them fairly quickly.

Q Had you received a comment from anyone who was receiving Medicaid coverage for treatment of gender dysphoria, how would you have factored that into your ultimate determination?

A Well, we would -- we would have looked at it. We would look at the content. We were wondering, like, what kind of services they were receiving and so forth, but it depends on what the comment was. If they provided a case for why they were getting it, you know, but we didn't -- we didn't receive anything like that.

Q For those people who lost Medicaid coverage for treatment of gender dysphoria, or were going -- stood to lose based on the categorical exclusion, during any of this process, was there any consideration given to the inability to access that care?

A There was. We did have questions. We wanted to make sure that if we were to discontinue individuals who were receiving, particularly cross-sex hormones, we wanted to -- we did have questions like, would there be

withdrawal? What would -- would they need some -- would they be weaned off the medication? How would -- how would the Agency take that into consideration? And we actually kind of realized that if, say, if they do need to discontinue testosterone because of the categorical exclusion and their doctor deems, well, they're going to need some small doses to wean themselves off, but we also realized that necessarily wouldn't be for gender dysphoria, that would be because of withdrawal symptoms, and that would be a different diagnosis.

Q Did you give that guidance to any treating professionals or Medicaid recipients?

A No, we didn't.

Q Okay. Why was it necessary to review the comments quickly?

A It wasn't necessary to; it was just -- I mean, most of the comments were because the nature, they were -- most of them were sensationalist, a lot of them just hurled insults at us, a lot of them ad hominem attacks, things like that. We just kind of went through a lot of them very fast.

Q So that wasn't quite my question. It sounds like you were able to review them quickly.

A I think I want to rephrase as we were able to. We weren't really in a hurry. Because, obviously, like,

we got a 47-page comment from Yale University. That was not a five-minute skim, obviously. So there were those we deemed to be substantive comments that warranted in-depth attention, and then there were those we deemed non-substantive comments and just read. They're like -- yeah, we received some ones that were using, I will say, the colorful metaphors. And then we don't -- I mean, obviously, not going to pay attention to those, so -- but the substantive ones that where they're putting together, like, an argument or making points, being something that we have to take back and think over, we did invest time in those, yes.

Q Were there any discussions about the comments between you and Cole and Mr. Chen?

A As far as the discussions go, no, most of discussions were like, okay, let's move on to that one, that one's just insulting us or that one's -- that one's expletive-laden, let's move on. So when we got the substantive ones, of course, those were -- those were handled differently.

Q How were they handled differently?

A So those, because they were going to take in-depth review is not something that's going to be a group activity. Of course, we printed those out and started reviewing with a fine-tooth comb.

Q Did AHCA review the underlying cases and studies cited in those substantive comments?

A Yeah.

Q Okay. How did they factor those in to the ultimate determination?

A So we did take a look. So we checked to see what studies that Yale University and the AAP brought into it. And we looked at two responses from the Yale University, not just the response that they made to us, because Yale University frequently cited their response to Texas and Arkansas, we pulled that up as well and did -- and analyzed that. So we looked to see what articles they were citing and we were -- so we checked to see whether our GAPMS report or any of the expert reports also did evaluations of those studies to see that -- make sure that we were in alignment.

Q Okay. Do you remember any particular underlying cases or studies?

A There's -- I think there's one by Jack Turban that they cited. I think there was one that we did cite in GAPMS review. We didn't discuss it at length, this was by Tordoff, et al. And we looked at that. And, of course, but we also captured those in Dr. Brignardello-Petersen's piece that they were evaluated as, like, being very low-quality or in a critical risk

of bias.

Q Okay. How did you determine whether -- okay. Turning to the implementation. Sorry.

A Okay.

Q Hold on. One second. Something breaking is coming in. Did you review any comments that reference court cases?

A We did see some comments that referenced, I think, like Bostock v. Clayton. I mean, there were some cases referenced in the comments, but, of course, I mean, we were primarily interested in -- we were looking for comments that were providing -- that were either providing examples of literature or anything that was going to contradict the GAPMS report. In other words, we were looking -- we were looking for anything that, I guess you could say, delivered, like, a mortal wound or something like that, something that would foreseeably cause us to have to go back and make revisions or cause us to have to retract the rule, or something that -- or a comment that we couldn't just dismiss or a comment that we couldn't explain. So those were what we were looking for.

Q What types of information provided by the public would have mortally wounded your conclusion?

A So a mortal wound would have come from a

quality study, or a number of quality studies.

Q And define a quality study.

A So something that -- well, a quality study, well, I mean, that -- that's a pretty broad definition of what you're asking for, and there are different ways a quality study can come about, but something that, of course, lengthy longitudinal histories on participants, either has adequate control groups. And this is not an all-inclusive list. These are just examples. Also follows participants for a lengthy period.

Q Well, what's the difference between that and a lengthy longitudinal study?

A Long -- when it comes to a longitudinal history, what we mean by longitudinal history, and this is often for behavioral health, is that longitudinal history is necessary to really ascertain the full impacts of somebody's mental health conditions. Because it's -- because mental health, it's not necessarily like an acute illness or a chronic condition diagnosis. So, like there's treatment histories, medications and -- like, in other words, and, of course, like activities of daily living, how that all is affected. So it's usually something that has to be obtained over a number of years.

So, mental health longitudinal histories, but

we also were finding in the studies that we evaluate for the GAPMS process that they lacked participants' longitudinal histories. If they even -- if they even did -- provided any histories or any -- identified the recipients or the participants at all. I mean, there were so many studies where they were -- I think there was one that we came across, and this was during the comment period, that was just a massive survey and they were trying to give gift cards to participants. And, of course, people were just completing it, but it was like a one-time snapshot, and it's subjective self-reports. So I mean, there are a myriad examples that we can say for high-quality evidence, and not to mention RCT's, as well. So --

Q What does that stand for?

A Randomized control trials. So there -- so, yeah, so that was what we were looking for, evidence that -- evidence that would hold up to questioning, and that's not what we were finding.

Q So in undertaking the review of the comments, the only thing you were looking for is anything that would, in your definition, cause a mortal wound to your conclusion in the GAPMS?

A That was among one of the things we were looking for.

Q What else were you looking for?

A I mean, we were looking -- we were looking for -- I mean, we, of course, we were looking to see if there's anything that would directly conflict with the GAPMS report. That was one thing, because the rule's foundation was the GAPMS report. So that's the big reason why we were looking for contradictory evidence or evidence that would be like, well, wait a second, we say it's all -- you know, because our primary argument is it's low-quality evidence and therefore experimental, experimental investigational. That basis doesn't sustain itself if all of a sudden there's modern, high-quality evidence out there. So we want to make sure that we had not left any stones unturned. But we were just -- you know, I mean, we -- this things we weren't -- that was the primary thing we were looking for.

Other things -- I mean, we also, I mean, anything that spoke to the legality of it, but I mean, of course, we wouldn't necessarily evaluate that. We'd turn that over to legal, but anything that was looking -- that was looking at the legality of what we were doing. So I mean -- so, I mean, there were different angles. I think when I was looking at it through my personal lens, that was what I was looking

for.

Q Are you aware that similar exclusions have been found unconstitutional in other federal districts?

A I am aware at the district level that there have been some -- some exclusions that have been tossed, yes.

Q All right. Turning to the implementation --

MR. JAZIL: We've been going for an hour and a half. Could we do a five-minute break?

