NO. 22-1927

In The

United States Court Of Appeals

For The Fourth Circuit

CHRISTOPHER FAIN; SHAUNTAE ANDERSON, individually and on behalf of all others similarly situated,

Plaintiffs - Appellees,

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; CYNTHIA BEANE, in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, Bureau for Medical Services,

Defendants – Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA AT HUNTINGTON

JOINT APPENDIX – Volume III of VI
(Pages 1076 – 1532)

Kimberly M. Bandy
Lou Ann S. Cyrus
Caleb B. David
Roberta F. Green
SHUMAN MCCUSKEY SLICER PLLC
P. O. Box 3953
Charleston, WV 25339
(304) 345-1400

Counsel for Appellants

Tara L. Borelli
LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC.
1 West Court Square
Suite 105
Decatur, GA 3003
(470) 225-5341

Counsel for Appellees

Carl S. Charles
LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC.
120 Wall Street
Suite 105
New York, NY 10005
(404) 897-1880

Counsel for Appellees

Anna P. Prakash
NICHOLS KASTER, LLP
4700 IDS Center
80 South 8th Street
Minneapolis, MN 55402
(612) 256-3200

Counsel for Appellees

Nora W. Huppert
LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC.
65 East Wacker Place
Suite 2000
Chicago, IL 60613
(847) 345-2094

Counsel for Appellees

Avatara A. Smith-Carrington
LAMBDA LEGAL DEFENSE & EDUCATION FUND, INC.
1776 K Street, NW
8th Floor
Washington, DC 20006
(202) 804-6245

Counsel for Appellees

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, *et al.*,
Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, *et al.*,
Defendants.

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

NOW COME Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, by counsel Lou Ann S. Cyrus, Roberta F. Green, Caleb B. David, Kimberly M. Bandy, and the firm of Shuman McCuskey Slicer PLLC, and, pursuant to Rule 56(c) of the Federal Rules of Civil Procedure, hereby respectfully submit their Motion for Summary Judgment on all claims asserted against them by Plaintiffs, along with their supporting memorandum of law.

Defendants are entitled to summary judgment for each of Plaintiffs' claims. Count I of Plaintiffs' Amended Complaint asserts a claim for alleged deprivation of rights in violation of the Equal Protection Clause of the Fourteenth Amendment. Plaintiffs' equal protection claim fails for several reasons. First, Plaintiffs have not been treated differently from others similarly situated to them. Second, Plaintiffs have failed to proffer any evidence of intentional or purposeful discrimination. Third, even if Plaintiffs can demonstrate some disparate treatment based on diagnosis, Defendants' classification survives rational basis review because the State's policy is rationally related to its interests in providing coverage consistent with CMS mandates and in conserving financial resources. Finally, if the Court determines that intermediate scrutiny applies to Plaintiffs' claim, Defendants' classification survives intermediate scrutiny because the

classification serves an important governmental purpose. Therefore, Defendants are entitled to summary judgment as a matter of law.

In Count II, Plaintiffs seek declaratory and injunctive relief against all Defendants and compensatory damages against Medicaid for violation of Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18116. Plaintiffs' claims under the ACA fail as a matter of law. Defendants have not created a classification that discriminates based on gender identity. Instead, Defendants provide coverage to transgender individuals to the same extent that they provide coverage to cisgender individuals. Plaintiffs' claim is based upon Medicaid not covering gender-affirming surgeries; however, the ACA and its accompanying regulations do not require Medicaid to cover any particular procedure or treatment. Therefore, Defendants are entitled to summary judgment as a matter of law.

In Count III, Plaintiffs seek declaratory and injunctive relief against Defendants Crouch and Beane for violation of the Medicaid Act's Availability Requirements, 42 U.S.C. § 1396a(a)(10)(A). Plaintiffs claim that Medicaid's policy not covering gender-affirming surgery eliminates mandatory Medicaid coverage and renders medically necessary services unavailable. Plaintiffs' claim fails as a matter of law. The Medicaid Act does not require Defendants to cover gender-affirming surgeries, and its accompanying regulations permit a State Medicaid plan to place limits on services even if those services are required to be covered. Even if gender-affirming care falls into one of the mandatory covered service categories, State plans are permitted to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Here, Medicaid has placed appropriate limits on gender-affirming care by providing coverage for most gender-affirming care and designating as non-covered gender-affirming surgeries, which Medicaid is permitted to do based on considerations such as medical necessity

and on utilization management considerations. Therefore, Plaintiffs' claim fails as a matter of law, and Defendants are entitled to summary judgment.

Count IV seeks declaratory and injunctive relief against Defendants Crouch and Beane for violation of the Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B). Plaintiffs allege that Defendants provide comparable services to cisgender beneficiaries while they do not provide those services to transgender beneficiaries. Plaintiffs' claim fails as a matter of law. The Medicaid Act and its accompanying regulations prohibit three types of discrimination: (1) against the categorically needy, (2) among the categorically needy, and (3) among the medically needy. Plaintiffs' allegations do not describe discrimination in any of these manners. Plaintiffs appear to be alleging that Defendants discriminate "among the categorically needy" by not providing coverage for gender-affirming surgery. Defendant do not, however, provide coverage for gender-affirming surgery to any Medicaid beneficiaries. Additionally, there is no requirement in the Medicaid Act that compels a state to provide a treatment for all diagnoses if the treatment is provided for any diagnosis. Therefore, Plaintiffs' claim fails as a matter of law, and Defendants are entitled to summary judgment.

Finally, Plaintiffs lack standing to bring any of their claims. Neither has submitted a claim for and been denied gender-affirming care by Medicaid. Neither has submitted a claim for gender-affirming surgery. Mr. Fain testified that he is not willing to undergo surgery until he has kicked his smoking habit, which has not yet occurred. Ms. Anderson has never had a treating physician find that she requires gender-affirming surgery to treat her gender dysphoria. Thus, neither Plaintiff has established a concrete and particularized injury that is actual or imminent. Therefore, both Plaintiffs lack standing, and Defendants are entitled to summary judgment.

In support of their Motion, Defendants submit the following exhibits, which are referred to within the Memorandum of Law by their respective Exhibit numbers:

Exhibit 1, Deposition of Sarah Young; with redactions;

Exhibit 2, Deposition of Bill Crouch;

Exhibit 3, Deposition of Cynthia Beane;

Exhibit 4, Deposition of Shauntae Anderson with redactions;

Exhibit 5, Deposition of Christopher Fain with redactions;

Exhibit 6, Affidavit of Jennifer Myers redacted version;

Exhibit 7, Deposition of Brian Thompson;

Exhibit 8, Deposition of Dan Karasic, M.D. with redactions;

Exhibit 9, Deposition of Dr. James Becker;

Exhibit 10, Deposition of Fred Lewis;

Exhibit 11, Report of Dr. Stephen Levine;

Exhibit 12, Deposition of Becky Manning;

Exhibit 13, Defendants' First Supp. Response to Plaintiff's First Set of Interrogatories;

Exhibit 14, Deposition of Jennifer Myers;

Exhibit 15, Deposition of Dr. Schechter;

Exhibit 16, Deposition of Dr. Olson-Kennedy;

Exhibit 17, Affidavit of Sarah Young;

Exhibit 18, Deposition of Dr. Stephen Levine.

For these and other reasons more fully set forth in the accompanying memorandum of law, William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services respectfully request that this Court grant summary judgment in their

favor on all claims advanced by Plaintiffs. These Defendants seek any and all further relief deemed appropriate by the Court.

WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/ Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN and **SHAUNTAE ANDERSON;** individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources Bureau for Medical Services, by counsel, and do hereby certify that on the 31st day of May, 2022, a true and exact copy of "**DEFENDANTS' MOTION FOR SUMMARY JUDGMENT"** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com
Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor

Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
65 E. Wacker Pl, Suite 2000
Chicago, IL 60601
(312) 663-4413
(312) 663-4307
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

/s/ Kimberly M. Bandy

Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF SARAH YOUNG

DATE: March 11, 2022
TIME: 8:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5096099

APPEARANCES

On Behalf of the Plaintiffs (Via Videoconference):

CARL CHARLES, ESQ.
TARA L. BORELLI, ESQ.
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Ave., Suite 105
Decatur, Georgia 30030
470.225.5341
ccharles@lambdalegal.org
tborelli@lambdalegal.org

AVATARA SMITH-CARRINGTON, ESQ.
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

NICOLE J. SCHLADT, ESQ.
Nichols Kaster PLLP
80 South 8th Street, Suite 4700
Minneapolis, Minnesota 55402-2224
612.256.3291
nschladt@nka.com

WALT AUVIL, ESQ.
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
304.485.3058
auvil@theemploymentlawcenter.com

On Behalf of Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services (Via Videoconference):

KIMBERLY M. BANDY, ESQ.
LOU ANN S. CYRUS, ESQ.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street East, Suite 200
Charleston, West Virginia 25301
304.345.1400
kbandy@shumanlaw.com
lcyrus@shumanlaw.com

On Behalf of Defendant Jason Haught (Via Videoconference):

ERIC D. SALYERS, ESQ.
Oxley Rich Sammons, PLLC
517 Ninth Street, Suite 1000
Huntington, West Virginia 25701
304.522.1138
esalyers@oxleylawwv.com

NOTE: The original deposition transcript will be delivered to Carl Charles, Esq., as the taking attorney.

organization, Ms. Young. Can you tell me what your job title is, please?

A. Deputy commissioner of policy and operations.

Q. Okay. And what responsibilities fall under your role within BMS?

A. Under the policy side I have staff who oversee all of the coverage policies that we have, that also includes our eligibility policy. And on the operation side I have oversight of all of the technical systems that we use to manage the program.

Q. Can you tell me what technical systems you oversee, that seems like a big bucket of work, can you just say a little bit more of what you mean by that?

A. It is. We have the Medicaid managed information system, you may see it referred to as MMIS, that is our claims processing system. Within that we have our provider enrollment documents or files as well. I do not see the, oversee the member eligibility system, but our staff do have input into the Medicaid portion of that system. There are various other systems that we oversee that touch on member eligibility as well.

Q. So there's another individual who specifically oversees eligibility, right, that formally falls under someone else, is that correct?

A. The policy for member eligibility falls under?

be weekly to go over as new codes are introduced or new, if there's a change in a scope of practice for a practitioner then they would evaluate the codes that are associated with that additional scope of practice if it's within our confines of covered services.

Q. Okay. And let me zoom out from the specific and just say, or just rather ask, does BMS make changes without the West Virginia legislature necessarily mandating it to do so?

A. Yes, we do.

Q. Okay, okay. And those changes that BMS makes independent of the legislature, does CMS have to approve those, so do those changes necessarily, if they include the required, if those changes include what CMS mandates for coverage, does CMS necessarily have to approve those changes?

A. Depending on the scope I guess of the change, yes. If we added a service that was not previously covered, if we added it or added limitations to a service that we currently cover, they would have to review and possibly approve the act. There may be a much minor scale change that we've made that doesn't require their approval. I think it depends on the scope and how substantial of a service change it is.

Q. Okay. And then on the enrollee side of

A. Yeah, it's a big question because I think we were aware on a personal and a professional level as to what was going on and we were approached by a number of state providers, members, different advocacy groups or different interested parties. There was specific funding that was made available around that time as well, so it was getting a lot of attention and obviously we were being asked to do what we could to address it as well.

Q. Thank you for that. So for a change like that which, I mean, tell me if this is right, you said that was a larger system change in the benefit structure for both enrollees and providers. Do you recall that CMS had to be consulted about that change?

A. Yes.

Q. Okay.

A. Yeah, specifically this type of authorization. We were aware of at least one other state at the time that had requested for the authority to do something like this. This demonstration waiver is a very lengthy process and CMS was involved from the very beginning of conceptualizing it through public comment and approving the actual application for the waiver.

Q. I see. And so thinking about CMS's role specifically as it relates to gender confirming care, to

your knowledge does CMS require that gender confirming care be excluded from any state Medicaid plan?

A. Not that I'm aware of.

Q. Okay. And are you aware of any other state Medicaid plans that include or provide coverage for gender confirming care? And I should say, I know this is tricky, but you the representative of BMS, not you, Ms. Sarah Young, in your personal capacity.

A. And I apologize, I don't, I have not done research on what other states cover and the degree to which they do cover.

Q. Okay. And have you seen any discussion of that specific nature come through emails from other members in the leadership team?

A. Regarding other states?

Q. Other states, yes, yes, mm-hmm.

A. Not that I recall.

Q. Okay. And then when the Bureau for Medical Services undertook the change to cover hormone therapy, do you know if CMS was consulted in that change?

A. My understanding of that is that we had always covered the hormone therapy until a change was made at some point, and I don't know when that was, that change was made that we didn't cover it. So then when the change was made it was basically reverting back to the

regardless.

Q. Got it. Okay. Thank you. And then sort of zooming out again, if BMS excludes a particular service, are the MCO's required to abide by that exclusion?

A. Yes, if they are reimbursing out of their Medicaid money.

Q. Okay. Sorry, Ms. Young, give me just a second. How are you doing, Ms. Young, would you like a break now or would you like to continue for about another 20 minutes and then we break for lunch?

A. I can continue.

Q. Okay. Thank you. So if you would look back again at the marked exhibits, the most recent one that we had open there, the second amended notice of deposition. We're still on Page 2. Oh, no, I'm sorry, we're on Page 3, if you would, and I'm looking at topic No. 5. Do you see it up there?

A. Yes, it begins with, "Your efforts to administer."

Q. It does. Could you just finish reading the rest of that topic for me, please.

A. "Your efforts to administer the Medicaid program in West Virginia and/or affirm your compliance with the Medicaid Act and the Patient Protection and Affordable Care Act."

A. Yes. I think we've called it the PPACA, but I believe it's the same thing, yes.

Q. That's a new one, I have not heard that one. We use ACA and I know, you know, often the general public it's ObamaCare, but tell me again what you call it?

A. The PPACA, just add the P's in there.

Q. Okay. I'll go with the ACA for today, if you'll indulge me, but that's a good one, I'm going to remember that. So returning to this topic, is it correct to say that BMS is the entity that administers the Medicaid program in West Virginia?

A. Yes, we are the single state authorized to, single state agency authorized to administer the program.

Q. And is that authorization, does that originate in the state code of West Virginia, to your knowledge?

A. I believe it's in the state code and it's also designated in our state Medicaid plan.

Q. Okay. Thank you. How would you describe what BMS does to administer the West Virginia Medicaid program?

A. Sure. So we base all of our policies and procedures within the confines of the federal regulation, the state code, state laws, and we ensure that the covered services are available to members and

that reimbursement is available to providers who provide those services to our members. We provide member education, provider education, we have a number of documents on our Website to guide those policies and procedures, and we contract with a number of systems and vendors that help us operationalize those policies.