MS. DEBRIERE: Sure.

VIDEOGRAPHER: This concludes video three. The time is 3:00 p.m.

(Brief recess.)

VIDEOGRAPHER: This is beginning of video four. The time is 3:08 p.m. we're on the record.

BY MS. DEBRIERE::

Q Just after that break, and I should have asked this earlier, just after that break, did you have any conversations with anyone during that break?

A During --

Q Just this recent break? Did you have conversations with anyone?

A I mean, talked about, like, personality types on 16 personalities, just had a conversation, but as far as the case goes, no.

Q Okay. What about at lunch?
A Just a quick touch-base with our attorneys.
Q Okay. How long did you talk?
A 15 minutes.
Q Okay. All right. Turning to implementation of the rule with managed care plans. Did Florida Medicaid managed care plans -- well, we've already answered that. What's the purpose of Inter-Qual?
A Inter-Qual?
Q Uh-huh.
A I don't have the answer to that.
Q Okay. Are you familiar with it at all?
A I'm not familiar with Inter-Qual.
Q Did AHCA develop, or help develop language for notices of adverse benefit determinations in order to incorporate the categorical exclusion of treatment for gender dysphoria?
A No.
Q AHCA didn't assist at all in developing the language for those denials for terminations?
A No, managed care plans were -- handled those themselves.
Q Okay. Did AHCA review any of the language that managed care plans submitted to AHCA for review?
A No.

Q Same question for notices of outcome relied on by EQ Health?

A No, AHCA wasn't directly involved in those.

Q Did they review the notices of outcome language?

A No.

Q Okay. What about Magellan?

A Magellan? No.

Q Did AHCA develop or help develop language for any other types of notices used to notify a Medicaid recipient of a denial or termination of treatment for gender dysphoria?

A No.

Q All right. Can I have the notice of adverse benefit determination, and that's Bates-stamped Defendant_ 000292335, I think. We'll check? Did I get it right? I don't think I did. I'll read the correct Bates-stamp on -- so this is going to be the Molina Health Care Notice of Adverse Benefit Determination. I'm not going to name the Medicaid recipient. And the date stamp appears to be cut off, but it is dated October 26th, 2022, and the initials for the recipient are AS.

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

MR. JAZIL: Counsel, can we agree that this should be confidential, attorney's eyes only?

MS. DEBRIERE: Absolutely.

MR. JAZIL: Do you mind if I write that on top of the --

MS. DEBRIERE: Not at all. Not at all. So the previous Bates stamp I gave was not correct, but the Bates stamp on this exhibit is cut off, so I can't provide the actual number, but I think I've sufficiently described it. And, of course, it will be Exhibit 15.

BY MS. DEBRIERE::

Q All right. This particular notice of adverse benefit determination is from Molina. In that second page there, it runs through AHCA's medical necessity definition, correct?

A Yes, that's consistent.

Q And that's consistent across notices of adverse benefit determinations?

A So each health plan is a little idiosyncratic in how they do NABD's. We'd have -- we'd have to verify with managed care plans. I mean, the contracts does provide specific requirements when it comes down NABD's and sending them.

MS. DEBRIERE: Mo, do you know if you guys have

produced an NABD template to us?

MR. JAZIL: We've never --

MS. DEBRIERE: I know they exist. They should be pretty easy to --

MR. JAZIL: I'll check. What's that stand for, again?

THE WITNESS: Notice of Adverse Benefit Determination. It's a long phrase for a denial.

BY MS. DEBRIERE::

Q Or termination or reduction?

A Or termination, or reduction.

Q Or partial reduction.

A It's --

Q Okay. So this particular notice of adverse benefit determination is to an actual Medicaid recipient, correct?

A Yes.

Q And it looks like it's been it's denying a request for coverage of testosterone cypionate.

A That's correct.

Q Okay. And what is the reason for the denial?

A The box for other authority non-covered benefits is checked off.

Q Why isn't the, request service is not a covered benefit, checked off?

A We would have to ask that question of the plans.

Q Okay. So you don't require some kind of uniform response to not -- that plans must provide when there's a non-covered benefit?

A We're not aware of one. There -- I don't think there's one mentioned in the contract.

Q Okay, but I guess my other question is, would it be equally sufficient, had they checked off, must meet accepted medical standards and not be experimental?

A They could have checked that box. They could have checked, the requested service is not a covered benefit. They could have checked other boxes, as well.

Q Okay, but it is accurate to say that it is not a covered benefit?

A Yeah, that is accurate.

Q Is any plan allowed to currently cover treatment for gender dysphoria of the services listed and 59G-1.050(7)?

A For any plan right now currently?

Q Yes.

A No. No plan can cover them.

Q Since the adoption of the categorical exclusion of treatment for gender dysphoria, how many notices of adverse benefit determination have been sent

to Medicaid beneficiaries that denied coverage for services on the basis of --

A So for MMA plans, so we did a little looking into this -- so for managed medical assistance, which most of these recipients, given their ages, are going to be on MMA, we do not actually require the MMA plans to submit reports regarding how many NABD's that they actually mail out to their enrollees. Long-term care, that process is different. We do require them for long-term care to mail those to report to the Agency how many NABD's they are sending out, but for MMA we currently don't have that as a requirement.

Q Okay. So is that -- does the same hold true for notice of appeal plan -- plan appeal resolutions?

A As far as that goes, I don't think -- I don't think we're collecting information from the plans on those.

Q Okay. So generally, not just as related to treatment of gender dysphoria?

A Generally.

Q What about notice of outcomes?

A Notice of outcomes, I don't think we're collecting them from those informations either.

Q Okay. Just generally, do any of those notices include reference to the variance in waiver process

described at Florida Statute 120.542?

A No. I mean, we definitely -- I mean, so looking at this, this is in compliance with what we do, we require them to have, which is an appeals process. So, no, we don't -- we do not require the plans to include the procedures for variances.

Q Okay. So those procedures are not listed in notices of denial?

A That would be correct.

Q Okay. How many grievances have been submitted to AHCA regarding a claim related to AHCA's adoption of the categorical exclusion of treatment for gender dysphoria?

A So that information, we do have a complaint hub for recipients and providers who'd like to submit complaints, be given the -- when the questions came in, we, of course, have to reach out because our complaint hub is actually down in Fort Myers, so it's not -- it's not here locally, so that's information we're still in the process of obtaining.

Q And once you obtain that, you'll provide it to us?

MR. JAZIL: Yes.

MS. DEBRIERE: Can you put that as a follow-up?

BY MS. DEBRIERE::

Q How many -- how many appeals of Notice of Adverse Benefit Determination denying care on the basis of the exclusion have there been?

A As far as appeals going up to the fair hearing level, I think that's zero.

Q Okay. What about -- yeah, so that would include both notice of plan appeal resolutions as well as notice of outcome?

A Yeah.

Q Okay. Prior to August 21st, 2022, did AHCA ever reverse a decision made by AHCA or by a plan to deny pubertal suppression therapy for the treatment of gender dysphoria?

A We did not.

Q You never reversed a decision to deny?

A To deny?

Q Yeah.

A No, we never did. Sorry. I misunderstood the question.

Q Okay. I just want to make sure you're understanding. So prior to the adoption of the categorical exclusion, did AHCA ever reverse a decision to deny puberty suppression therapy for the treatment of gender dysphoria?

A So if a plan reviewed for medical necessity

criteria decided, no, it didn't meet the criteria and issued denial, no, we never reversed it.