Q. That was a nice succinct job for what I understand to be a very large undertaking. So it's fair to say then that BMS oversees all matters pertaining to Medicaid recipients' access to West Virginia Medicaid services?

A. Yes.

Q. Okay. Does BMS establish a process for individuals to apply for West Virginia Medicaid eligibility?

A. We do in partnership with a sister Bureau who actually does the application processing.

Q. Oh, I think you mentioned that earlier. What is the name of that Bureau?

A. The original name was Bureau For Children & Families, I believe their current name is Bureau for Family Assistance.

Q. Okay. And that is not housed within BMS?

A. No, it is under the umbrella of DHHR, it is separate and distinct from BMS.

Q. Okay. So in conjunction with that sister Bureau, BMS reviews applications for West Virginia Medicaid coverage and either grants or denies them, is that accurate?

A. In conjunction with the sister Bureau, yes.

Q. Okay. And does BMS maintain a list of West Virginia Medicaid recipients to track enrollment numbers in the program?

A. The eligibility system provides those reports and we have a number of reports that are available on our Website to track enrollment, yes.

Q. Okay. Does BMS disseminate plan benefit and enrollment information to West Virginia Medicaid recipients?

A. We have a guide, it's called "Your Guide to Medicaid" that's available on our Website. Again, with there being a fee for service population and a managed care population, that guide is very general for both. And then the managed care organizations are responsible for disseminating information to their members.

Q. So who disseminates that information to West Virginia Medicaid recipients who are fee for service rather than MCO, rather than managed care members?

A. The Bureau does.

Q. Okay.

A. Through that guide to Medicaid, yes.
Q. So it has separate information available for the fee for service recipients?
A. It does, yes.
Q. Okay. And does BMS oversee all matters relating to providers who accept West Virginia Medicaid recipients as patients? Or I should say -- well, let me see what you say to that question and then I can rephrase it if I need to.
A. Within our purview. So we would oversee everything regarding our rules and regulations and our conditions for reimbursement, yes.
Q. Okay. Right. So you said BMS does cover establishing provider reimbursement rates?
A. Yes.
Q. Okay. Does BMS oversee all of the fiduciary responsibilities related to the West Virginia Medicaid program?
A. Yes. In conjunction with DHHR, like I said earlier, there's a separate finance division under DHHR that assists with that as well. But yes, under that umbrella agency and within BMS we are responsible for that.
Q. Okay. How much of the state, how much of the budgetary responsibilities for the administration of

West Virginia Medicaid falls in BMS's bucket of work?

A. I can only ballpark it.

Q. That's completely fine.

A. It would be at least 75 to 80 percent I would assume. I'm not day-to-day in the financial part of that, that's not under my division, but it is the bulk of the work.

Q. Okay. So the bulk of the work would fall to BMS for constructing budgets and sort of understanding how the various earmarked monies are distributed, is that fair to say?

A. Yes, I believe so.

Q. Okay. And is BMS the agency responsible for managing the amount of federal dollars, so that would be monies coming from CMS to the various programs and constituents within West Virginia Medicaid?

A. Yes. We are responsible for claiming of the federal dollars that comes into the Bureau, yes.

Q. Okay. And does BMS oversee benefits for providers and enrollees that are both included and excluded?

A. Let me make sure I understand. So we oversee all covered services and we maintain noncovered, the services that are not covered are not reimbursed. Does that answer?

Q. I think so. But I guess what I mean is, there's no other agency making those determinations or maintaining that information, right, that is BMS's sole purview?

A. Yes, correct. And again, unless dictated by another entity to add a service or to recover something, those decisions are at our level.

Q. Okay. Perfect. And then we touched on this, but let me just understand or just ask more specifically, BMS also determines which benefits to enrollees are available under the MCO, that is the Mountain Health Trust, and which benefits are available under the fee for service coverage, right?

A. Correct, yes.

Q. Okay. So let's talk a little bit about BMS's efforts to ensure compliance with the Medicaid Act. What do you generally understand that the Medicaid Act requires of BMS in its administration of West Virginia Medicaid?

A. My understanding is the Act requires certain services to be covered, it requires certain individuals, meaning certain circumstances to be eligible for the program, and it may also dictate which type of providers are able to do certain services. Generally speaking, I think that's what it covers.

Q. Okay. Are you aware of any annual compliance obligations for BMS with regard to the Medicaid Act?

A. Again, our Medicaid state plan forms our basis for the program. There are, like I said, there are some annual rate changes, I'm not aware of an annual review of that whole plan though.

Q. Okay. Are you aware or has anyone communicated to you what might happen if BMS is found to not be in compliance with the Medicaid Act?

A. Sure. If there is something that's been brought to our attention usually CMS will either contact us for more information or there will be what they call our state health officer letter that is sent from CMS to the various state Medicaid agencies that will either clarify how something is to be done or will provide a change that needs to be made.

Q. So it's fair to say that CMS will give you all a heads-up before any adverse action is taken against the plan?

A. Correct, yes.

Q. Okay. And can you think of a time that's happened in your tenure where you've gotten a notice from CMS that an adjustment needs to be made?

A. Sure. As I said earlier, we have the 1115 demonstration waiver, and so we added some medication

assisted treatment coverage of that and it was an optional service and it was authorized through that waiver. Within the last, I believe the last year or so CMS made that a mandatory service. So they sent out a state health officer letter to all the states and each state had to review their state plan coverage of that service and they dictated what information needed to be included, how the service was to be covered, and then we had to submit a state plan amendment to come into compliance with that requirement.

Q. All right. And then in your tenure have things ever moved beyond the state health officer letter posture? So I guess what I mean by that is, have you ever gotten, has BMS ever received a state health officer letter that they have ignored or not complied with, in your tenure?

A. Not intentionally that I'm aware of.

Q. Okay.

A. There may be things that we've missed, but again, I'm not aware of that.

Q. Sure. Are you aware of the comparability requirement within the Medicaid Act?

A. Are you referring to like parity?

Q. It's a related provision, yeah. Let me rephrase, sorry, let me rephrase. What do you

understand to be a comparability requirement of the Medicaid Act as it relates to BMS's administration of West Virginia Medicaid?

A. I'm afraid I might need a little more context, comparability to?

Q. So I'm referring to a provision within the Medicaid Act that's referred to as the comparability requirement, and my question is just do you have an understanding of that requirement, and if so, what is it?

A. I apologize, not off the top of my head, I don't recall what that states.

Q. Nothing to apologize for. And then how about are you aware of the availability requirement within the Medicaid Act, and if so, what is your awareness or understanding of that requirement?

A. Again, without reviewing the document, I'm sorry, I can't speak to that.

Q. All right. No problem. To your knowledge has BMS ever been audited for its compliance with either of those provisions?

A. Generally speaking, there have been times when we have been asked to confirm that we have a certain type of policy or coverage, I believe that would fall under the, loosely under an audit. I think that, I'm

not aware of an official audit that I've been involved in.

Q. Okay. And then moving over to the PPACA, see, I got it, okay, moving over to the Patient Protection and Affordable Care Act, can you just tell me generally what you understand to be BMS's obligations under that act as it relates to the administration of West Virginia Medicaid?

A. Sure. So our largest portion of that was the Medicaid expansion, that was a huge undertaking that expanded Medicaid coverage to previously uncovered or noncovered childless adults of certain ages. And with that states had to come up with an alternative benefit plan for that coverage group. Ours very closely resembles our what might be referred to as regular or nonexpansion benefit group. There were a few differences in, you know, service limits on a chiropractic benefit, but the Act dictated coverage of I believe it was eight or nine essential health benefits that had to be in that alternative benefit plan.

Q. I don't suppose you recall what those eight or nine essential benefits are? If not, I'm sorry, I know it probably sounds like you're back in school, but any of them that you recall would be fine.

A. Yeah, in our state plan it specifically called

out each one of them, that there are what, by name what you'd consider essential health benefits. So coverage to medical services, coverage, I believe, like I said, there's chiropractic services, there's, you know, any number of basic health services.

Q. Okay. So thinking about what the Act requires of BMS, are there things that the Bureau does on an annual basis to ensure compliance with its understanding of its obligations under the Act?

A. So I wouldn't say that there's a specific activity on an annual basis that is geared towards this, but we have oversight by, you know, CMS and by any number of agencies that are, that have a vested interest in the administration of the plan. So anything that is, obviously you mentioned earlier an audit, anything that is brought to our attention as being out of compliance we would take action to correct.

Q. Have you, again, referring to BMS, to your knowledge has BMS received any communications from the Federal Department of Health and Human Services about its administration of West Virginia Medicaid?

A. I can't think of anything specifically.

Q. Okay. Are you aware of Section 1557 of the Affordable Care Act?

A. Without seeing it, I don't know what that

section is.

Q. Okay. So then is it, let me ask then, does anything jump out at you in your tenure in your current role as specific actions BMS has taken to comply with Section 1557 of the ACA?

A. Without seeing that section, I couldn't respond to that.

Q. Okay. All right. Let me pause here briefly.

(Discussion held off the record.)

(Lunch break taken from 10:59 a.m. to 11:35 a.m.)

AFTERNOON SESSION

BY MR. CHARLES:

Q. So when we left off speaking before the lunch break we were talking about topic No. 5 and we had just started discussing what you understand to be BMS's obligations and efforts to comply with the Patient Protection and Affordable Care Act. So I'm going to introduce an exhibit here.

(Exhibit 9 marked for identification.)

Q. So you should see that populate in the marked exhibit folder. Just let me know when you see that, Ms. Young.

A. It's 0009?

Q. Yes, I apologize, it's marked PL0009, yes.

Thank you.

MR. CHARLES: So, Kelley, I'm showing the witness what has been marked as Plaintiff's Exhibit 0009.

Q. Just very quickly, Ms. Young, do you know if you've seen this before?

A. Yes, I have.

Q. Okay. Do you need to take a minute to review it?

A. If you would speak to any specifics I would.

Q. Sure. I'll call your attention to a couple of sections, but if you say you recall seeing it, then we'll leave it there and I can just direct you to the sections. So can you just tell me the title of this document, please?

A. Sure. Section 1557 of the Affordable Care Act.

MR. CHARLES: And so the witness is reviewing Plaintiff's Exhibit 0009, which is a slide deck of, "State operations technical assistance call."

Q. And, Ms. Young, can you just read me the date there at the bottom of the first slide.

A. July 19, 2016.

Q. Great. Was this the point in time where you were still an interim director or were you formally the director or deputy director at this point in time?

A. I believe this was still when I was in an interim position.

Q. Okay. But just for the benefit of the record, even as an interim deputy director -- well, sorry, let me back up. As an interim deputy director were your responsibilities virtually the same as they are now in your formal role?

A. They are, yes.

Q. Okay. Thank you. Okay. So do you recall, Ms. Young, if you were on the state operations technical assistance call?

A. I do not recall this one specifically. There were a series of, again, we abbreviated it to SOTA calls, we like to do that, but I don't specifically recall this one.

Q. Okay. But is it fair to say that you do attend SOTA calls regularly in your duties?

A. I did. They've stopped this particular series, but yes, it's something I would do when available or I would have specific staff attend for me.

Q. And what was the purpose or benefit behind having a member of your staff or you yourself attend these briefings?

A. So this was one of the ways that the federal government communicates the specific requirements to us

in a better method than maybe the federal regulations have things stated in, you know, generally how to operationalize things or call attention to specific parts of the Act.

Q. Okay. So let's turn quickly to, it doesn't have to be quickly, but if you would please scroll down, and the page numbers are located in the lower right-hand corner, so let's just start at Page No. 2.

A. Okay.

Q. And that first bullet point, can you just read that to me, please.

A. Sure. "Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in health programs and activities that receive federal funds."

Q. Thank you. And now that, I mean, does this description of Section 1557, does this sufficiently recall to your mind what that section of the ACA is about?

A. It does. Earlier out of context I didn't recognize it by the name, but the summary does, yes.

Q. Okay. So would you then say having, you know, having this material in front of you now, can you recall other times in your tenure as deputy commissioner that you may have come across this Section 1557 referenced in

government?

A. Yes. I would have expected it to be in that state health officer format, the letter.

Q. Okay.

A. Maybe as an attachment, but with some more guiding information for the state agencies.

Q. I see. Okay. And is this the kind of information that BMS would consider in its efforts to ensure compliance with PPACA and other federal laws regarding healthcare?

A. Yes. We would consult with CMS for guidance on how to ensure that we are in compliance with this, but yes.

Q. Okay, great. All right. Give me just a moment here. So, Ms. Young, if you would in the marked exhibit folder please return to that deposition notice again, it's two exhibits previous, so it's 08 is the number. Just let me know when you've toggled to that.

A. Okay.

Q. So then on Page 3 of that notice you'll see topic 8 about a third from the bottom of the page. Do you see topic 8 there?

A. I do, yes.

Q. Okay. And go ahead, would you please, and read topic 8.

A. "Healthcare coverage and/or denials through Medicaid for transgender West Virginians generally and Christopher Fain and Shauntae Anderson specifically."

Q. Okay. Thank you. So you have been designated to testify about topic 8, which you just read into the record, but only as to medical claims and not pharmaceutical claims, is that your understanding for today's testimony?

A. Yes.

Q. Okay. And are you prepared to testify about this topic today?

A. Yes.

Q. Okay. And with respect to this topic specifically, how did you prepare to testify about this topic today?

A. I reviewed our policies and when I spoke with Jennifer Myers we spoke to what information was available in the member file in our claims processing system.

Q. Great. Did that discussion with Jennifer Myers happen in the same discussion that we talked about earlier today in your preparation generally for your testimony?

A. Yes.

Q. Okay. Thank you. Because counsel has not

designated you as the witness to talk about pharmaceutical care, my questions won't be oriented to that, so that's why I'm reformulating my question here. So does BMS provide coverage for gender confirming medical care for transgender people who are West Virginia Medicaid participants?

A. We do not cover gender confirming surgery. We do cover counseling for any reason.

Q. Okay. Do you know if BMS provides coverage for other medical care for transgender West Virginia Medicaid recipients which is not surgery or counseling?

A. Are you asking about general services?

Q. Yeah.

A. Yeah, our system does not designate whether an individual is transgender, so all services that are available to all members are available to all members. There's no designation as a specific benefit or package for transgender versus non-transgender, it's not in our system or policies.

Q. I see. Okay. So let me clarify a little bit. To your knowledge do non-transgender members access coverage through West Virginia Medicaid for gender affirming care?

MS. BANDY: I'm just going to object to the extent that that's, I mean, gender confirming care could

Technologies.

Q. Okay. And does BMS have, does BMS have access to Gainwell and Kepro? I guess what I mean is, the way you described the MCO's is that they have their own similar process, but it's separate and run through their systems. Is it accurate then to say that fee for service is under BMS and BMS does sort of provide oversight and management and can access both Gainwell and Kepro as necessary?

A. Yes, that's correct.

Q. Okay. All right. As far as you're aware, are there other vendors that BMS works with to understand and utilize accurate criteria in evaluating costs for reimbursement?

A. I believe that there are other vendors on the pharmacy side.

Q. Okay.

A. And they may have another person to speak to that. On the medical side we do engage consultants from time to time, we have a project management contract, so they might do research for us and help us with researching various topics. But offhand, I can't think of another contracted entity that helps with the medical evaluation.

Q. Sure. Let me just ask you about the one I'm

aware of. Are you familiar with InterQual?

A. Yes.

Q. And is that, what is InterQual, as you understand it?

A. As I understand at a very high level, InterQual criteria is a nationally accredited criteria for determining medical necessity for procedures and that is the criteria that our contractor Kepro uses.

Q. Oh, okay. And do you know if the MCO's use InterQual as well for those criteria for assessing medical necessity?

A. I don't know which specific criteria they use. I would believe that their contract states that they must use a nationally accredited criteria.

Q. Okay. What's the importance of using a nationally accredited criteria for those indicia?

A. I think it speaks to the validity and the quality of the product that it is nationally accredited. It's not a homegrown made-up process, it's something that is readily available and has been peer reviewed and all the things that might go into their accreditation.

Q. Thank you. Do you know how long, again, estimate, ballpark is fine, do you have a sense of how long Kepro has been using InterQual? And let's focus, I'm sorry, just on your tenure, I don't expect you to

answer beyond that.

A. Sure. I'm not aware of them using another criteria.

Q. Okay.

A. I've only ever heard of the InterQual criteria.

Q. Okay. Let me, I'm just going to introduce another exhibit here, if you'll give me just one moment.

(Exhibit 12 marked for identification.)

Q. So, Ms. Young, there should be an exhibit now in the marked exhibits folder labeled PL0012.

A. I can see it.

Q. Okay. I'm guessing not, but have you seen this document before?

A. No, I don't believe so.

Q. Okay. If you would please just take a, it's only, it's basically three pages, if you'll take just a quick minute and just review it to your satisfaction and then I've just got a couple of questions.

MS. CYRUS: Are there Bates numbers on that?

MR. CHARLES: No. I think it was in the production that came -- it is not Bates stamped, no.

MS. CYRUS: Okay. Thank you.

A. Okay.

Q. Okay. So what is this document?

A. So it appears that Jennifer Myers had reached out to Kepro and asked them criteria for a number of services and they have provided the, it looks like, yeah, at the top it says this is the InterQual criteria, or it's got the trademark.

Q. Right. Okay. Have you seen, do you see in the blue text there there's six different SmartSheets listed, do you know what a SmartSheet is?

A. I do not.

Q. Okay. So then scrolling down here, on the first page there's a sentence that begins, "This criteria subset," do you see that sentence? It's a quarter of the way up from the bottom of the page.

A. I do, yes.

Q. Okay. So I'm just going to read this aloud, if you'll follow along, "This criteria subset covers primary genital and chest procedures for patients undergoing gender affirmation surgery, or GAS, including single and multistage procedures. The criteria set does not cover revisional procedures for GAS." Did I read that correctly, Ms. Young?

A. Yes.

Q. Okay. Thank you. On the second page there, the fourth paragraph on Page 2 begins, "Delaying treatment for." Let me know when you found that paragraph.

A. Okay.

Q. So I'll read it aloud again, "Delaying treatment for those with gender dysphoria is not a reasonable treatment option. This can lead to negative consequences such as delay or arrest in emotional, social or intellectual development. Isolating one's self from family and friends, being excluded from society, becoming a victim of bullying and self-harm all may be seen when there's an impediment or interruption in care. Some individuals, notably adolescents, may develop psychiatric issues including anxiety, depression and suicidal ideation." And sorry, let me pause here. Did I read that correctly?

A. Yes.

Q. Okay. And then the subsequent paragraph beginning with, "Guidelines agree." It says, "Guidelines agree that gender affirmation surgical intervention is appropriate for individuals 18 years of age or older as the procedures are irreversible. However, behavioral health counseling and hormone therapy may be used to treat individuals who have been diagnosed with gender dysphoria at an earlier age. The sooner the diagnosis is made and treatment options are discussed, the more successful the individual is when transitioning." Did I read that paragraph correctly as

well?

A. Yes.

Q. Okay. And then beginning with the paragraph beginning with, "InterQual," and it has a little trademark mark. It says, "InterQual content contains," do you do see that paragraph?

A. Yes.

Q. Okay. "InterQual content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level a variety of factors including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender specific anatomy. With these considerations in mind, all references to gender and InterQual have been reviewed and modified where appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals when appropriate." Did I read that paragraph correctly?

A. Yes.

Q. Okay. And then finally, I'm just going to read

a couple parts of this last paragraph, so bear with me. "InterQual procedures criteria," do you see that there?

A. Yes.

Q. Okay. "InterQual procedures criteria are derived from the systematic continuous review and critical appraisal of the most current evidence based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted." Did I read those two sentences accurately?

A. Yes.

Q. Okay. Thank you. I'm going to introduce a couple more exhibits here related to InterQual, if you'd just give me one moment. Okay. So looking at this information from InterQual and in the context of what you shared about what Kepro contracts with InterQual for, did BMS consider the recommendations included in InterQual's medical necessity criteria when determining that coverage for transsexual surgery or for sex transformation were not included in West Virginia Medicaid?

A. I can't speak to the practice when the decision was put in policy in 2004, but I can say that since then we would have not, we would have not reviewed the

criteria for noncovered services.

Q. Okay.

A. So I would imagine InterQual criteria includes every single possible procedure that could be performed and we would only have contracted with Kepro to review the criteria for covered services.

Q. Okay. So in terms of the scope of this topic as it refers to denials of coverage, I know we've talked a number of times about what coverage isn't provided under the West Virginia Medicaid plan. Do you know or are you aware of any instances where BMS has ever communicated with a managed care organization regarding denials for surgical procedures for the treatment of gender dysphoria when it's otherwise medically indicated? Let me rephrase, I'm sorry, I made that a little complicated.

So are you aware of a time where an MCO or, I mean, obviously a person working for the managed care organization has reached out to BMS to say, you know, we have this person, this procedure is medically indicated for them, we understand this limitation in the coverage, what should we do, are you aware of any instances of that kind of request coming from an MCO?

A. Not off the top of my head. I mean, we do receive a number of inquiries, you know, to confirm what

the policy is, I don't recall a specific conversation though.

Q. Okay. And excluding hormone therapy, are you aware of BMS providing coverage for gender confirming medical care for Mr. Fain? He's one of the plaintiffs in this case.

A. I've seen the claims that have been collected and provided as part of our evidence and that's what I'm aware of.

Q. And in what you've seen have there been, have there been payment or reimbursement I guess is what I mean for, you know, some of his claims related to gender confirming medical care?

A. Not anything related to surgery.

Q. Okay.

A. Nothing related to surgery that I'm aware of.

Q. Okay. Anything related to counseling that you're aware of?

A. I'd have to see the list of claims, but it is a covered service, so if it was requested, then it would be covered.

Q. Okay. And then are you aware of any denials of medical claims for reimbursement for Mr. Fain for gender confirming medical care?

A. Not for surgery, I'm not aware of any denials.

Q. Okay. I'm guessing the answer is the same, it would be helpful to see the list, but in the knowledge you have presently, has BMS provided coverage for Mr. Fain's preventative medical care?

A. Again, to the extent that it's a covered service.

Q. Okay. That's fine. Thank you. That you are aware of, has BMS provided coverage for any gender confirming medical care for Ms. Anderson, she's the other purported class representative and named plaintiff in this case, we haven't talked about her yet, but are you aware of any coverage for gender affirming medical care for her?

A. There hasn't been any surgery covered, if this is an ongoing service. If there are counseling claims for that reason it would have been covered.

Q. Would BMS cover a medical visit associated with gender confirming care? So, for example, if a transgender West Virginia Medicaid recipient went to see their endocrinologist for blood work, lab work related to, you know, regular maintenance of hormonal levels, would such a medical visit be included in coverage in West Virginia Medicaid?

A. Yes, I believe it would.

Q. Okay. And to your knowledge has BMS as the

administrator of West Virginia Medicaid denied any medical claims for Ms. Anderson related to gender confirming care?

A. Not that I'm aware of.

MR. CHARLES: Kelley, can we go off the record.

(A break was taken at 12:53 p.m.)

BY MR. CHARLES:

Q. Ms. Young, if you would, let's return again to marked Exhibit 8. That's again the second amended notice of the 30(b)(6) deposition. And let me know when you're there.

A. Okay.

Q. And we'll be on Page 3, at the bottom of Page 3, No. 10. Just let me know when you see that.

A. Okay.

Q. All right. And if you would please just read No. 10, and there's just one sentence of No. 10 that goes onto the next page.

A. "Your policies, practices and procedures related to the exclusion including, but not limited to, how the exclusion is developed, approved and maintained."

Q. Thank you. And so do you understand that you've been designated to testify as to this topic today?

A. Yes.

Q. And are you prepared to do so?
A. Yes.
Q. Okay. And again, with respect to this topic specifically, can you please tell me what you did to prepare for today?
A. Sure. So I considered what might all fall into the policies, practices and procedures and reviewed the policies.
Q. So in those preparations can you tell me what you, what did you determine to be policies related to the exclusion?
A. The policy that we reviewed in Chapter 100 simply states the exclusion.
Q. Okay. Thank you. And what about practices, what did you, based on your expertise and knowledge what qualifies as practices related to the exclusion?
A. Yeah. So in my conversations with Jennifer Myers we identified the diagnosis codes that would be related and some of the procedure codes that could be related to that as far as practices and procedures because that would be the basis for it.
Q. And I don't think I've asked you yet, although you've mentioned it, so let's, what are the, what codes specifically did you review with Ms. Myers?
A. The diagnosis codes in the F64 series. And I

Q. Okay. Let's go back to the other half of this topic. So the other part of this topic says, let me just read the topic again to you, "Your policies, practices and procedures related to the exclusion including, but not limited to, how the exclusion is developed, approved and maintained." I asked you earlier what, if anything, you had done to prepare for this topic. Did you do anything specifically to prepare to testify about how the exclusion is developed, approved or maintained?

A. Like I said, I looked at the policy based on the date of the policy, I wasn't privy to or able to find anything regarding why it was created, I wasn't able to find anything about when that was added or what the basis of it was.

Q. Okay. Do you know how the exclusion itself was developed within the Medicaid manual that we looked at at the beginning of the day?

A. Not other than how the manuals are maintained probably the way that they are. I wasn't able to find any notes or drafts or recorded discussions regarding adding, you know, when that language was added and I couldn't find any earlier versions of the policy.

Q. Okay. So the only policy that you're aware of is as it exists in the Medicaid manual that we reviewed?

A. Yes.
Q. Okay. And I remember we looked at the 2012 archived version, but you said there is an updated version on the Website that is from 2013 you said?
A. I believe the Chapter 519 has a more recent revision that's included in the list of chapters in the current policy manual.
Q. Okay.
A. The Chapter 100 that we reviewed is the exact same version that's available today.
Q. You mean on the Website?
A. Yes.
Q. You said the archive was from 5/19, okay. So you said that's the earliest iteration you can find of that language in West Virginia Medicaid BMS promulgated documentation?
A. Yes, I did. As to what I have access to, we have a paper copy of all the manuals up to a certain date, and so I pulled the book for that Chapter 100 and all that's in that book is that exact copy that's online.
Q. Okay.
A. For whatever reason any earlier versions were not kept in that book, if there was an earlier version.
Q. Okay. But you said to your knowledge the

exclusion did exist before that version, you just weren't able to find the documentation that showed that?

A. If there was an earlier version, I can't tell from the information that's listed in the change log for 100 that says what was specifically added in that change.

Q. Okay.

A. It could have been a previous version. There's nothing that indicates the level of specificity as to what was added in those changes.

Q. I see. Okay. Thank you. So generally speaking, do you know when the exclusion was originally developed?

A. I do not. That policy is the earliest version that I can find where it appears.

Q. Okay. And since the Chapter 519 and Chapter 100, does BMS do anything actively to maintain the exclusion or is it just that year-to-year it doesn't change and so that's all that's done as maintenance?

A. Yeah, I think year-to-year it doesn't change. Until now it has not been challenged legally, so it has been maintained.

Q. Okay. And so were you able to find any information about how it was developed, if it was developed with anyone outside of BMS?

A. No, I couldn't find anything.

Q. Okay. With regard to those manuals in particular, does BMS have to do anything year-over-year to reauthorize them, do you know what I mean, like is it required that sort of Cynthia Beane or somebody similarly situated sort of rubber stamps those manuals each year?

A. So I'll say ideally each manual would be reviewed by the specific program manager for that area to see if anything has changed. I'll admit that, you know, there's a lot going on all the time, so that doesn't always happen. But any time that something, we are aware that something has changed we will go to see what we have written about that policy or procedure and review it to see if it needs to be changed.

We have, as I mentioned, those waivers, they're reauthorized on a regular basis. And so there's changes to the programs that have to be, that are authorized that have to be rewritten into those policies. Our goal is to review them on a regular basis, but unfortunately it doesn't always happen.

Q. Okay. So is it safe to say that unless there's a, unless there's an affirmative change, members or other parties reviewing those materials should just assume they are updated because -- well, sorry, let me

end my question there. Like if something needs to be revised it will be, but absent that happening, that is the most accurate documentation?

A. Yes. The effective date is the date that we made the policies on that page effective, to the extent that we do have the disclaimer that it's not all encompassing of everything.

Q. Okay. Let me introduce another document here. Let's actually return to Exhibit 8, the deposition notice again.

A. Okay.

Q. So then looking at the notice on Page 4 at topic 13. Just let me know when you're there.

A. Okay.

Q. And then if you would go ahead please and just read topic 13.

A. "Any research, consideration and/or analysis by or on behalf of you regarding the legality of the exclusion."

Q. Great. Thank you. And you've been designated to testify about this topic. Are you prepared to do so?

A. Yes.

Q. And once again, can you tell me what, if anything, you specifically did to testify about this topic?

A. Again, I considered everything that we have written on the topic and I was aware that other individuals on the leadership team were aware of this and, you know, in the absence of anyone saying that this is illegal or against regulations, I believe it to be legal.