Q What about upon a fair hearing review?

A Are we talking about, like, since 2015?

Q Well, I'm asking ever, but if 2015 is a helpful marker.

A I don't have that information offhand.

Q Is that information you can obtain?

A I think we can.

Q Prior to August 21st, 2022, did AHCA ever reverse a decision to deny cross-sex hormone therapy for the treatment of gender dysphoria? And by reverse I include at the fair hearing level.

A That's information that we would have to obtain.

Q Same question for surgery in furtherance of the treatment for gender dysphoria.

A At the fair hearing level, we would have to obtain that.

Q So you will tell us the number of times, if ever, that AHCA reversed a decision at the fair hearing level to provide treatment in furtherance of -- services and treatment for gender dysphoria?

A We can confirm it. It's probably zero.

Q Okay.

A As far as overturning a decision that was already a denial, it's probably going to be zero, but we just want to confirm.

Q Okay. I'll tell you, we have different information.

A Okay.

Q How many AHCA fair hearings have been provided where the categorical exclusion of treatment for gender dysphoria was an issue?

A Well, can you repeat that?

Q How many AHCA fair hearings have occurred where the subject at issue was the categorical exclusion of treatment for gender dysphoria? So where the rule exclusion --

A We'll have to obtain those numbers.

Q Did any -- do final orders in general reference the variance and waiver process described at Florida Statute 120.542?

A You'll have to slow down and ask the question a little bit --

Q Sure. Sure. The final orders that are issued at the end of any AHCA Medicaid fair hearing, do those written final orders contain any reference to the variance and waiver process at Florida Statute 120.542?

A I don't think the final orders do. I don't

think they do.

Q Okay. Is there any way you can get confirmation of that answer?

A I mean, we could obviously pull up a copy of the final order and see if that information is included.

Q If we had a copy of an AHCA final order, would that be sufficient to determine, and it did not list it, would that --

A I'll defer to our attorneys, if that's sufficient.

MR. JAZIL: That'd be sufficient. If you have one, you can show it to him.

MS. DEBRIERE: Well, we can pull one up, can't we?

MS. CHRISS: Just one?

MS. DEBRIERE: Yeah. Yeah. Why not. Yeah, as long as their name's blocked out, which really shouldn't matter here because we're dealing with an AHCA employee.

THE WITNESS: Yeah. I mean, I'm cleared to review PHI and recipient information. It shouldn't be a problem.

MS. DEBRIERE: Do you want another one? I can send you another one. Bear with me one second.

I'm going to forward you this email. And

it's -- I can tell you what the name of the document is. It's the last document, 23. That should be the last one. Chelsea's copied on that one, too.

THE WITNESS: Okay.

MS. DEBRIERE: Okay. Okay. So feel free to just scroll through it and see if you see any reference -- oh I'm sorry, it isn't a touchscreen?

THE WITNESS: I don't know where the scroll bar.

MS. CHRISS: It's just -- just use two fingers and just go like that.

MS. DEBRIERE: Oh, it's a Mac.

MS. CHRISS: I'm sorry.

THE WITNESS: Okay. There it goes. Yeah. Ipads and iPhones I'm good with, Mac's I never got comfortable with.

MS. DEBRIERE: The next exhibit I'm going to do is emails related to the policy transmittal and the policy transmittal itself, if that helps.

MS. DUNN: Yep.

THE WITNESS: So are we talking about the -- that last paragraph on the final page that's, like, notice of judicial review?

BY MS. DEBRIERE::

Q Yes. So does that relate to the variance waiver process?

A I mean, it doesn't point out the variance processes as described in section -- or Chapter 120. I think that's more if they want to appeal to the next level -- next court level. I don't think that's in response to the variance process. That's a different process.

Q Okay. Thank you. So it does not mention the variance waiver process --

MR. JAZIL: Would it be possible just to read off the --

MS. DEBRIERE: Yes, absolutely. So it says at the bottom: Notice of a right to judicial review. A party who is adversely affected by this final order is entitled to judicial review, shall be instituted by filing the original notice of appeal with the Agency clerk of AHCA, and a copy along with the filing fee prescribed by law with the District Court of Appeal and appellate district where the Agency maintains its headquarters or where a party resides. Review proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days at the rendition of the order to be

reviewed.

THE WITNESS: Our various processes doesn't involve appellate courts, so it would not be an appellate case, so it's a different affair.

BY MS. DEBRIERE::

Q Thank you. Okay. Did AHCA work with Florida Medicaid managed care plans to implement the exclusion set forth in 59G-1.050(7) in any way?

A No. I mean, the publication's in the Florida Administrative Register, that was to provide ample notice -- public notice that the rule's changing, the managed care plans are responsible for keeping up with changes to manage -- to AHCA's coverage policies and administrative policies.

Q What about plan transmittal? Are you maybe forgetting those?

A We do not do a plan transmittal for this. Are you referring to a policy transmittal?

Q Yes.

A We did not send out a policy transmittal.

Q Okay. Okay. So we have what's marked as Exhibit 16 and Exhibit 17. Exhibit 16 is some emails from Dede Pickle to Jason Weida, cc'ing Ann Dalton. And those are dated August 22, 2022. I believe that's where they start. Also involved are you, Matt, and Ashley

Peterson. Also, I just want to note that Exhibit 17 is an SMMC policy transmittal dated August 22nd, 2022.

(Whereupon, Exhibit Nos. 16 - 17 were marked for identification.)

BY MS. DEBRIERE::

Q Getting back to the list of questions. So did AHCA not send the plan policy transmittal out, Exhibit 17?

A We did not send them out.

Q Why?

A Pretty much because all it's doing is reproducing what was already stated in the rule. The rules -- the rule -- the policy changes already in rule, that was announced through the FAR. Policy transmittal's a little superfluous at this point.

Q Why draft an entire plan transmittal and then not send it out?

A Which this happens frequently. Sometimes we will draft something and later decide not to -- not to use it, or not to utilize that content in favor of different strategy. So, in this case, since the rule -- since the rule change itself was pretty self-explanatory and pretty direct, just we later deemed wasn't necessary.

Q Who made the decision not to send out the

policy transmittal?

A I think that would have been -- that would have been Secretary Weida.

Q Only Secretary Weida? Is it Weida or Weida?

A Weida. I mean, as Assistant Deputy Secretary, he would be within his purview to decide whether or not to send something out -- or to send something out, but given that the rule itself was self-explanatory, and we just decided that a policy transmittal wasn't necessary.

Q All right. In the email exchanges -- I think it's on the second page -- oh, and Jason Weida, at this time that he made this decision, was not the Secretary -- AHCA's Secretary, correct? At the time this was sent, Mr. Weida was not the AHCA Secretary, correct?

A Right, he was Assistant Deputy Secretary for Policy and Quality.

Q On the last page, it looks like you were the person who drafted the first policy transmittal, is that correct?

A Yes. Yeah, I mean, Dede and I, it was a collaborative effort between the two of us. We were, of course, working on each other's language.

Q Why did you think Dede -- why did you and Dede think it was important to draft a policy transmittal?

A We were asked to.
Q By who?
A I think Ann Dalton asked Dede to work on it.
Q Okay. And later -- well, let's look to -- Ashley Peterson says on August 22, 2022 at 10:35 a.m.: I added one thing to help clarify that these drugs will still be provided, just not for gender dysphoria. Please let me know if you think this is unnecessary or adds confusion.

So at least Ashley thought there was some clarity that could be provided to plans on the implementation of the exclusion.

MR. JAZIL: Object to form.

THE WITNESS: Okay. There's several emails. Which one are you --

BY MS. DEBRIERE::

Q This one is from Ashley to Dede, copying you.
A August 22nd, 11:04 a.m. That's Dede --
Q 10:35 a.m.
A Okay.
Q It's DEF_0002587.
A Okay. I think it was just a minor, minor technical catch. I mean, when we worked on this, I mean, we were just fine tuning the drafts.
Q And further up Ann wants to include the 60-day

language in the alert, which has been later included. What is the 60-day language?

A That would be the bottom paragraph of the policy transmittal.

Q Okay. And that you're referring to starts with: To ensure the safe discontinuation of puberty blockers or hormone and hormone antagonists for the treatment of gender dysphoria?

A Uh-huh.

Q Then the managed care plan must notify its subcontractors, providers, enrollees receiving active treatment and changes in coverage, and they must honor any current prior authorization of prescribed outpatient drugs for the treatment of gender dysphoria through 60 days after the date of this policy transmittal. So that means that under the 60-day rule for continuity of care, the managed care plans were to continue coverage of the prescribed outpatient drugs for the treatment of gender dysphoria, correct?

A Only for those existing prior authorizations had already been approved.

Q Okay. So that meant that AHCA was -- or that Florida Medicaid was covering this drugs?

A Yeah, just for the sake of honoring existing PA's.

Q Was it not important that the plans know that they should maintain continuity of care?

A It's actually in the contract. I mean, when you refer to continuity of care, can you clarify what you mean by continuity of care?

Q In this instance, I'm talking about the continued coverage for 60 days of those prescribed outpatient drugs for the treatment of gender dysphoria.

A As far as the continuity of care went, I mean, there -- as far as medically necessary services, enrollees are always going to have access to those. So when it comes to the continuity of care, whether or --

Q They're not going to have access to services that have been previously covered, but now are excluded, correct?

A That'd be correct.

Q Okay. So the 60-day continuity of care ensures that after that categorical exclusion is adopted, those individuals continue to access that care for 60 days?

A This, of course, was a draft. It was never sent out.

Q At some point, AHCA thought that the 60-day period of continuity of care should apply in this situation, correct?

A Since this was a draft and it was not -- not officially sent out, this is not -- since it is draft language, it is not an official transmittal, we sent out to the health plan, so this does not formally represent the views of the Agency. This is a -- this is a draft that we created, deliberated upon and decided not to send out.

Q Who decided?

A That would, of course, been leadership. That would have been -- would have gone to Assistant Deputy Secretary Weida.

Q And he was the only one who was involved in that decision, correct?

A I mean, since he oversees the bureau policy, that's -- which means policy transmittal, yes, he had -- is within his -- is within his job description and his responsibilities and rights to veto sending out a policy transmittal.

Q Okay. Since the policy transmittal was not sent out, then is it AHCA's position that those who had a current prior authorization at the time that categorical exclusion was adopted, was not entitled to the 60-day continuity of care period -- were not entitled?

A So once the rule went into effect, that was,

of course, the notice of the plans that the coverage for these services has to stop.

Q Immediately?

A Well, I mean, that's based on what the rules say, yeah.

Q Okay. So they -- that means that the plans were not to implement this 60-day period of continuity of care as described in this transmittal?

A Right, we didn't provide notice of -- them of this.

Q Okay. And it was AHCA's position that Medicaid beneficiaries were not entitled to that?

A That's correct.

Q Okay. You previously noted how people on hormones may go through withdrawal, there was something as part of your 2022 GAPMS request. Why wasn't that important to communicate to the plans?

A Well, because withdrawal is not gender dysphoria. It's a different -- that's a different -- it'd be a different diagnosis altogether.

Q But in the decision to no longer cover drugs that may cause withdrawal, was it important to communicate to the plans or providers that they may need to help facilitate transition off those drugs that would no longer be covered?

A We were leaving that to the health plans to manage independently, as well as the providers of these services.

MS. DEBRIERE: Do we have a document titled Florida Medicaid health alert? You just -- under DEF_000258815. I feel like I've had the same Bates stamp number. So we're marking as Exhibit 18, the Florida Medicaid health care alert sign-off form.

(Whereupon, Exhibit No. 18 was marked for identification.)

THE WITNESS: I'm familiar with that. I drafted it.

BY MS. DEBRIERE::

Q That would definitely have been one of my questions.

A No, I'm listed on there as the analyst who drafted it.

Q And there's Dede and Ann.

A Yeah.

Q Okay. Did this healthcare alert go out to all providers?

A That provider alert did not go out.

Q And the provider alert on the back, it lists that same language to ensure the safe discontinuation of puberty blockers or hormones and hormone antagonists for

the treatment of gender dysphoria, or allow transition to payment to non-Medicaid funding sources. You incorporated the reference to the 60-day continuity of care period. You drafted that one. Did you include that 60-day language?

A Yeah. I -- yeah, I did include that.

Q Why did you think it was important to include?

A Because at the time we were -- we were creating a provider alert in sync with -- in sync with the policy transmittal, so we wanted to make sure that they used the same language and addressed the same things.

Q And why wasn't this sent out?

A Because -- because, well, we've deemed that the notice of the rule is sufficient, and that once the rule had said that AHCA will no longer cover these services, we could no longer cover those services. I mean, the rule was clear-cut. It's very -- I mean, language is pretty -- pretty straight to the point and direct.

Q Who made the decision not to send this out?

A That would have come from Assistant Deputy Secretary Weida at the time.

Q Did you agree with that decision?

A I thought it was sufficient. I actually

thought given that we put the rule out there, the rule is very straightforward, noticing, like, we had the providers, health plans, adequate notice was given.

Q Did Ms. Dalton agree with the decision not to send any of this out?

A I can't speak to Ms. Dalton. She and I didn't confer on our opinions of whether to -- we didn't confer on how we felt about it.

Q Was there any stated opposition to not sending these out?

A Not that I'm aware of, no.

Q So in managing withdraw, how would a plan or provider know how to navigate that if AHCA wasn't -- if AHCA notified them that they weren't going to cover the service that was needed to help titrate individuals off of their hormones or puberty suppression therapy?

A So it comes back down to practitioners delivering treatment to their -- to their patients. Once again, it comes down to how, like -- you know, when they know that they can't treat for gender dysphoria anymore, and they know that the individual might suffer -- might suffer withdrawal symptoms from testosterone. We, of course, did see some conflicting information on that one, whether they would experience symptoms or not, or estrogen, or if there were

withdrawal symptoms, you'd be treating the withdrawal. And, of course practitioners, we do trust the medical professionals to know what condition they're treating, when the -- because they do so every day when their course -- when they're, of course, diagnoses. And, of course, when the medical coders come in there to do the billing, it's --

Q If transition involved smaller dosages of hormones over time to treat gender dysphoria, how was the provider and the plan to know that they could continue to prescribe that?

A It would be coming through a different diagnosis code. And since we only said that for -- we only said in the rule only for the diagnosis of gender dysphoria. So if they're -- so if they're taking on some small doesn't testosterone because of withdrawal, that's a different -- that's a different diagnosis altogether.

Q How would they know what diagnosis code to use?