Q. Okay. So were you able to find any research that was done by BMS about the legality of the exclusion of gender confirming care in West Virginia Medicaid?

A. No, nothing specific to this.

Q. So are you aware of any research that was undertaken to support the particular coverage decision?

A. No, it was honestly more the absence of any guidance or notification from CMS that I found to speak to the legality of it.

Q. Okay. Let me back up just a little bit. From the previous topic that we were discussing, you were not able to find, don't know of any reasons why the exclusion was developed?

A. Correct.

Q. Okay. And you also were not able to find and are not aware of any, what was considered I guess in making the decision to include that exclusion in the Medicaid manuals we were discussing?

A. Correct.

about some of these requests?

A. Yes, I'm aware.

Q. Okay. So let's start with you have been, as a part of addressing topic 18, one of the responses from BMS that you've been designated to testify about is interrogatory No. 2. And I'm going to introduce that so that you know what I'm talking about, so give me just a moment.

(Exhibit 18 marked for identification.)

Q. So in your marked exhibits folder you should be seeing what has been marked as Plaintiff's Exhibit 0018.

A. Yes.

Q. Okay. And I'll read that title, "Defendants' response to plaintiffs' first set of interrogatories to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services." Did I read that correctly?

A. Yes.

Q. And then if you would please scroll down to Page 2 and No. 2. So this is one of the interrogatories you've been designated to testify about today. So would you please just read No. 2 in its entirety, it's just there in the middle of the page, both the request and the response, please.

A. "Describe in detail the factual basis for each governmental interest that defendants contend supports the exclusion. Response: These defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare/Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations."

Q. All right. Thank you. And before I introduce this, had you seen this document before?

A. Yes.

Q. Okay, great. And did you do anything specifically to prepare to testify about interrogatory No. 2 today?

A. Not more than read it.

Q. Okay. But you are prepared to provide testimony about this interrogatory?

A. Yes.

Q. Okay, great. So based on this response, what do you understand to be the governmental interest that BMS maintains supports the exclusion?

A. The Centers for Medicare and Medicaid Services.

Q. Okay. And what are the factual basis for that assertion?

A. As I've discussed earlier, the program is mandated and is overseen by the CMS in that they

maintain the Code of Federal Regulations and approve our state plan and state plan amendments.

Q. Okay. Does CMS mandate the exclusion of gender affirming care, as far as you know?

A. They list mandatory services and optional services. To my knowledge it is not specifically addressed.

Q. Okay. But to your knowledge it's not listed as a service that must be excluded?

A. Correct, it is not listed as a, what you said, I'm sorry.

Q. That's okay. A must be excluded or a mandatory exclusion I guess would be an easier way to say that?

A. Correct, yes.

Q. So beyond that is there, is there another factual basis or any other factual basis in response to that government interest?

A. I think the fact that CMS does not mandate that we cover the service is our basis for excluding it as well.

Q. Okay. Sorry, I just want to make sure, that's it for the factual basis for that interest?

A. I believe so, yes.

Q. Okay. And then for the second governmental interest that BMS contends supports maintaining the

exclusion, can you just tell me what that is?

A. You're referring to the budgetary and cost considerations?

Q. Yeah, that's the other governmental interest BMS identifies?

A. It appears so, yes.

Q. Okay. And so what then is the factual basis for that governmental interest?

A. So we receive a match on our state funds, so the program is only allocated so many funds from different sources by the legislature, so we only have so many state dollars that can then be matched with the federal dollars. So obviously there is a limit to what we can cover, we have to be able to pay for it, so that would be the, the constraints and considerations.

Q. Okay. Can you point to facts about the BMS budget that require maintenance of the exclusions specifically, other than just what you stated generally about the general obligations?

A. I'm sorry, can you ask it one more time.

Q. Sure. So are there any facts, are there any more specific facts than just sort of the general overview you provided about the budget, about BMS's budget that require the maintenance of the exclusion?

A. Generally speaking, our current membership is

over 600,000 individuals, and so as I spoke, the limited budget that we have, we have to ensure that it will cover the benefits that we have promised and outlined in our policies that we do cover. So the addition of anything extra or anything on top of that is what limits us, you know, we have to be able to do what we said we were going to do.

Q. Sure. And has BMS done research about the cost of providing gender affirming service in West Virginia Medicaid?

A. Not that I'm aware of.

Q. Sorry, can we go back. You said there was a match that happened. Can you just, as you've been doing such a generous job of today, explain generally to me what that refers to?

A. Sure. So each state is allocated a federal match based on a bunch of factors, but basically the economics of the state. So states that are the poorer states get a greater match. I believe the bottom is 50/50, so prosperous states get a 50 percent match on the state dollars. So our budget, the amount of claims that we have to reimburse or capitation that we have to pay on a monthly basis we are required, generally speaking let's say our match is 75 percent, so we would be required to pay 25 percent of that and we can draw

down on the 75 percent to match that amount. Does that make sense?

Q. I think so. So you can spend, let's say you have $25 from the state of West Virginia and 75 from the federal government, is that sort of it, like you can use 25 West Virginia dollars and 75 federal dollars to pay for that $100 Medicaid bill?

A. Right, if something cost $100, our obligation would be $25 of that.

Q. Okay. So it takes into consideration the, you know, sort of not being an economist here, it takes into consideration the relative wealth or GDP of a state and what dollars are able to be allocated by that state's Medicaid program in its match determination?

A. Basically speaking, yes.

Q. Okay. All right. I got the basics. So we talked about the budget and meeting the obligations of the 600,000 West Virginia Medicaid members and the obligation to be able to pay for what you said of those claims you will pay for. Are there any additional facts related to costs that you know of that require the agency to maintain the exclusion?

A. Not that I can think of.

Q. Okay. So then are there any other government interests that BMS contends support its maintenance of

the exclusion?

A. None that are listed in the response. Is that what you're asking?

Q. Yeah. And I think, yes, in the response or are you aware of any other governmental interest?

A. None that I'm aware of.

Q. All right. So let's return to that exhibit we were just on, Exhibit 18, and look at No. 3 there on Page 2.

A. Okay.

Q. All right. And I'll go ahead and read that, "Identify and describe in detail every instance in which a health plan offered through West Virginia's Medicaid program provides partial or full coverage for gender confirming care of any kind including, but not limited to, counseling and/or therapy, hormone therapy or surgery. Include in your answer the coverage criteria for such care and the date such coverage began." First of all, did I read that correctly?

A. Yes.

Q. Okay. And are you aware that BMS has designated you as the organizational representative to testify about their response to this request?

A. Yes.

Q. And you are designated to respond to this

request as to medical claims including counseling and/or therapy and surgery, but there's a different witness designated for pharmaceutical care, is that your understanding?

A. Yes.

Q. Okay. So then I'll just read a little bit of the response here because much of it is relevant to that other witness' testimony. So, "Response: Objection. This question seeking every instance is overly broad and burdensome. Without waiving the objection with respect to any gender confirming care that it has requested through the managed care organizations, these defendants are not in possession of this information. This question would be best directed to the individual MCO's regarding any care requested through them. Upon information and belief, counseling is a covered service. These defendants would not necessarily know the reason for counseling and whether it was related to gender confirming care or some other reason." Did I read that correctly?

A. Yes.

Q. All right. So in administering West Virginia Medicaid, does BMS cover medically necessary healthcare?

A. Yes, within the constraints of our policies.

Q. So is it correct to say then that if West

Virginia Medicaid, I'm sorry, if in its administration of West Virginia Medicaid BMS provides coverage for healthcare, then that healthcare has been deemed medically necessary?

A. If I understand correctly, our criteria for covering, our criteria for approving request for covered services is based on whether or not it meets medical necessity.

Q. Yeah, I think I asked that question in a double negative, so let me try to ask it again. BMS would not reimburse for a service that while covered has not been determined to be medically necessary?

A. Correct, that did not meet their requirements.

Q. Yes. So I guess in a plainer way of what I'm asking is, if a given procedure could be determined to be included in the coverage, but if the patient or the provider, if it has not been assessed to be medically necessary, then that doesn't fall within what BMS would cover?

A. Correct.

Q. Okay. Sorry, I was sure there was some easier way to ask that, but I couldn't figure it out, so thank you for your patience. Okay. So as we just reviewed in the response to that interrogatory request, counseling is a covered service. So if that therapy was undertaken

for the treatment of gender dysphoria, that claim would not be denied by BMS solely on the basis that it was for the treatment of gender confirming care?

A. Correct.

Q. Okay. So for those, for that particular coding, the gender dysphoria coding of those visits is accepted, not rejected by BMS West Virginia Medicaid?

A. Correct.

Q. Okay. And as far as you know, does BMS cover office visits related to gender confirming care?

A. Can you be specific as to the type of office.

Q. Sure. So, for example, I know this is tricky, but I'm asking about the office visits to an endocrinologist, not for the purpose of prescribing hormones, but for the purpose of monitoring, blood work, kidney, kidney and liver testing, thyroid. Would those kind of medical visits, again, I'm trying not to get into what the other witness is going to talk about, would those visits be covered under the existing policy?

A. Yes.

Q. Okay. And as far as you're aware, Ms. Young, has BMS in its administration of West Virginia Medicaid provided any partial or total coverage for any surgical procedure for the treatment of gender dysphoria?

A. Not that I'm aware of.

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

I hereby certify that I reported the Zoom deposition of Sarah Young on the 11th day of March 2022, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was reserved.

WITNESS MY HAND AND SEAL THIS 11th day of March 2022.

Kelley E. Zilles, RPR
Notary Public, Washington County, Minnesota
My commission expires 1-31-2025

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096099
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/11/2022
WITNESS' NAME: Sarah Young

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

04-07-2022 Sarah K. Young
Date Sarah Young

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 7th day of April, 2022.

Kimberly M. O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St. Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5096099

PAGE/LINE(S) / CHANGE /REASON

pg 36/line 2 / who "was" changed to who "is" / correction, staff is still in this role

pg 38/line 38 / attended a different college for the fall semester of '92 then tranferred to WVU for spring semester beginning January '93 / clarification

pg 56/line 20 / change "OARM" to "OAMR" / correction

pg 102/lines 2-4 / clarify that answer is specific to gender confirming medical procedures, like surgery. This does not apply to counseling, as there is not an edit on the diagnosis code. / clarification

pg 105/lines 9-10 / clarify that the report did not ask for claims for gender confirming care. It only asked for the "number of health plan participants who have submitted one or more claims with a diagnosis code for gender dysphoria or gender incongruence." The report is based on diagnosis codes and not procedure codes. / clarification

pg 108/line 12 / change "incoming assets" to "income or assets" / correction

pg 130/line 13 / change we had covered it "with our" to we had covered it "without" / correction

pg 158/line 6 / change "thousands" to "hundreds"

04-07-2022 Sarah K. Young

Date Sarah Young

SUBSCRIBED AND SWORN TO BEFORE ME THIS 7th

DAY OF April, 2022.

Kimberly M O'Brien

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Service
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

July 28, 2026

Commission Expiration Date

Exhibit
0001

CHAPTER 100– GENERAL INFORMATION

CHANGE LOG

Replace	Title	Change Date	Effective Date
Sections: 110, 121, 150, 151, 152, 153, 160, 161, 170, 180, 191	Various	12/02/04	01/01/05
Section 140	Manual Updates	12/02/04	01/01/05
Section 153	Other Contact Information	12/02/04	01/01/05
	Medicaid Managed Care	12/02/04	01/01/05
Section 161	General Non-Covered Services	12/02/04	01/01/05

CHAPTER 100– GENERAL INFORMATION

12/2/2004

Sections: 110, 121, 150, 151, 152, 153, 160, 161, 170, 180, 191

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 140

Introduction: The manual update process has undergone some changes. Also the contact phone numbers in this section have changed.

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Section 153

Introduction: Some of the contact phone numbers in this section have changed because of the change in contractors.

Directions: Replace the page containing this section.

Change: Replace old phone numbers with the new ones.

Introduction: Added wording related to PCCM Program.

Directions: Replace the page containing this section.

Change: Add PCCM Program.

Section 161

Introduction: Removed Gastric By-pass from the section since this surgery is now a covered service under certain conditions.

Directions: Replace the page containing this section.

Change: Delete gastric by-pass as a non-covered service.

CHAPTER 100—GENERAL INFORMATION

TABLE OF CONTENTS

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

CHAPTER 100–GENERAL INFORMATION

100 INTRODUCTION

This chapter provides a general overview of the Medicaid Program and organization of the provider manuals. It includes general information regarding the legal basis of Medicaid in West Virginia (WV), its relationship to other programs (for example, Children with Special Health Care Needs), provider telephone contact information, a general description of covered and non-covered services, its relationship to the Medicare Program, and basic information on reimbursement for out-of-state providers.

110 MEDICAID PROGRAM OVERVIEW

Congress established the Medicaid Program under Title XIX of the Social Security Act of 1965. Title XVIII of the Social Security Act of 1965 created Medicare. Title XIX created the Medicaid Program to provide access to health care for certain low-income individuals and families. Medicaid is funded and administered through a cooperative state-federal partnership. Nationally, the Centers for Medicare & Medicaid Services (CMS), operating within the U.S. Department of Health and Human Services (DHHS), provide federal financial assistance to the states, establishes minimal program requirements, and provides regulatory oversight. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design and administer their programs within federal guidelines. These guidelines are in the Code of Federal Regulations, Title 42, Sub-part C.

The WV Medicaid Program is administered pursuant to regulations promulgated under Title XIX of the Social Security Act, as amended. State administrative authority for the Medicaid Program is provided pursuant to Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the Medicaid Program in WV.

The mission of the WV Medicaid Program is to provide access to appropriate health care for Medicaid-eligible individuals. In its administration of the program, BMS strives to assure access to appropriate, medically necessary and quality health care services for all members while maintaining accountability for the use of resources.

BMS establishes eligibility standards for Medicaid providers, determines benefits, sets payment rates, and reimburses providers. BMS also coordinates with other entities in DHHR to develop and implement Medicaid-related programs and services. In particular, BMS contracts with the Office of Families and Children to determine eligibility for Medicaid. BMS monitors and tracks program information related to member eligibility, service utilization, program expenditures, fraud and abuse, and financial management.

BMS maintains the WV Medicaid State Plan and files amendments to the plan with the appropriate regulatory authorities. If BMS identifies the need for major change to the Medicaid State Plan, the Medical Services Fund Advisory Council, appointed by the Commissioner, reviews the change and makes appropriate recommendations to BMS prior to implementation.

120 PURPOSE OF THE MANUAL

WV Medicaid provider manuals contain detailed information about the WV Medicaid Program. The manuals document and communicate current policy requirements applicable to Medicaid-covered services as provided by specific provider types.

The following information is included:

- General and specific provider information
- Service delivery requirements
- Provider participation requirements
- Covered services, exclusions, and limitations
- Reimbursement and billing instructions.

All Medicaid providers, BMS employees and contractors, and other interested parties are encouraged to familiarize themselves with the content of applicable manuals by types of services.

121 ORGANIZATION OF THE MANUAL

The WV Medicaid provider manuals are organized consistently for all providers and services. The following is a listing of the organization and format of each manual:

- **Cover Page** – The cover page identifies the types of services included in the manual.
- **Table of Contents** – The table of contents follows the cover page. Chapter titles, chapter subtopics, and appendices are identified and labeled to facilitate information retrieval.
- **Chapter Titles** – There are a minimum of seven chapters in each manual. The right corner of the page header identifies whether the information contained in the chapter applies to all or specific providers.

The Chapter Titles are:

- Chapter 100 General Information
- Chapter 200 Definitions
- Chapter 300 Provider Participation Requirements
- Chapter 400 Member Eligibility
- Chapter 500s Covered Services, Limitations, and Exclusions
- Chapter 600 Reimbursement Methods
- Chapter 800 General Administration

130 OTHER RESOURCE INFORMATION

The manuals summarize the description and administration of the WV Medicaid Program. BMS makes every attempt to ensure that the information contained in the provider manuals is concise and reliable as of the date of issuance. Compliance with all applicable WV state laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations, is required. Specifically, you must consider the content in this manual, along with applicable federal and state laws and regulations, when determining actions or interpreting guidelines.

140 MANUAL UPDATES

BMS will distribute new, revised, or clarified information, as applicable to all or specific manuals, using the Medicaid Provider Manual Update process. The update notification from BMS will include information related to the manual change and identification of the actual section number(s) to replace or add to the manual by chapter, appendix, or attachment. Updates may be communicated by letter or posted on BMS' website (www.wvdhhr.org/bms).

Retaining, filing, and understanding the WV Medicaid Program Instructions and manual revisions are your responsibility. If any information is not clear or not understood, please call the Medicaid Provider Services at either of these numbers:

- (304) 348-3360
- (888) 483-0793

BMS maintains mailing lists of all providers and other interested parties who receive program instructions. To ensure that you receive all mailings or emails, it is essential that you notify BMS in writing of mail/email addresses or any type of health care or business organizational change. Refer to Chapter 300 for additional information on your responsibility for reporting changes.

150 WRITTEN OR PHONE INQUIRIES

Questions regarding the Medicaid Program including service, coverage, provider participation, member eligibility, prior authorizations, claims inquiries, or billing procedures may be addressed in writing or by telephone. Additional information is available on the DHHR website (www.wvdhhr.org/bms

151 VOICE RESPONSE SYSTEM

WV Medicaid's Voice Response System is an automated Provider Inquiry System. It is a quick and easy way to verify member eligibility and obtain Medicaid accounts-payable information. For the Voice Response System, call 1-888-483-0793.

Information on the Voice Response System is available 24 hours a day, 7 days a week. Your 10-digit Medicaid Provider number is required to access the system. Call and follow the voice prompts to:

- **Obtain recent accounts payable information**

Enter the 10-digit Medicaid provider number and select **Option 1**. The Voice Response System will provide cumulative payment information. This information can assist you in managing your receivables. It provides the amount and date of the reimbursement and the amount of the accounts payable (approved but not released for payment) as of the date of the inquiry. The Voice Response System does not provide specific claim information. For claim specific information, call the Provider services Unit.

- **Verify member eligibility**

Enter the 10-digit Medicaid provider number and select **Option 2**. Enter the member's Medicaid ID number from the Medicaid ID card and follow the prompts. The Voice Response System should be used each time a member requests service.

When the member's ID number is not available, you can follow the voice prompts and use the member's social security number or a combination of the member's last name and date of birth.

Request the Medicaid ID card from the member with each office visit and verify the effective dates, provider restrictions, managed care information, and other insurance information on the member's Medicaid ID card. Obtain the Medicaid Member Number from the ID card (MAID #) and call the Voice Response System to verify eligibility. Members enrolled in the Medicaid Health Maintenance Organization (HMO) program Mountain Health Trust (MHT) have the name and telephone number of the HMO on their ID cards. Members enrolled in the Medicaid Primary Care Case Management (PCCM) Physician Assured Access System (PAAS) managed care programs have their Primary Care Physician's name on their ID cards.

Verification of a member's eligibility does not guarantee payment for the services you provide. The services you provide, in addition to verification of the member's eligibility, must be:

1. Determined to be medically necessary
2. A covered Medicaid service
3. Prior authorized or approved when applicable
4. Referred or approved by the PAAS primary care provider (PCP) or HMO when applicable
5. Billed to the HMO for medical services provided to members enrolled in MHT
6. Properly documented in your office or facility medical records including, but not limited to, items one through four above, as applicable.

Additional information on your responsibility as a participating provider for verifying member eligibility is covered in Chapter 400.

152 CONTACTING PROVIDER SERVICES

BMS ensures that provider services and support services are made available through their fiscal agent organization. To obtain general information or make a general or specific inquiry regarding denied claims, claims status, accounts payable, program coverage, member eligibility, billing procedures, managed care issues, Electronic Data Interchange (EDI) training, or Electronic Funds Transfer (EFT) issues, call:

- (304) 348-3360
- (888) 483-0793

Provider Services Representatives are available Monday - Friday excluding state holidays from 8 a.m. to 5 p.m. Charleston providers should use the local provider services number. Provider Services staff will respond to requests during the call whenever possible. Occasionally, calls may be referred to another state agency for assistance. When the inquiry cannot be answered during the call, the representative will take the request and follow up appropriately at a later time. Consider the complexity of the request when waiting for the response. The response to the inquiry may be in writing or by telephone and may identify that further research and time is necessary to respond to the initial request.

EDI technical support is available to answer your inquiries related to: software issues, transmission difficulties, EDI enrollment procedures, claim format issues, EDI testing procedures, and rejected reports. To obtain technical support on electronic claims, excluding Pharmacy Point-of-Sale (POS), call 1-888-483-0793.

To obtain technical information regarding Medicaid's Pharmacy (POS) Program, call 1-888-483-0801. For technical support on electronic remittance vouchers, call Monday - Friday 8 a.m. to 6 p.m. at 1-888-483-0793. You may also access the EDI provider website, www.edihelpdesk@unisys.com, for additional information.

153 OTHER CONTACTS

Other important telephone numbers available for use by Medicaid providers are listed below:

- **Provider Enrollment**

  For information and requirements regarding participation in the WV Medicaid Program as a provider, contact the Provider Enrollment. Any change to information supplied in your provider enrollment application must be sent to BMS in writing. This includes changes to addresses, group affiliations, specialty services, telephone numbers, tax ID, Medicare provider numbers, etc.

- **Inpatient Admission Approval And Prior Authorization**

  To obtain inpatient hospital pre-certification and prior authorization of services, call 1-800-982-6334.

  This telephone number will connect you with the utilization management services manager for the WV Medicaid Program, including hospital pre-certification and prior authorization of applicable services. (Note: For HMO enrolled members, follow the respective HMO's admission approval and prior authorization requirements.)

  Pre-service review and prior authorization is performed for the following services:

  - General and Acute Inpatient Hospital Services
  - Organ Transplant Services
  - Psychiatric Inpatient Facilities and Psychiatric Residential Treatment Facilities
  - Inpatient Medical Rehabilitation Services
  - Intensive Medical Case Management
  - Home Health Services exceeding calendar year limits
  - Certain Durable Medical Equipment (DME), Orthotics and Prosthetics Services, and Medical Supplies
  - Speech Therapy
  - Physical Therapy and Occupational Therapy exceeding calendar year limits
  - Private Duty Nursing Services
  - Nursing Visits for Home IV Services
  - Outpatient Partial Hospitalization Services
  - Chiropractic Services exceeding calendar year limits
  - Nursing Facility Services
  - Aged and Disabled Waiver Services

- Home-based Community Services
- Certain General Dental Services
- Certain Vision Care Services
- Children with Special Health Care Needs
- Mentally Retarded (MR)/Developmentally Disabled (DD) Waiver Services
- Intermediate Care Facility (ICF)/Mentally Retarded (MR) Services.

In addition, you must obtain prior authorization on members who have exhausted their service limits. All services that require prior authorization are identified in the applicable provider manual that addresses the services.

- **Behavioral Health Services**

  You may obtain prior authorization for behavioral health clinic and rehabilitation services by calling American Psychiatric Systems (APS) Healthcare at 1-800-343-9663.

  Prior authorization of behavioral health services provided by private practitioners is obtained from BMS. All services that require prior authorization are identified.

- **Audits and Settlements**

  To obtain information regarding audits and cost settlements, call:

Hospital	1-304-558-0460
Nursing Facility	1-304-558-0460

  If you need information regarding the payment of audits and cost settlements, call 1-304-558-1700.

- **Pharmacy Help Desk**

  To obtain both procedural and technical information regarding the Prescription Drug Program, call 1-800-847-3859.

- **Rational Drug Therapy Program**

  To obtain procedures, prior authorizations, and information regarding the Prescription Drug Prior Authorization Process, call or fax:

Call	1-800-847-3859
Fax	1-800-531-7787

- **Third Party Liability/Coordination of Benefits(TPL/COB)**

  To ask questions regarding commercial insurance and Medicare applicability to Medicaid member claim reimbursement, call 1-304-558-1700 or visit www.wvrecovery.com.

  Medicaid is always "the payer of last resort." BMS, in conjunction with its subcontractors, conducts coordination of benefits, third party liability identification, cost avoidance activities, and recovery functions for the WV Medicaid Program, and maintenance of compliance with federal regulations.

- **Medicaid Managed Care**

The BMS contracts with an Enrollment Broker to inform Medicaid members about managed care. The enrollment broker enrolls applicable members in either the HMO or PCCM programs. The HMO and the PCCM (PAAS) programs are known as the Mountain Health Trust (MHT) program.

The enrollment broker assists eligible members in selecting a managed care program and a primary provider of their choice. BMS assists providers who have managed care member assignment issues. For assistance on managed care assignment questions for the MHT Program, call the enrollment broker at 1-800-449-8466.

- **Department of Health and Human Resources (DHHR) Offices**

  To refer a member for Medicaid coverage or obtain information regarding policies related to member eligibility call your local DHHR office. These telephone numbers vary by geographic area. Use your local telephone directory, State Government section, to find the telephone number of the local DHHR office.

- **Medicaid Related Programs**

  The Office of Maternal, Child and Family Health (OMCFH) of the Bureau of Public Health has a toll free telephone number for information about specific health and Medicaid-related programs. To obtain information related to the programs below, call 1-800-642-8522 or 1-800-642-9704.

  - Children Specialty Care (CSC) Program
  - WV Birth to Three Program
  - Women, Infants, and Children Nutrition Program (WIC)
  - Family Planning Program
  - Breast and Cervical Cancer Diagnosis and Treatment Fund
  - Right From the Start Program (RFTS)
  - Ryan White Fund
  - Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) (HealthCheck) Program
  - Children's Dentistry Services.

  These toll free telephone services are available weekdays between 8:30 a.m. and 5:00 p.m. except holidays. The lines are staffed by registered nurses and licensed social workers that serve as the initial service coordinator for children, families, and professionals seeking information on the services offered. They can also offer instructions on how to apply for programs.

- **Medicaid Waivers**

  WV's Medicaid website contains additional information that includes, but is not limited to, information on the BMS organization, Medicaid Program Instructions and policies, Resource Based Relative Value Scale (RBRVS) with specific reimbursement issues, general information related to the Health Insurance Portability and Accountability Act (HIPAA), and specific information related to pharmacy services. You are encouraged to routinely access and view new information posted on the BMS website (www.wvdhhr.org/bms).

The Centers for Medicaid and Medicare Services is also an excellent resource to use in conjunction with the above WV website. The Centers for Medicaid and Medicare Services website is located at www.cms.gov.

160 COVERED SERVICES

The WV Medicaid Program pays for medically-necessary, covered health services, as well as certain waiver services that are provided to eligible members by Medicaid providers. The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. The following is a general listing of services covered by the WV Medicaid Program:

- Aged and Disabled Waiver Services
- Behavioral Health Clinic and Rehabilitation Services
- Chiropractic Services
- Dental Services for Children
- Durable Medical Equipment (DME) and Medical Supplies
- Early & Periodic Screening, Diagnosis & Treatment Program (EPSDT) – also known as HealthCheck
- Family Planning Services
- Free Standing Ambulatory Surgery Services
- Home Health Services
- Hospice Care Services
- Intermediate Care Facility Services for the Mentally Retarded (ICF/MR)
- Inpatient Hospital Services, Acute care
- Inpatient Psychiatric Services for individuals under age 21
- Inpatient Rehabilitation Services for individuals under age 21
- Mentally Retarded/Developmentally Disabled Waiver Services (MR/DD)
- Nurse Practitioner Services
- Nurse Midwife Services
- Nursing Facility Services
- Occupational Therapy Services
- Optometry Services
- Orthotic/Prosthetic Services
- Outpatient Hospital Services
- Personal Care Services
- Pharmacy Services
- Physical Therapy Services
- Physician Services
- Podiatrist Services
- Private Duty Nursing Services
- Psychiatric Services
- Psychological Services
- Rural Health Clinic Services and Federally Qualified Health Center Services

- Speech and Hearing Services
- Transportation Services
- Vision Services.

Certain services are covered only for specific categories of eligible members. All covered Medicaid services, both traditional and special services, must be medically necessary, may be limited in scope, i.e., specific number of units of services, and may be subject to prior authorization.

BMS contracts with West Virginia Medical Institute (WVMI) for the review and approval of all hospital inpatient services for Medicaid members. However, physicians, acute care hospitals, rehab hospitals for members under age 21 only, and psychiatric hospitals for members under 21 only, must obtain prior authorization before admission of the patient. For documented emergencies, the patient may be admitted, but the request for prior authorization must be made to WVMI within 24 hours or the first working day after admission.

Refer to appropriate the applicable provider manual for specific provider policy and billing instructions for each of these covered services.

161 GENERAL NON-COVERED SERVICES

The WV Medicaid Program does not cover certain services and items regardless of medical necessity.