A So, practitioners and providers often don't -- aren't that familiar with the coding system. That's where their coders do to figure out. So their coders, of course, review the medical records and, of course, put in the CPT codes, they put in the ICD-10 codes, the

place of service. So usually the claims process is usually done either by often, like, a clearing house or individual coders that sometimes just rotate like a circuit through different physicians offices and so forth.

Q So when we're talking about the safe discontinuation of a medication, wouldn't the prudent thing to do would be to notify providers and plans of the options they had to ensure that individuals who could no longer access this treatment could at least come off of it as safely as possible?

A Given that physicians deal with that kind of situation, for other diagnoses and medical services, we just didn't feel it was necessary. That's one area we were going to, like, leave it. Practitioner discretion was how to withdraw their patients from testosterone or estrogen, if it was even necessary at all.

Q Did any managed care plan ask questions about how to implement the categorical exclusion of gender-affirming care?

A I don't think we received any questions for managed care plans.

Q What about from providers?

A I don't think we received any provider questions either.

Q Did any plan communicate that they will continue coverage in spite of the categorical exclusion?
A Definitely no.
Q Could a plan do that?
A Well, they hypothetically can --
Q Would Florida Medicaid allow them to do that?
A No, we would not.
Q I'm showing you what's marked as -- well, I will be in a second -- what is marked as DEF_ 000169125. It's the template member handbook -- actually, let's skip that one. I'm sorry. I'm sorry.
MS. DUNN: Oh, I'm sorry, we have numbers that aren't lining up with --
MS. DEBRIERE: Yeah, let's actually -- let's move to the emails from Susan Williams between her and Magellan. I'm not sure what the Bates stamp is. Okay. Thank you.
(Whereupon, Exhibit No. 19 was marked for identification.)
BY MS. DEBRIERE::
Q And that's marked as 19 and it's a series of emails between Susan Williams, Jessica Forbes at AHCA, Ashley Peterson, and the first date on the document is June 3rd, 2022. The subject is for treatment of gender dysphoria for children and adolescents.

A Well, this was -- well, we received this prior to the promulgation of the challenge exclusion.

Q You did. So, Stephanie McGriff over at Magellan says, Hi, Ashley and Susan, attached are the internal criteria not publicly posted. CCM that the implemented all meds with the gender code equals B, both in the subsequent updated denial letter that includes the non-discriminatory verbiage. What are the internal criteria she's referring to?

A So it looks like the email chain started on April 20th, following the release of the Department of Health's guidelines. So there were 14 impressions to AHCA at that time. We had just initiated the GAPMS process for these treatments.

Q Yeah. In fact -- so looking at the email from Alicia King Wilson dated April 20th -- so that would be the day that the Florida Department of Health released its guidance, right?

A Yes.

Q And Secretary Marstiller directed Tom Wallace just to start the GAPMS process.

A Yes.

Q It says: Leslie noted MMA does have an internal gender dysphoria criteria, which is attached. This internal document serves for a GnRH analog used to

delay puberty in adolescence with gender dysphoria, but it does not speak to use of hormone therapy. This document was provided by the Agency due to a fear of hearing requests received from Lupron for recipient with this diagnosis. All requests for use of the drug at that time to delay puberty were to be vetted by AHCA before a final determination is made. Can you explain that a little bit more? What does it mean that AHCA had to vet all determinations? What determinations was AHCA vetting?

A I don't -- I mean, it's tough to fully understand the context of this email. I mean, the context level is light throughout the chain, because I mean, Magellan does handle the prior authorization of clinical reviews for drugs in the fee-for-service system.

Q Okay, but it says that this document was provided the Agency due to a fair hearing request received from Lupron first, recipient with this diagnosis, all requests required vetting by AHCA before a final determination was made. So, I mean, I interpret that to mean that anytime Magellan received a request for Lupron to treat gender dysphoria, AHCA had to vet it before a decision as to coverage would be reached. Am I wrong?

A No, that's what it sounds like. The pharmacy -- the pharmacy processes may involve -- as far as like the pharmacist job descriptions go -- I mean, as far as like vetting, that's the kind of the questions like, are they -- because we don't do in-house prior authorizations or clinical determinations anymore. We haven't done those since SMC went into a fact.

Q Was a special exception made for the coverage of hormone therapy to treat gender -- I'm sorry -- for the treatment of puberty suppressant?

A No. No. Yeah.

Q So not to your knowledge --

A I'm just trying to figure out what they mean by vetting. Like, in other words, does this mean -- like, is Magellan sending the determination back to AHCA for yes or no approval?

Q Yeah.

A So they could be doing that.

Q But you don't know?

A Don't know.

Q Can we find that information out?

A We might be able to, because like -- because it's only a few emails, and we're trying to go over the process. I mean, it is possible that we could ask people who do oversee this area. I mean, they might

give us some information, but they may not be able to describe the exact context of the email because, I mean, sometimes things get lost in translation.

Q Does Susan Williams still work here?

A Yes, she does.

Q Does Ashley Peterson still work here?

A Ashley Peterson recently left us.

Q What's recent?

A Last week.

Q Find another opportunity?

A Yeah.

Q How about Kelly Reuben?

A Kelly Reuben's still here.

Q Jessica Forbes.

A Jessica Forbes is still with the Agency.

Q Shantice Green.

A No, she's not here anymore.

Q She find another opportunity?

A I believe so, yes.

Q All right. So, as a reminder, all gender codes were removed from programming as directed by the Agency in 2017. What does that mean?

A I'm not sure because I'm not sure what they mean by CCM. Generally, when we do -- when we make systems updates, it's either done through a file

maintenance or a customer service request to Gainwell Technologies oversees the FMMIS, so --

Q You were familiar with the programming of the ICD-10 codes, but you're not familiar with programming of the gender codes?

A Well, no, I'm familiar with the -- how diagnosis codes are programmed in the system, but this CCM acronym I'm not familiar with.

Q What is a gender code?

A You mean a gender code? Well, what they mean by gender codes, I'm assuming that means the ICD-10 Code F64. That's -- that's assuming that's what that means.

Q What's a B for both?

A Maybe that's written reference to male and female.

Q What is the significance of that? Why does it matter if it's -- what are the options? B for both and then, what, M for male, F for female?

A That could -- I mean, that's what I'm assuming based on -- based on this email chain. I mean, it's a little difficult because -- I mean, there's a lot of extrapolation and it's -- much of it's open to interpretation, so --

Q Sorry, I lost my place. Please prepare a CCM to remove gender code from all the NDC's. What are

NDC's? You said that?

A National drug codes. So that's almost like -- kind of like a procedure code, because each drug has a corresponding NDC. So the system doesn't recognize drug names or recognize national drug codes.

Q Okay. And that was actually -- that instruction was provided to someone -- Arlene Elliot sent that instruction to someone back in 2017, to remove the gender code. Do you have any idea why Magellan and AHCA were talking about this on June 3rd?

A No. We hadn't announced that we were going to do a categorical exclusion yet.

Q Okay. I think this is just a place where we're going to need to reserve some time for deposition after you're able to do some adequate research on what the information this email contains, and then we can do some follow-up questioning. Okay.

You mentioned earlier, were there any communications from the plans about the exclusion prior to its adoption?

A What do you mean? Do the plans have any -- do we discuss with the plans prior? No.

Q All right. Turning to waivers and variances under Chapter 120, are you familiar with that process?

A Oh, yes, I am.

Q Okay. I'm going to hand you a copy of the statute, Section 120.542. We'll mark that as Exhibit 20.