Some examples are identified below:

- Acupuncture
- Artificial insemination, in vitro fertilization, infertility services, or sterilization reversal
- Autopsy
- Christian Science services
- Cosmetic surgery services
- Dental services for members 21 years of age and over (except for treatment of fractures of mandible and maxilla and biopsy), removal of cysts and tumors, and emergency extractions
- Drugs for weight gain or loss, hair growth, fertility, cosmetic use, and those considered investigational or unproven
- Duplicate services
- Equipment or supplies which are primarily for patient comfort and/or family or caretaker convenience (Note: One mobility item is covered in a five-year period.)
- Experimental or investigational/research services or drugs
- Inpatient psychiatric services for individuals between 22 and 65 years of age, except acute care admissions
- Optometry services for individuals over age 21, except the first pair of glasses after cataract surgery
- Personal comfort and convenience items or services, whether on an inpatient or outpatient basis, such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
- Radial Keratotomy; Lasik surgery

- Services rendered outside the scope of a provider's license
- Sterilization for individuals under age 21
- Transsexual surgery
- Fees for missed appointments*
- Fees to copy medical records
- Weight loss programs or drugs for weight loss
- Services rendered by students as part of their clinical or academic training.

* Enrolled providers cannot bill Medicaid members for missed appointments.

The above list is illustrative only. It should not be construed as a complete or exhaustive list of excluded items or services.

Refer to Chapter 400 for additional information on member responsibilities for payment, and appicable provider manuals for specific covered and non-covered services.

The "WV Works" Program covers dental and optometry services for certain eligible adult Medicaid members. Please note: Not all Medicaid-eligible members are eligible for enrollment in the "WV Works" Program. Contact the local DHHR office for questions regarding specific benefits and possible coverage for patients.

170 RELATIONSHIP TO MEDICARE

Medicaid covers medically necessary health services furnished to individuals who meet specific income, resource, and eligibility standards. Medicare is a federal program that offers health insurance coverage to individuals 65 years of age or older, to those who have received social security disability benefits for 24 consecutive months, to those who have end-stage renal disease, to those on advanced life support, and to other eligible individuals, as specified by other provisions of the Social Security Act.

WV Medicaid covers the applicable co-insurance and deductible amounts, not to exceed Medicaid's allowable payment, for services covered by Medicare Parts A and B for all eligible Medicaid members who are also entitled to Medicare benefits. The Medicaid Program may also provide payment for services not covered by Medicare.

A member with both Medicare and Medicaid coverage is identified as "dual eligible." Medicaid reimburses secondary to Medicare. If a Medicare Supplemental policy exists in addition to Medicare and Medicaid coverage, Medicaid is the third-party payer subsequent to Medicare and Medicare Supplemental payments. Medicaid is always the payer of last resort.

Refer to Chapter 300 for more specific provider information on the Medicare program and its relationship to WV Medicaid, including Medicare provider numbers as part of your Medicaid participation responsibilities.

For information related to claim submission procedures for services rendered to a "dual eligible" member, refer to Chapter 300.

180 OUT-OF-STATE SERVICES

Non-emergency, out-of-state services provided to WV Medicaid members routinely require prior authorization from the BMS Out-of-State Unit, Bureau for Medical Services. For HMO members, follow the respective HMO prior-authorization requirements. If applicable, contact BMS at 1-304-558-1700.

The following are exceptions to this policy:

1. Services provided by WV Medicaid-enrolled border providers
2. Services provided by out-of-state providers who are enrolled as in-state providers
3. Services for WV Medicaid-eligible children who have been placed in foster homes outside WV.

A physician practicing in WV, who determines it necessary to refer a Medicaid member out-of-state for outpatient physician services should submit a request to the BMS Out-of-State Unit. Information that must be provided in the request is as follows:

1. Reason for the out-of-state referral
2. Patient's diagnosis
3. Expected treatment
4. Whether or not treatment is available within WV (services available within the state are not covered outside the state)
5. Other pertinent information.

Payment to out-of-state physicians is made at the same reimbursement rate as payment to in-state physicians. Under Federal law, the Medicaid Program prohibits balance billing by all providers, regardless of location. All out-of-state providers' claims for providing non-emergency medical services will deny unless:

1. The provider is enrolled as a "border" provider
2. The provider is enrolled as an "in-state" provider
3. The services have been prior authorized.

Emergency out-of-state Medicaid-covered services are eligible for Medicaid reimbursement. The documentation provided with the claim must clearly indicate that an emergency situation existed. The emergency room patient record must be submitted with the claim.

Refer to Chapter 300 for additional information regarding out-of-state providers.

190 FRAUD AND ABUSE

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to either the person or another. In particular, any provider that acts intentionally and with knowledge to deceive or misrepresent information used in Medicaid administrative processes, and the deception or misrepresentation results in some unauthorized benefit to him/her or another, commits fraud. It also includes any act that constitutes fraud under applicable federal or WV state law.

Abuse is defined as provider practices that are inconsistent with sound fiscal business or medical practices and result in an unnecessary cost to the Medicaid Program. It also includes reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. In particular, any provider that acts in a repetitive manner to cause unnecessary costs for the Medicaid Program is considered abusive of the Medicaid Program.

Examples of activities that constitute fraudulent practices or abuse of the Medicaid Program are identified in Chapter 800, General Administration. A person is subject to prosecution by federal and state authorities when any actions identified during the Medicaid administrative process is determined to be fraudulent or abusive.

It is recommended that 42 U.S.C. §1320a-7a, 42 U.S.C. §1320a-7B, and 42 U.S.C. §1320 a-7 be reviewed by appropriate provider office staff. These codes contain information related to fines and exclusions that can be imposed upon persons and/or entities convicted of submitting false or fraudulent claims to federal or state medical programs.

191 CONFIDENTIALITY

Information you obtain from BMS or any other DHHR bureau regarding Medicaid members' eligibility, health history, health care services, or any other personal information, is to remain strictly confidential and shall not be disclosed for any purpose other than those directly concerned with Medicaid administrative requirements.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' SEVENTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE: See documents received from Aetna, marked as Exhibit 125, regarding Plaintiff Anderson. The undersigned bates numbered the pdf documents using the number assigned by Aetna as FAI0000000578 to FAI0000000603. All materials are CONFIDENTIAL.

4. All Documents and communications relating to the Exclusion, including but not limited to:

a. All Documents and communications relating to the decision to maintain the Exclusion in the Health Plans in any plan year.

b. All Documents and communications relating to the decision to permit coverage for hormone therapy for the purpose of treating gender dysphoria.

c. All Document and communications relating to evaluating, examining, analyzing, and/or considering the Exclusion in any way.

SUPPLEMENTAL RESPONSE: See BMS Policy Manual, Chapter 100, attached as Exhibit 123 (Bates No. DHHRBMS020639 – 20653).

17. Documents obtained from third parties as a result of authorizations, releases and/or subpoenas relating to the subject matter of this lawsuit.

SUPPLEMENTAL RESPONSE: See Exhibit 125, which consists of documents provided by Aetna regarding Plaintiff Anderson. See also documents provided by Unicare regarding Plaintiff Fain, previously produced and marked as Exhibits 93 and 94.

20. All communications related to legislation and/or lobbying surrounding the Exclusion and/or coverage for medical care for transgender people and gender dysphoria.

SUPPLEMENTAL RESPONSE: These Defendants are not aware of any responsive documents.

23. All Documents which Defendants considered, relied upon, or intend to rely upon, in answering each interrogatory and each request for admission in this action.

SUPPLEMENTAL RESPONSE: See BMS Policy Manual, Chapter 200, attached as Exhibit 124, (Bates No. DHHRBMS020654-20683).

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

SUPPLEMENTAL RESPONSE: See all documents produced in this matter.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 9th day of March, 2022, a true and exact copy of **DEFENDANTS' SEVENTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF SECRETARY BILL J. CROUCH

DATE: March 17, 2022
TIME: 10:30 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5096130

APPEARANCES

On Behalf of the Plaintiffs (Via Videoconference):

TARA L. BORELLI, ESQ.
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Ave., Suite 105
Decatur, Georgia 30030
470.225.5341
tborelli@lambdalegal.org

AVATARA SMITH-CARRINGTON, ESQ.
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

NICOLE J. SCHLADT, ESQ.
Nichols Kaster PLLP
80 South 8th Street, Suite 4700
Minneapolis, Minnesota 55402-2224
612.256.3291
nschladt@nka.com

WALT AUVIL, ESQ.
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
304.485.3058
auvil@theemploymentlawcenter.com

On Behalf of Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services (Via Videoconference):

KIMBERLY M. BANDY, ESQ.
LOU ANN S. CYRUS, ESQ.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street East, Suite 200
Charleston, West Virginia 25301
304.345.1400
kbandy@shumanlaw.com
lcyrus@shumanlaw.com

On Behalf of Defendant Jason Haught (Via Videoconference):

ERIC D. SALYERS, ESQ.
Oxley Rich Sammons, PLLC
517 Ninth Street, Suite 1000
Huntington, West Virginia 25701
304.522.1138
esalyers@oxleylawwv.com

NOTE: The original deposition transcript will be delivered to Nicole Schladt, Esq., as the taking attorney.

like in normal conversation we have a tendency to use mm-hmm or huh-un to answer questions. If in the event you do that I may follow up and ask you for a yes or no, and that is likely not because I don't understand what you're saying, but because we just need to have a clear record. Is that fair?

A. That is fair.

Q. And then sometimes there's a tendency for people to talk over each other. It seems like this morning we aren't going to have a problem based on how things are going already this morning, but in the event we end up talking over each other on accident then I might have to repeat myself or Kelley here might have to jump in and get us, attempt to get us to stop talking over each other. Is that okay?

A. Great.

Q. Okay. And so that finishes up my ground rules here and I think we can launch into a couple of questions about your background. Mr. Secretary, can you state your full name for the record, please.

A. Bill J. Crouch.

Q. And is your first name William?

A. No, it is not.

Q. It's actually Bill?

A. It is Bill.

Q. Great. Glad that we established that. And, Mr. Secretary, do you use he/him pronouns?

A. No, I do not.

Q. What pronouns do you use?

A. I've never been asked that. For me?

Q. For you, yes. If I wanted to refer to you like Bill went to the store, instead of saying Bill, would I say he went to the store?

A. Yes, that would be fine.

Q. Great. Thanks. And you are the Cabinet Secretary of West Virginia Department of Health and Human Resources, is that correct?

A. That is correct, yes.

Q. How do you refer to the West Virginia Department of Health and Human Resources, because I know that's quite a mouthful?

A. How do I refer to them?

Q. Do you have a short terminology for that, like WVDHHR or DHHR?

A. DHHR, yes.

Q. Great. So if I use DHHR today, you'll know that I'm talking about the full West Virginia Department of Health and Human Resources?

A. I will, yes.

Q. Great. That will save us both a few words

today.

A. All right, good.

Q. And you were appointed Cabinet Secretary in January 2017, is that right?

A. That is correct, yes.

Q. And you were appointed by Governor Jim Justice of West Virginia?

A. That is correct.

Q. And you held the position for a little over five years then, is that right?

A. That is correct.

Q. And, Mr. Secretary, what are your job duties as Cabinet Secretary of DHHR?

A. DHHR is a provider of, of funds and services and a safety net for individuals, vulnerable individuals throughout the state. So we have a 7 and a half billion dollar budget, we have over 6,000 employees, we have over 150 programs. So I try to make sure that the funding that comes in from the federal government or through the state legislature is pushed out appropriately to those folks in communities who need those funds to provide services.

We also provide some direct services such as CPS and APS, Child Protective Services and Adult Protective Services to those children and vulnerable adults who

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

I hereby certify that I reported the Zoom deposition of Secretary Bill J. Crouch on the 17th day of March 2022, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was reserved.

WITNESS MY HAND AND SEAL THIS 17th day of March 2022.

Kelley E. Zilles, RPR
Notary Public, Washington County, Minnesota
My commission expires 1-31-2025

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096130
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/17/2022
WITNESS' NAME: Secretary Bill J. Crouch

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

April 26, 2022 Bill J Crouch
Date Secretary Bill J. Crouch

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 26th day of April, 2022.

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
G Elizabeth Jarrett
2744 Daniels Avenue
South Charleston WV 25303
My Commission Expires June 13, 2026

Notary Public

June 13, 2026
Commission Expiration Date

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5096130

PAGE/LINE(S) /	CHANGE	/REASON
Page 18 / Line 1	rates (not rights)	Wrong word
Page 19 / Line 1	93-641	Hyphen needed
Page 28 / Line 11	Mars Hill College (not Marshall)	Wrong word
Page 40 / Line 20	re-bid (not redid)	Wrong word
Page 43 / Line 23	LOCHHRA (Not LCRA)	Incorrect acronym
Page 43 / Line 25	LOCHHRA " "	" "
Page 44 / Lines 4, 6, 7, 8, 16, 17	LOCHHRA " "	" "
Page 45 / Line 22	LOCHHRA " "	" "
Page 46 / Lines 3 & 7	LOCHHRA " "	" "
Page 46 / Line 24	recipients (not clinics)	Wrong word
Page 60 / Line 18	well (not want)	Wrong word
Page 61 / Line 21	LOCHHRA	Incorrect acronym

April 26, 2022 — Bill J. Crouch

Date — Secretary Bill J. Crouch

SUBSCRIBED AND SWORN TO BEFORE ME THIS 26th

DAY OF April, 20 22 .

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
G Elizabeth Jarrett
2744 Daniels Avenue
South Charleston WV 25303
My Commission Expires June 13, 2026

June 13, 2026

Commission Expiration Date

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF COMMISSIONER CYNTHIA BEANE

DATE: March 29, 2022
TIME: 8:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5096149

APPEARANCES

On Behalf of the Plaintiffs (Via Videoconference):

CARL CHARLES, ESQ.
TARA L. BORELLI, ESQ.
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Ave., Suite 105
Decatur, Georgia 30030
470.225.5341
ccharles@lambdalegal.org
tborelli@lambdalegal.org

AVATARA SMITH-CARRINGTON, ESQ.
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

NICOLE J. SCHLADT, ESQ.
Nichols Kaster PLLP
80 South 8th Street, Suite 4700
Minneapolis, Minnesota 55402-2224
612.256.3291
nschladt@nka.com

WALT AUVIL, ESQ.
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
304.485.3058
auvil@theemploymentlawcenter.com

On Behalf of Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services (Via Videoconference):

KIMBERLY M. BANDY, ESQ.
LOU ANN S. CYRUS, ESQ.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street East, Suite 200
Charleston, West Virginia 25301
304.345.1400
kbandy@shumanlaw.com
lcyrus@shumanlaw.com

NOTE: The original deposition transcript will be delivered to Tara Borelli, Esq., as the taking attorney.

distinction is important to your answers, will you agree to clarify that for me?