(Whereupon, Exhibit No. 20 was marked for identification.)

BY MS. DEBRIERE::

Q Are you familiar with the statute?

A Yes, I'm familiar with it.

Q Based on your understanding, what is the purpose?

A So the purpose of this is because, of course, agencies are granted rulemaking authority. And because agencies now -- and, of course, the rulemaking process, I mean, it's public, transparent, but there are times that there may be an exception that's required, so it's kind of like the check and balances that if a variance is required on a rule that -- like a party could apply to that agency that administers that rule for consideration of a variance.

Q Does the purpose of the underlying rule have to -- the spirit of it have to be met in granting the variance or waiver?

A What's meant by the spirit?

Q I'm trying to look for the specific language. So under subpart two, variance and waiver shall be

granted when the person subject to this rule demonstrates the purpose of the underlying statute -- I guess in this case it would be a rule -- or what statute will we be referencing?

A Well, in legal terminology, I mean, differences between rule and statute, I mean, statutes, of course, are approved by the legislature, goes to the Governor, and the rules are done under the authority of the statutes. So, I mean, like agencies are authorized to grant variances and waivers to requirements of the rules consistent with the section and with rules adopted under the authority of the section. So, I mean, they do call out rules, specific. Then, of course, this applies to all state agencies, so --

Q Who makes a determination at AHCA whether a petitioner has established a substantial hardship under the statute?

A Those come through our General Counsel's office. So if somebody wants to request a variance, they do so through our agency clerk.

Q And how is the determination itself made?

A So the agency clerk will reach out to individuals to, of course, who have pertinent knowledge about the -- about the circumstances of the request of the variance, will ask for input. And, of course, the

determination's made. It rides up to the Secretary. The Secretary has to do the final approval for a variance.

Q So same question as to determining whether principle -- principles of fairness are violated, who makes that determination?

A So when it comes to waivers and variances, that's same process. Goes to the agency clerk. Then, of course, does an investigation, consults with individuals who are knowledgeable about the pertinent subject, and then it goes up to the Secretary.

Q Has AHCA developed any criteria to guide its determination of whether to grant a variance or waiver from the categorical exclusion of gender-affirming care?

A No. No, we haven't. Variances are determined on a very individualized basis.

Q So, again, turning back to the -- ensuring the purpose of the underlying statute, 120.542 specifically states that variance and waivers shall be granted when the person subject to the rule demonstrates that the purpose of the underlying statute will be or has been achieved by other means for the person. So that means the granting of the variance or waiver shows that the purpose of the underlying statute will be or has been achieved by granting it. What statute -- in reviewing

any request for a variance or waiver from 159G-1.050(7), how would you demonstrate that the purpose -- well, what statute will be at issue, first of all?

A Well, for the statute -- I mean, would be Chapter 409. Those are the Florida Medicaid -- that consists of the Florida Medicaid statute, so --

Q What specific -- what specific provision of 409 would you be looking at?

A I mean, we'd be looking at -- well, for the variance, we'd probably be looking at, like, I mean, somewhere under 409.9, probably under covered services or optional services.

Q Okay. So how -- if someone requested a waiver or variance from 59G-1.050(7), under what circumstances would AHCA authorize coverage of the services listed in that rule?

A Well, we can't speak to those because I don't think -- we haven't gotten a request for variances on this yet. So like it says, a highly individualized process. We will be looking at in-depth at the recipient, looking at all the records available, and, of course, discussing things with various experts and so forth. But each request is individualized. So because each request is individualized and focuses on the specific individual, we can't project on what grounds we

would grant a variance under.

Q Well, so the June -- the categorical exclusion of treatment for gender dysphoria was adopted because the certain -- AHCA found that those services were experimental, correct? And Florida Medicaid cannot cover services that are experimental?

A That's correct.

Q So in what situation could AHCA grant a waiver or variance covering services that AHCA has found to be experimental?

A Well, I mean, based on the rule we wouldn't. I mean, based on the rule, we would deny the variance, but because each variance, it's individualized requests, we would have to go through and evaluate each one individually.

Q Would the person have to establish that the service they're requesting is not experimental?

A We will not be placing the burden on the recipient.

Q Who would the burden be on?

A Well, that would be on -- it'd be an individualized process, evaluating all the -- all -- whatever medical records that we can get a hold of. That's -- that's process that we use in the past, but based on the rule, I mean, yeah, we say that these

would -- you have a categorical exclusion. While we -- while the variance process is available, but because we have a categorical exclusion, we do declare the services to be experimental, investigational due to very-low-quality evidence that -- yeah, I mean, we would deny variance, but because variance reviews are individualized, we don't want to speak in absolute terms on the variance process. But for -- because, I mean, there's all kinds of questions that could come up in the review of the medical records. Maybe it was a -- maybe it was a misdiagnosis. Maybe something else could come up. That's pretty much why. So --

Q Okay.

A Everything is different and --

Q If a person sought a waiver of the application of 59G-1.050(7) so they can receive Medicaid coverage for a mastectomy that is specifically to treat their gender dysphoria, under what circumstances would that waiver be granted?

A For -- under what circumstances?

Q Yeah.

A Well, I mean, we did declare this service to be experimental investigational.

Q So they could not get a waiver, correct? The waiver would be denied?

A Based on the very general, hypothetical situation that you provided, straight out just for gender dysphoria, they got denied by their insured so they request a variance.

Q Yeah.

A Based on our rule language, yeah, it'd be denial.

Q And someone is entitled to a fair hearing when Medicaid coverage is denied, correct?

A Yes, they are.

Q Given that the Agency has found the services in 1.057 -- 59G-1.050(7) to be experimental, and therefore never medically necessary, correct?

A Correct.

Q Could someone ever prevail at a fair hearing where they sought coverage of the services for gender dysphoria?

A Well, based on our rule, based on our findings, no.

Q Could someone use the variance or waiver process to get around the final decision issued after the fair hearing?

A Well, I mean, they can request a variance, but then they would go through the process, but based on our rule and our findings, no.

Q How often do Medicaid beneficiaries file variance requests?

A So in the research for this case, we found 10 requests, and that's since going back to about 2015, 2016.

Q Okay. So between 2015, 2016 to present, there has been 10 requests?

A That's correct.

Q Okay. These variances -- and I have copies of all of them, if you'd like to reference them. They request that a service that AHCA affirmatively covers. So there's -- there's a few types of variances we found in our review. There's situations in which AHCA affirmatively covers the service, but the individual wants an amount greater -- in a greater amount or duration.

A Yeah, I'm familiar with that one. It's -- there was a variance request -- and it was actually several various requests, because they were granted for six months at a time. We're talking about our recipient under our I-budget waiver. So, of course, our I-budget waiver -- and no, it isn't, it's codified in rule. So, of course, there was a service limit on these behavior assistance services at the time. They were requesting additional behavior assistance services. So while -- so

because we already covered the service, and they're just looking for additional services, you know, and that that's -- that's flexibility that we can grant because we haven't actually gone through -- the service they are requesting, we have not codified as a categorical exclusion, and we've not deemed that service be experimental investigational.

Q Okay. And that's true for all the services that are contained in the variances --

A Yeah, from what I could tell, they're pretty much all I-budget.

Q Okay. And they -- none of the services that they were requesting some kind of variance on had been categorically excluded, correct?

A Correct.

Q Okay. And none of them have been determined experimental?

A Right.

Q Okay. Do you know of every Medicaid recipient who made a request for a variance, if they were represented by counsel?

A No, we don't know if they were all represented by counsel or not.

Q Because I did notice that the recipients were all listed.

A Yeah, the recipients were listed. The information is referred to the agency clerk. Then the Agency does its internal processes.

Q Do you know what pro se means?

A No.

Q So, in any of the requests for variances to the Medicaid recipient, him or herself, do any of the direct request for the variance, or did they need assistance?

A Given the complexities of request and legalities of it, I would -- I think it's safe to say that they had some assistance, although it's not required.

Q Okay. Between April of 2022 and August 21st of 2022, did anyone at AHCA ever discuss the variance or waiver process for use in challenging a denial based on the categorical exclusion of treatment for gender dysphoria?

A No.

Q All right. Turning to our specific clients, at anytime prior to August 21st, 2022, did Florida Medicaid cover any of the services listed at 59G-1.050(7) for the treatment of gender dysphoria and that actually --

A You're talking about --

Q Everyone.
A You're talking about after the hard date when the ruling took effect?
Q Anytime prior to that, did Florida Medicaid cover any of the services listed at 59G-1.05 --
A Prior to the effective date, yes.
Q Okay. So they covered puberty blockers?
A Yes. Well, for that small handful of recipients we pulled the data on, yes.
Q They cover cross-sex hormone therapy for the treatment of gender dysphoria?
A Yeah. I mean, as far as data showed.
Q Did they cover surgery for the treatment of gender dysphoria?
A From our data revealed, yes.
Q At any time prior to August 21st, 2022, did Florida Medicaid cover any of the services listed at 59G-1.050(7) for August Dekker?
A We did go through our -- we did go through there the recipient's histories, yeah.
Q Did Florida Medicaid cover puberty blockers for August Dekker to treat gender dysphoria?
A For August Dekker?
Q Yes.
A Puberty blockers?

Q Yes.
A I don't believe so, no.
Q Did Florida Medicaid cover hormone therapy for August Dekker in treatment of gender dysphoria?
A For August Dekker, yes. I think -- I think his managed care plan, Humana was providing him those.
Q And he's still currently eligible for Florida Medicaid?
A Last time we checked he was still Medicaid eligible.
Q Okay. And he's still enrolled in Humana, or did he switch to another plan?
A Well, we haven't -- we haven't verified since -- we did have an enrollment period and recipients are eligible to switch plans during that enrollment period.
Q In the coverage of hormones for treatment of August Dekker's gender dysphoria, how long -- for how long did AHCA authorize that treatment? For how long did Florida Medicaid cover that treatment?
A I don't know the exact length. We would have to go back and take a look at the records we received from Humana on the case.
Q More than six months?
A I think it was more than six months.

Q More than a year?
A That's where it gets hazy.
Q Was coverage for hormones to treat gender dysphoria terminated for August Dekker after August 21st?
A According to rule, yes, it would be terminated.
Q Did Florida Medicaid cover surgery for August Dekker and treatment of gender dysphoria?
A Yes.
Q When?
A So that would have been prior to the -- that would have been prior to the challenge exclusion being implemented. Then to clarify, that was -- is -- the managed care plan was covering that outside our state plan benefits.
Q How do you know that?
A Because our state plan does not -- does not specify the service as being -- as being mandated for coverage. In other words, if Humana had denied the service, well, it would have just been a denial because it's not a -- Medicaid doesn't -- we don't have that in our state plan. Managed care plans have to cover all state plan services. Sex change operations are not a state plan covered service.

Q Surgery is a state plan covered service?

A Surgery, yes, but for -- but not for this -- necessarily this condition.

Q Does the state plan specify for what conditions services are provided?

A No, it doesn't break down the diagnosis codes, but this was one -- was the plan's discretion. The plan could have said yes. The plan could have said no. It was up to the plan.

Q Were federal Medicaid match dollars used to pay for August Dekker's surgery?

A So capitation rates that we pay to the plans are per-member per-month rate. That is a combination of federal matching dollars and state revenue.

Q Okay. At any time prior to August 21st, 2022, did Florida Medicaid cover any of the services listed at 59G-1.050(7) for Brit Rothstein?

A Based on the -- based on the records that we pulled, based on the recipient's individual histories that we were -- we were able to locate, looked like, yes, we did.

Q Okay. Did Florida Medicaid ever cover puberty blockers for Mr. Rothstein?

A So for Mr. Rothstein -- so for Mr. Rothstein -- I -- so. Sorry. I think he's one of the

adult plaintiffs?

Q Yes. Yes. And you said that he -- I'm sorry -- pulled in a lot of directions.

A We did cover services that we did determine to be experimental investigational prior to the challenge exclusion.

Q And no longer cover them, correct?

A Yes, because of the challenge exclusion.

Q Same question for KF.

A Since -- with KF, we did have a hard time since for the minors we didn't have, like, their full identification information. Trying to locate their records in the system, I think there were encounters, based on information we had, that did show they were receiving GnRH.

Q Okay. For the treatment of gender dysphoria?

A Yeah.

Q Okay. And that includes Susan Doe, as well?

A Based on what we could find, looked like they -- that there had been some coverage.

Q And they're -- KF is still currently eligible for Florida Medicaid, is that correct?

A We would have -- I think -- I think they would be, because we haven't been doing these determinations because of COVID. So, yes, they would still be

Medicaid-eligible. That would go for all the plaintiffs.

MS. DEBRIERE: Okay. Let's -- can we take a five-minute break?

MR. JAZIL: Sure.

VIDEOGRAPHER: Okay. This concludes video four. The time is 4:15 p.m.

(Brief recess.)

VIDEOGRAPHER: This is the beginning of video five. The time is 4:30 p.m. We're on the record.

BY MS. DEBRIERE::

Q All right. Turning back quickly to plaintiff August Dekker, did Humana violate Florida Medicaid policy by covering his surgery for treatment of gender dysphoria?

A No, they did not at the time.

Q Okay. And then I just want to talk about a few more exhibits. One labeled -- we've marked as Exhibit 21, and that is the GAPMS queue that was provided to us.

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

BY MS. DEBRIERE::

Q And it looks like the most recent date on that queue was maybe an update to one of the GAPMS in 2019.

That's as far as it goes. Are all -- are these the only GAPMS that are currently pending?

A So the requests came in to pull the most recent GAPMS queue.

Q Yeah.

A So at this -- when I went through our -- we have a GAPMS folder that's on our shared drive. I did look through to see what -- we have a folder for the GAPMS queues. I did pull the most recent one. This was the most recent one that had been updated that was in there --

Q I'm sorry. Go ahead.

A This does -- this does consist of a lot of GAPMS reports, which I do remember drafting some of those as well, but this was our most recent one.

Q And have there been GAPMS reports created after 2018?

A Yeah, I think there have been.

Q Why aren't they on this list?

A I'm not -- I'm not sure why they wouldn't be included on this list. This list should be updated on regular basis, so I'm not sure why they wouldn't be included on this, or on the list on the share drive, because the GAPMS queue is really is not so much for the GAPMS analyst, because GAPMS analysts generally have a

pretty good idea of what's outstanding, what's pending, and what's been turned in. It's more for leadership -- or their supervisor to pull and take a look at when necessary, so I'm not sure why this hasn't been listed to update in this current.

Q So whoever's working in GAPMS at the time has a good understanding of which GAPMS are pending.