A. Yes.

Q. In this next set of questions I'll be asking about your professional background for purposes of your individual testimony and as an organizational representative for BMS. What is your current job title?

A. I'm the commissioner for the Bureau of Medical Services.

Q. How long have you held that position?

A. I've been in this position fully appointed since 2017 and before that I was acting commissioner for a couple years.

Q. Did you begin serving as acting commissioner in approximately July 2014?

A. Yeah, I guess I did.

Q. Okay. LinkedIn is a helpful thing. You mentioned being appointed to this role. Let's start with your acting commissioner role beginning in 2014. Were you appointed as acting commissioner?

A. At the time the commissioner had left abruptly and I was a deputy commissioner and I was asked to take the acting role and I did so.

Q. Who asked you to take that role?

A. Deputy Secretary Jeremiah Samples.

Q. And then in 2017 you became the commissioner. Were you appointed to the role of commissioner in 2017?

A. Appointed probably is not maybe the correct word I should have used. I was asked to take the role fully in 2017 by then Secretary Crouch and to come out of the acting role. And the significance of that was it's whether or not you're covered by Civil Service. And so at the time when the commissioner had left abruptly before we were, we get new governors every four years, and so I was kind of like not sure if I wanted to take it knowing that there was a possibility I would not be the chosen commissioner in a year and a half or so.

Q. I see. And so when you were asked to become commissioner by Secretary Crouch you agreed in 2017?

A. Yes.

Q. And you referred to the prior commissioner leaving abruptly. Can you confirm that that didn't have anything to do with the subject of this case?

A. That had nothing to do with the subject of this case.

Q. Prior to becoming commissioner have you held other roles within BMS or DHHR?

A. Yes. I have been with the Department since 2000. Prior to becoming the acting commissioner I was deputy commissioner and then for a number of years prior

and be the spokesperson for Medicaid services in West Virginia.

Q. Is it fair to say that you administer the Medicaid program?

A. Yes.

Q. Do you recall any other duties or responsibilities in your current role?

A. I believe the answer I gave are a very broad brush of all the things that I do here at Medicaid, you know, all the leadership reports to me and there are several different divisions under that and lots of nuances when it comes to Medicaid, but yes, I make sure we're administering the Medicaid program. Medicaid is a state and federal partnership. West Virginia has a very good rate when it comes to what our federal match is, and so I make sure that we are not putting that federal match at risk.

Q. How do you perform the function of making sure that the federal match is not being put at risk?

A. Pretty much we follow CMS guidelines. If CMS directs us to do something, they mandate us to do something, we make sure that we do it. We update our state plan as needed. If we are to add a service, if the legislature gives us additional monies to add a service, we make sure before we do that that we have

CMS's permission to do it before we are collecting the match for the services.

Q. Who do you report to?

A. I report to Deputy Secretary Samples and Secretary Crouch.

Q. Are there any others that you report to?

A. Those two gentlemen are it.

Q. Let me make sure that I get the name of the, Secretary Crouch, can you repeat the other, the title and the name of the other individual?

A. Deputy Secretary Jeremiah Samples and Secretary Crouch, Bill Crouch.

Q. Thank you. How often do you report on your work to Secretary Crouch?

A. Secretary Crouch has meetings, they've been a little bit different since COVID just because things just got kind of crazy busy with the pandemic, but he has like weekly leadership meetings where all the commissioners are there. But then of course if I need something from Secretary Crouch, for example, yesterday I needed to make sure he signed something and so I, you know, called him and, you know, made sure that he saw that on his desk and signed it. So the formal meetings, about once a week.

Q. And how often do you report on your work to

meet with any mental health providers who provide any care to transgender people, even if they do not specialize in that care?

A. Not to prepare for this.

Q. And as the organizational representative did you meet with any medical providers who provide any care to transgender people, even if they don't specialize in providing that care?

A. Not to, I have not met with them to prepare for this.

Q. You also mentioned reviewing expert testimony in connection with preparing to testify as the organizational representative. Do you recall the name of the expert whose report you reviewed?

A. I honestly do not recall the name, but it is, I'm assuming it is an exhibit that you probably already have, but I honestly don't remember the name of the doctor, it's just escaping me.

Q. Was it Dr. Steven Levine, by any chance?

A. Yes.

Q. And did you read any other expert materials from the case to prepare for your testimony as organizational representative today?

A. I did not.

Q. And when was the first time that you reviewed

the report of Dr. Steven Levine?

A. Last week.

Q. Okay. Have you ever spoken with Dr. Levine?

A. I have not.

Q. Does BMS have one or more medical directors?

A. One.

Q. And who is that medical director?

A. Dr. Becker.

Q. Are there any other medical professionals, for example, nurse practitioners within BMS?

A. Yes, we have several nurses that work for BMS.

Q. And did you speak with any of those nurses in order to prepare to testify as the organizational representative today?

A. I have not spoke to them, but some of them have pulled some of the information that I think is being used as different exhibits in evidence.

Q. And did you review that information that they pulled?

A. Yes, I reviewed some of the exhibits, yes.

Q. All right. I'd like to ask you actually a quick follow-up question. Do you remember which ones you reviewed?

A. Which -- well, I remember we had a pull with regards to how many individuals with gender dysmorphia

So as the state plan evolves and as you have more money in order to offer additional healthcare services and as healthcare has changed in the last 50 years as well, different state plans become submitted. So the state plan will have pages from literally the 1970s and '80s if you look at our state plan to most recent pages in the 2000s. And so as we add services that were not thought of 50 years ago, so we add new additional state plan pages.

Q. And are the pages in the state plan that you're referring to which bear different dates, are those different pages generally organized by the service provider?

A. Yeah, so they're, they're like, the state plan has pages, like the 419 pages are more your service pages, then there are a different section for financial pages, and then there are some other sections when they're really talking about some of the eligibility pages. And then they'll have different pages for like your, for the most recent with the ACA, your alternative benefit plans and those pages. So it's all there, it's a very thick convoluted document, I'm not going to sugarcoat it.

Q. And changes are periodically made to the Medicaid plan, correct?

A. Yes.

Q. What kinds of circumstances would lead to a change in the Medicaid plan?

A. If we were to add a service, if CMS would mandate a service. So our most recent state plan changes that we made, CMS has recently said states will cover all forms of medication assisted treatment, they directed us on where in the state plan they wanted that, and so we had to submit a new state plan amendment to assure compliance with MAT services.

Q. And you just started describing this, but can you walk me through the process for how changes are made to the Medicaid plan?

A. Okay. So we'll just stick with that since I started with it. So for that particular example we got a State Health Officer letter that said you must cover, you know, these services and they must be spelled out in your state plan, then we drafted the state plan. We typically, you don't have to do this, but we have a fairly positive relationship with our federal partner, so what we do is we'll share the draft with them before the formal submission so we can kind of get off the record kind of feedback from them if, you know, if something is in the wrong place or, you know, or if it's a preprint and they want us to use a specific format,

something like that.

And then after that back and forth and then, you know, they seem to like what we've got and we're assured that it's ready to go, then we'll have what we call like a medical fund advisory council. Typically those typically have met once a quarter before the pandemic. Once the pandemic happened everything kind of went crazy and we weren't meeting with that group. But typically during normal times when there's not a pandemic that group would review the state plan, we would have to put the state plan up for public comment, and then after that it routes over to the secretary and then for his sign-off, governor's sign-off and submission.

Q. Thank you. So do all changes to the Medicaid plan require CMS approval?

A. Yes, yes. In order to get the federal match, because they're not going to give you federal match for services if they haven't approved.

Q. And who would you describe as having the authority to negotiate these changes to the state plan with CMS?

A. That would be my office.

Q. Okay. And does that include you as well individually?

A. Yes, yes.

A. Yes.
Q. Does this appear to be an attached copy of the 2021 model purchase of service provider agreement between BMS and Aetna?
A. Yes.
Q. Please scroll now down to Page 65 of the document, that's Page 73 of the pdf, Page 65 based on the document's internal numbering.
A. I'm on 65 internal number.
Q. And you should see a Bates number in the lower right-hand corner that reads DHHRBMS001193. Do you see that?
A. I do.
Q. Towards the bottom of the page is a heading that reads, "1.4, noncovered services," do you see that?
A. Yes.
Q. Right below that it says, "MCO's are not permitted to provide Medicaid excluded services that include, but are not limited to, the following." Do you see that?
A. Yes.
Q. And if you scroll to the next page. Let me know if you see a Bates stamp DHHRBMS001194, do you see that?
A. Yes.
Q. And do you see language on that page that says,

"No. 6, sex transformation procedures and hormone therapy associated with sex transformation procedures"?

A. Yes.

Q. Does this indicate that BMS's contract with Aetna requires Aetna to exclude gender affirming care?

A. It is excluded as far as a service that is considered in your rates.

Q. Can you explain what that means?

A. So, for example, No. 1 says, "All nonmedically necessary services." We know that MCO's sometimes provide services that are not medically necessary, but it might be an incentive. So they might give you a $20 gift card if you went to all of your well checks or you had your baby do all of your well checks. That's not, that's not a medically necessary service, but we allow the MCO's to do those value added services.

Q. And so does that indicate that if the MCO's cover this care, gender affirming care, they will not receive any reimbursement from the Medicaid program?

A. It means that that service was not in their rates. So when we do the rates for the MCO's we have our benefits and what we cover. This is a service we don't cover. So when the actuaries look at all the history and everything in their rates and they come up with an adult member gets a $400 a month PMPM, that

surgery would not be considered in that rate, but once I give that money over to the MCO and they have that $400 a month, they have to cover all the benefits that are required, but if they want to cover additional benefits that we don't cover here, they wouldn't be penalized other than it's not in their current rate, they would have to say they're going to do it based on their management of the program.

Q. So in other words, BMS will not cover what this document refers to as sex transformation procedures, correct?

MS. CYRUS: Object to the question. But go ahead.

A. Correct.

Q. And if the MCO's did want to cover that care, specifically gender affirming surgery, they would have to come up with their own money to do so, is that correct?

A. Yes. It would, it would be within the rates that we give them, but it would not constitute what, what the actuaries use to bill their rate.

Q. Let me make sure I'm understanding what you're saying. So let me go back to first principles. I think I heard you say gender affirming surgery is a noncovered service for BMS, correct?

A. Correct.

Q. And so when BMS negotiates with the MCO's for the amount of money that they will receive from BMS to cover all of the required care, that calculation does not include any money to cover gender affirming surgeries, correct?

A. Correct.

Q. And if the MCO's wanted to cover gender affirming surgeries, they would need to come up with their own money, correct?

A. Yes, they would use their own money. So can I give like an example --

Q. Sure.

A. -- what this would be? So I'm going to use like two examples. So we don't cover acupuncture, it's not a benefit in our state plan that we cover, it would not be in the rates. But let's say the MCO saw a benefit and covered acupuncture, that if we cover acupuncture we're not going to have to do as many back surgeries and in the long run it's going to be a cost-saving to us, which in the end a managed care company is going to look at that financial obligation in their businesses, so they're going to try to make as much money as they can with regards to still providing the services they have to provide, but also any cost savings that they have up

to a certain point then they can use as profit. So if they determine that by covering acupuncture, even though it's not something that is in our rate, will benefit us and actually save us money, they can do that.

So for gender affirming care the assumption would be, perhaps, I don't know, if they wanted to cover the surgery and maybe this person wouldn't require as much counseling later, then they might decide to do that. I do not believe any of them have.

Q. Correct. So to your knowledge none of the MCO's are in fact covering gender affirming surgery using their own funds?

A. Correct.

Q. Okay. Why does the exclusion that we reviewed together refer to hormone therapy when West Virginia Medicaid provides access to that care?

A. I believe that that was a historical thing that was in there at one time. Our MCO's did cover the pharmacy benefit, they have not covered our pharmacy benefit for a number of years now, and so I just believe it's something in the, it's a very long contract that just wasn't caught when we were renewing the contracts and had them signed off year after year.

Q. That's helpful. What I'd like to do is really quickly see if we can establish that there are similar

the document has the Bates stamp DHHRBMS020685. Do you see that?

A. Yes.

Q. And do you recognize this document?

A. Yes.

Q. Does it appear to be a table showing the monthly number of Medicaid members for 2022?

A. Yes.

Q. And does this appear to be formatted in a similar table to the one that we just reviewed?

A. Yes.

Q. And does this table indicate that in March of 2022 there were a total number of 628,825 Medicaid members?

A. Yes.

Q. And based on the numbers that you just reviewed, your best estimate of the current number of Medicaid participants is still 615,000 approximately, is that correct?

A. It looks like I was a little off, it's 628.

Q. So 628. And I recognize we're still in the month of March, I'm not sure if there's much fluctuation within a month or not, but is the number in this chart for March of 2022, to your knowledge does that remain accurate for the approximate number of total Medicaid

Q. Topic 11 reads, "Any governmental interest that you contend supports the exclusion and their factual bases." Did I read that correctly?

A. You did.

Q. Are you prepared to testify about this topic?

A. I am.

Q. And with respect to Topic 11 specifically, what did you do to prepare to testify today?

A. Made sure we didn't have any directive from CMS directing us to cover the service.

Q. And when you did that review did you find anything from CMS directing BMS not to cover gender affirming surgery?

A. I didn't find anything telling us that it was a mandatory service.

Q. And did you find anything telling BMS to exclude the care?

A. No.

Q. My understanding from your counsel is that you would be addressing Topic 11 as it relates to CMS, while your colleague Becky Manning will address the request as it relates to the budget. Is that your understanding as well?

A. That I'm going to address it as it relates to CMS, yeah, sure, yes.

Q. And you also have been designated to give testimony as the organizational representative for the discovery request on the same topic. So I want to turn to that next, and for the sake of efficiency I'll ask you questions about these related topics at the same time. Is that agreeable?

A. Yes.

Q. All right. Give us a moment to load the next exhibit and I will tell you when it's available.

(Exhibit 15 marked for identification.)

Q. All right. Go ahead and click on the exhibit folder and you should see what has been marked as Plaintiff's Exhibit 15. Let me know once you've had a chance to open and review the document.

A. Is this in a pdf? The computer is like asking me what to open it in, or is it Word?

MS. CYRUS: Yeah, I got the same message. Is it Adobe?

MS. BORELLI: You know what, I'm having the same issue myself. Given that we've been going not quite an hour, why don't we go ahead and take a break and we'll resolve the exhibit issue on our end and then we can come back and talk about it further, how does that sound?

MS. CYRUS: Sure. By the way, so while I

said that, I did click on Adobe and it did open it, if it's plaintiffs' response to first set of interrogatories, if that's what it is, Exhibit 15, it did open it, just FYI.