A When I was -- when I had the role, I could tell you exactly where all my reports were, what their status was and where they stood in the queue. So, yeah, I kind of had all committed to memory.

Q Okay. Would that be true of anyone holding that GAPMS position?

A As far as pulling it from memory, I couldn't vouch for the other employees as to their memories, when it came down to their reports that are outstanding.

Q But they should have a good sense?

A They should have a good sense of what's pending and what's been turned in.

Q Can you provide us a list of what's pending that's not listed on this queue?

A So I think -- so I think the ones that are still pending aren't -- I think there were, like, reopened reports. I think we had gotten requests from the manufacturers of Atheno, was the asthma tests that I

discussed earlier. That was one I had to have finalized. We've gotten a request for them to -- for us to review it, provided that they don't send some more evidence and more studies that have been done after our original report. So I think that one was reopened. That one should still be pending. Then there was specially modified low-protein foods. That was another one that I had written up. We had gotten requests to reopen that one that, and to reevaluate that service. I think there was another one, which was the -- which was a bone growth stimulator called Exigent. I think that one is still outstanding and pending. Now, those are just some examples of ones I can think are still pending.

Q Were there any new requests made after December of 2018?

A Yeah. I mean, there have been some new requests for either, like, expedited GAPMS or full GAPMS. I mean, we do get the service requests in fairly frequently, so --

Q Because it would be odd if any new requests hadn't come in almost five years --

A Correct. Yeah.

Q Okay. But there's no way -- all right. And then I just want to put into the record, because we've

been referring to it quite a bit, we'll Mark it as Exhibit 22, and that is the document from Health and Human Services that we've referenced multiple times during the deposition. Is that the one you're referring to?

A That's correct. This is it.

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

BY MS. DEBRIERE::

Q Thank you. And then the guidance from the Florida Department of Health regarding treatment of gender dysphoria for children and adolescents dated April 20th, 2022. That's Exhibit 23. Is that the document that we've been referring to when we're talking about DOH guidance?

A Yes, it is.

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

MS. DEBRIERE: And then -- I think that's it for my questions. The only thing I wanted to put on the record, Mo, is we are at what time, Videographer?

VIDEOGRAPHER: Do you mean the whole run time or --

MS. DEBRIERE: Just the questioning time.

Yeah, the time that we've been live and active on the record.

VIDEOGRAPHER: Five hours, eight minutes plus five and a half minutes.

MS. DEBRIERE: Okay. So want to just say that we have an hour and 45 minutes of questioning --

MR. JAZIL: Sure.

MS. DEBRIERE: -- to reserve?

MR. JAZIL: And so the depo is open. I'd like to ask questions at the end. So I'll just reserve that until after our second session, is that okay, or would you like for me to --

MS. DEBRIERE: Can I confer with my team quickly? Okay.

VIDEOGRAPHER: We will remain on the record?

MS. DEBRIERE: We'll go off the record.

VIDEOGRAPHER: Okay. Off the record at 4:36 p.m.

(Discussion off the record.)

VIDEOGRAPHER: We're back on the record. The time is 4:37 p.m.

MS. DEBRIERE: And plaintiff's counsel is all finished with their questioning.

EXAMINATION

BY MR. JAZIL::

Q This is Mohammed Jazil for the defense. I'll try to be brief, recognizing we have time limitations here. Mr. Brackett, I'd like to have you look at Exhibit 3 again.

A Okay.

Q Exhibit 3 has a date on it, May 20th, 2022. I want the record to be clear, why is that date not accurate?

A This date isn't accurate because that date is -- automatically sets to the date you print it out.

Q And what sets that date?

A The template is automatically set to enter in this current date that you're viewing the document. So it automatically updates the second you open it.

Q And that's the template in the AHCA document?

A That is our template, yeah.

Q And when was this GAPMS report created?

A This GAPMS was originally created in 2016.

Q Thank you. You discussed with my friend the variance and waiver process. Do you recall that testimony?

A Yes.

Q You testified that the variance and waiver process is individualized. Do you recall that testimony?

A Yes, I do.
Q Once a variance and waiver request comes in, it goes to the clerk is what you testified to, if my understanding is correct?
A Yes.
Q And then the clerk routes it to whom?
A The clerk gathers information and it has to be routed up to the secretary.
Q Is it routed directly to the Secretary or is there any other office that it goes through first?
A I'd have to take a look at the variances again. It might be -- I think it probably have to route through General Counsel before it goes to the Secretary.
Q Okay. And is the General Counsel's office responsible for the formulating the Agency's position on legal issues?
A Yes.
Q Does that include the variance and waiver process?
A Yes.
MR. JAZIL: I have no further questions.

FURTHER EXAMINATION

BY MS. DEBRIERE::
Q Just one redirect. Very brief. On Exhibit 3, which is the GAPMS memo dated May 20th, 2022, that was

the date it was printed out. It also appears changes were made on that date, is that correct?

A Based on the comments in the edits, yeah, it looks like somebody had made changes to that document on that date.

Q But you don't know who that person is?

A SG, I'm -- I can't speak to who SG is.

Q But you will find that information out for us?

A We can -- we can figure out who, but we would -- probably want to verify with IT.

MS. DEBRIERE: Okay. That's all.

MR. JAZIL: So, counsel, while we're still on the record, he's still under oath, so I'm not going to obviously talk to him about any issues that might come up, but with your consent, I'd like to at least work with him to gather the additional information that's being sought. Is that appropriate?

MS. DEBRIERE: I mean, I would assume that would be your process.

MR. JAZIL: He is under oath, and so I'm obviously not going to try to, you know --

MS. DEBRIERE: I see. I see.

MR. JAZIL: -- work with him while -- work with him on his testimony, I say, as I try to gather

additional information, so I'll make that clear on the record.

VIDEOGRAPHER: Anyone else? Anybody by Zoom?

MS. DEBRIERE: No.

VIDEOGRAPHER: Okay. This concludes the February 8th, 2023 portion of the video-recorded deposition of Corporate Representative for Agency for Health Care Administration. The time is 4:40 p.m.

COURT REPORTER: Are you going to be ordering this?

MS. DEBRIERE: Yes.

COURT REPORTER: All right. And Mo has requested a rough draft. I told him I could get it to him tomorrow. Do you guys -- would you guys like one, as well?

MS. DEBRIERE: Yes, please.

(Whereupon, the deposition was concluded at 4:40 p.m., and the witness did not waive reading and signing.)

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

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

Gary V. Perko, Esq.
gperko@holtzmanvogel.com

February 21, 2023

RE: August Dekker, et al. vs. Jason Weida, et al.
February 8, 2023/Matthew Brackett/5696545

The above-referenced transcript is available for review. The witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason on the attached Errata Sheet. The witness should, please, date and sign the Errata Sheet and email to the deposing attorney as well as to Veritext at Transcripts-fl@veritext.com and copies will be emailed to all ordering parties. It is suggested that the completed errata be returned 30 days from receipt of testimony, as considered reasonable under Federal rules*, however, there is no Florida statute to this regard. If the witness fail(s) to do so, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions
*Federal Civil Procedure Rule 30(e)/Florida Civil Procedure Rule 1.310(e).

August Dekker, et al. vs. Jason Weida, et al.

February 8, 2023/Matthew Brackett

E R R A T A S H E E T

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REASON_____

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

_____ _____

Matthew Brackett DATE

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m

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.

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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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