MS. BORELLI: Okay.

BY MS. BORELLI:

Q. Commissioner Beane, are you able to do the same thing?

A. Okay. Mine opened down here on my laptop for some reason, I can't get my mouse down there. Hold on.

MS. CYRUS: That's weird.

A. Why did it not open up there.

Q. It downloaded directly on my laptop as well. I'm not sure what about the file format caused it to do that, but are you able to view it as a downloaded file on your laptop?

A. Let me see if it will let me. Hold on. I can't get the mouse to go over here to the laptop screen, why can't I do that.

Q. All right.

MS. BORELLI: How about this, let's go off the record and go ahead and take that break.

(A break was taken at 12:27 p.m.)

(Exhibit 16 marked for identification.)

BY MS. BORELLI:

Q. So just before a break we were having a technical issue with the document that was introduced as Plaintiff's Exhibit 15. We think we have resolved the issue by uploading a duplicate of the same document, which should now be in your exhibits folder as Plaintiff's 16. So the record will reflect that the documents are the same and that exhibit appears twice as 15 and 16 because of this technical issue.

Commissioner Beane, are you now able to open up what's marked as Plaintiff's Exhibit 16?

A. I have opened it.

Q. Please take a moment to review the document and let me know when you are done.

A. I've looked at it.

Q. Have you seen this document before?

A. I have.

Q. Did you review it in connection with your testimony as BMS's organizational representative today?

A. I did.

Q. You've been designated to testify about the response to interrogatory No. 2. Please turn to Page 2 of the document. In approximately the middle of the page you'll see text that reads, "No. 2, describe in detail the factual basis for each governmental interest that defendants contend supports the exclusion." Did I

read that correctly?

A. You did.

Q. And the response reads, "These defendants state that they provide coverage that is mandated for coverage by the Centers of Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations." Did I read that correctly?

A. You did.

Q. And are you prepared to testify about this interrogatory as the organizational representative for BMS?

A. I am.

Q. With respect to interrogatory 2 specifically, what did you do to prepare to testify today?

A. I went back and made sure we didn't have a SHO letter, a State Health Officer letter, mandating us to cover the service and, and reviewed our budget to make sure that, well, to make sure that I was aware of when we were going into our budget deficient.

Q. So referring to the response to interrogatory 2 that I read a moment ago, is that an accurate description of the governmental interest in the exclusion?

A. I'm sorry, what?

Q. Were you having trouble hearing me or is it that

you would --

A. Can you say the question again, I was having trouble hearing you.

Q. No problem. I'll repeat. Referring again to the response to interrogatory 2 that I read a moment ago, is that an accurate description of the governmental interest in the exclusion?

A. Yes, we have no mandate from CMS to provide the coverage.

Q. And does that response to interrogatory 2 constitute a complete description of all of the governmental interest being claimed in the exclusion, it does, correct?

A. Correct.

Q. What is the factual basis for the statement in response to interrogatory 2 that defendants, "Provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services"? Let me repeat, what is the factual basis for that assertion?

A. So Medicaid has mandated coverages that CMS assured that we have state plans for and that we are covering those services. And so if there's a service that they are mandating all 50 states and territories to cover that not all 50 states and territories are covering, they will send out what's called the State

Health Officer letter and it will direct us to add that coverage.

Q. I think you said a moment ago that you looked to see if there was a SHO letter, I assume that's the abbreviation S-H-O, correct?

A. Correct.

Q. And that abbreviation refers to State Health Officer letter?

A. Correct.

Q. And a SHO letter is a letter that's sent by CMS, is that correct?

A. Correct.

Q. And you said a SHO letter might be sent if there's a mandated service that a state Medicaid program is not covering, correct?

A. Correct. So the most recent example that we have of that, which is fairly recent because sometimes you can go quite a while without having it, is the medication assisted treatment services. Every state is mandated to cover all forms of MAT services, and so if your state was not previously covering all those services, you had to do a state plan. Or if you were covering these services but they were not outlined correctly in your state plan, you had to revise your state plan to assure CMS that you were covering those

services without any kind of restrictions that would not allow individuals to receive those MAT services.

Q. And did you just use the abbreviation MAT?

A. Yeah, that's medication assisted treatment services, it's services for persons who are with substance use disorder.

Q. Understood. So you said in connection with preparing to testify as the organizational representative today you looked to see if CMS had sent a SHO letter to BMS about gender affirming surgery, is that correct?

A. Correct.

Q. And did you find any such letter?

A. I did not.

Q. Are there any other facts that you're aware of that support the governmental interest, which is again, to quote, "Defendants state that they provide coverage that's mandated for coverage by CMS," are there any other facts that support that governmental interest?

A. I cannot find any directive from CMS telling me I have to cover this service. If there was, we would have to cover the service or lose billions of dollars, and we would not be able to put that at risk.

Q. Understood. And are there any other facts that you're aware of that are related to that interest?

A. Not that I'm aware of.

Q. So I think you testified earlier that counseling is covered for treatment of gender dysphoria through the Medicaid program, is that right?

A. Correct.

Q. Do you have knowledge of why counseling is covered for gender dysphoria?

A. We do not have a restriction on the diagnosis code of why you might seek counseling, it might be for situational depression, it might be for schizophrenia, it could be for gender dysphoria, it could be for a variety of reasons.

Q. And who made the decision to allow coverage for counseling even if the only diagnosis code for the counseling is gender dysphoria, was it BMS that decided to do that?

A. BMS has decided not to edit based on diagnosis for counseling, meaning if your doctor, your therapist thinks you need some counseling because of whatever reason, we don't have an edit that says you can only get counseling for these five diagnoses. You can receive counseling initially for any diagnosis.

What will come into play is if you're going to counseling and you've been going for a few months and there's no progress and you want to continue to go to

another exhibit. So we'll go ahead and get that marked and I will tell you when it's available.

(Exhibit 21 marked for identification.)

Q. And just to set the stage for this, so I'm essentially returning now to Topic 18 in the plaintiffs' 30(b)(6) deposition notice. This is the topic we reviewed earlier today which relates to certain discovery requests. So I'll now be asking you about some additional discovery requests pursuant to that Topic 18.

All right. Go ahead and click on the exhibit folder and you should be able to open Plaintiff's Exhibit 21. Let me know when you've had a chance to review that document.

A. I've reviewed it, I've seen it.

Q. You've seen this document before?

A. Yes.

Q. Did you review it in connection with your testimony as BMS's organizational representative today?

A. Yes.

Q. You've been designated to testify about the response to request for admission 7 pursuant to Topic 18 in the 30(b)(6) notice of deposition. Please turn to Page 2 so we can review it together.

A. Okay.

Q. Towards the bottom of the page you'll see text that reads, "No. 7, admit that the Medicaid plan only covers care that is medically necessary." Did I read that correctly?

A. Correct.

Q. And the response reads, "Response. Admitted, however, these defendants deny any suggestion that Medicaid covers all care as medically necessary." Did I read that correctly?

A. You are correct.

Q. Are you prepared to testify about this request?

A. Yes.

Q. With respect to your request for admission specifically, what did you do to prepare to testify today?

A. I'm familiar with what services we cover and do not cover.

Q. To make sure that I understand this response, can you confirm that in order for care to be covered by Medicaid it must be medically necessary?

A. Yes, we cover medically necessary services.

Q. In other words, if coverage is covered by Medicaid, the care has been deemed medically necessary, correct?

A. Correct.

look at the Medicaid budget and see that it's a $4.5 billion budget, and even if every individual that we've identified in the suit requested the surgery, how much would that really cost in such a large budget. But even this session we had a bill to cover blood pressure cuffs for individuals with uncontrolled blood pressure. And so we have, so when bills go through our legislature you have to do a fiscal note. And so our state share of that coverage was going to be right around $500,000 and it fell due to the fiscal note, the legislature didn't want to increase the Medicaid budget at all. So we have to be very aware of where our budget is at all times and knowing that our deficit is coming, we are not spending any extra dollars if at all possible.

MS. BORELLI: I just want to object to this line of questioning because in the communications sent to plaintiffs' counsel it was communicated to us that a different witness would be addressing the budgetary interests that have been invoked by defendants in support of the exclusion, so I would object to this entire line of questioning.

MS. CYRUS: Sure. And I'm asking her this as a fact witness since you designated it for purposes of both and I think it completes her testimony, but the objection is noted.

Q. You said the legislature rejected an opportunity to provide blood pressure cuffs this session that would have cost around $500,000?

A. It was a little over 500,000, I can't remember the exact number, Lou Ann, but it was 500 and change, maybe 520, something like that.

Q. Okay. And what is the status of Medicaid's budget, you made reference to it earlier?

A. We currently have actually -- sorry, it's late in the day. We currently have a surplus, but we are predicting that we will be in the red in two years from now.

Q. Okay. And what does that mean that you will be in the red in two years?

A. We will have a budget deficit.

Q. Would that indicate that BMS would have to cut existing services?

MS. BORELLI: Object to form.

A. We would either have to cut existing services or receive additional appropriations from the legislature to continue services of this.

Q. Based on the existing budget, would Medicaid have to add funds to cover transgender surgeries?

MS. BORELLI: Object to form.

A. We would have to add dollars in order to cover

it ongoing. We have a surplus this year, but for it to be ongoing services, because services don't end, they're not one-time services, we would have to add dollars.

Q. Okay. And does Medicaid have funds to add those dollars ongoing?

MS. BORELLI: Object to form.

A. We do not have the extra funds for that right now, no.

Q. Okay. Now let me ask you this, if CMS were to mandate the coverage of the transgender surgeries, do you know whether CMS would then provide some federal dollars to assist with those surgeries?

MS. BORELLI: Object to form.

A. They would provide the FMAP which we've discussed which is like the 3 to 1 match, you know, because it would be a mandated service and it's a partnership, so typically, you know, we'll come up with a quarter, they'll give us the 75.

Q. So if CMS mandated coverage for the transgender surgery, it's your understanding that CMS would provide 75 percent of the cost of that and the state would only pay a quarter of that?

MS. BORELLI: Object to form.

A. Correct, and that's based on our FMAP.

Q. All right. Thank you. That's all the questions

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

I hereby certify that I reported the Zoom deposition of Commissioner Cynthia Beane on the 29th day of March 2022, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was reserved.

WITNESS MY HAND AND SEAL THIS 29th day of March 2022.

Kelley E. Zilles, RPR
Notary Public, Washington County, Minnesota
My commission expires 1-31-2025

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096149
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/29/2022
WITNESS' NAME: Commissioner Cynthia Beane

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

05/04/2022 Cynthia Beane
Date Commissioner Cynthia Beane

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 4th day of May, 2022.

Kimberly M. O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Exhibit 07

DEFENDANTS' EIGHTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

1. Documents sufficient to show the total annual number of West Virginia Medicaid participants.

SUPPLEMENTAL RESPONSE: ***See*** **Managed Care and Fee for Service Monthly Enrollment Report 2021, attached as Exhibit 126, (Bates No. DHHRBMS020684), and**

Managed Care and Fee for Service Monthly Enrollment 2022 (through March), attached as Exhibit 127, (Bates No. DHHRBMS020685).

7. If Defendants contend that the Exclusion of Gender-Confirming Care is supported by any governmental interest not encompassed in the Requests above, all Documents supporting that contention.

SUPPLEMENTAL RESPONSE: *See* budget-related documents attached as Exhibits 128 to 171, Bates Nos. DHHRBMS020686 - DHHRBMS021559. Exhibit 171 is an updated version of the six year projection previously produced as Exhibit 85.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 22nd day of March, 2022, a true and exact copy of **DEFENDANTS' EIGHTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lambdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

CONFIDENTIAL

West Virginia Medicaid
Managed Care and Fee for Service
Monthly Report 2021

Managed Care	January	February	March	April	May	June	July	August	September	October	November	December
Aetna Better Health of WV	156,874	158,680	154,992	161,014	162,627	163,703	164,655	165,405	166,161	167,391	168,354	169,308
The Health Plan	107,994	109,485	106,440	111,926	112,953	113,955	115,228	116,085	116,909	118,230	119,141	120,196
Unicare	174,119	176,084	171,940	178,867	180,488	181,514	182,632	183,469	184,292	185,591	186,665	187,788
Total	**438,987**	**444,249**	**433,372**	**451,807**	**456,068**	**459,172**	**462,515**	**464,959**	**467,362**	**471,212**	**474,160**	**477,292**
Mountain Health Promise	**24,070**	**21,051**	**24,162**	**24,591**	**25,269**	**25,419**	**25,533**	**25,689**	**26,063**	**26,459**	**26,862**	**27,108**
Fee For Service	**110,816***	**111,602***	**126,289***	**112,976***	**111,301***	**111,640***	**111,288***	**112,643**	**114,753**	**114,352**	**114,576**	**114,291**
Total	**573,873**	**576,902**	**583,823**	**589,374**	**592,638**	**596,231**	**599,336**	**603,291**	**608,178**	**612,022**	**615,598**	**618,691**

*During the COVID-19 crisis, WV Medicaid has allowed individuals who were eligible in March 2020 to remain covered, even if ineligible, to help prevent any gaps in care. The increase in enrollment is not attributed solely to new applicants, but due to multiple policy changes made during this time.

Exhibit
08

EXHIBIT
126

DHHRBMS020684

West Virginia Medicaid Managed Care and Fee for Service Monthly Report 2022

CONFIDENTIAL

Managed Care	January	February	March	April	May	June	July	August	September	October	November	December
Aetna Better Health of WV	170,450	171,280	171,965									
The Health Plan	121,163	121,976	122,834									
Unicare	188,894	189,815	190,699									
Total	**480,507**	**483,071**	**485,498**									
Mountain Health Promise	**27,310**	**27,583**	**28,018**									
Fee For Service	**114,072**	**115,215**	**115,309**									
Total	**621,889**	**625,869**	**628,825**									

*During the COVID-19 crisis, WV Medicaid has allowed individuals who were eligible in March 2020 to remain covered even if ineligible, to help prevent any gaps in care. The increase in enrollment is not attributed solely to new applicants but due to multiple policy changes made during this time.

Exhibit 09

EXHIBIT 127

DHHRBMS020685

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL;BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Exhibit 13

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' THIRD SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

DOCUMENT REQUESTS

27 [sic]. To the extent not already produced, Documents sufficient to indicate the number of claims submitted annually involving the diagnosis and/or treatment of gender dysphoria, the number of such claims that were denied, and whether the denials were based in whole or in part on the Exclusion.

SUPPLEMENTAL RESPONSE:

Please see the spreadsheet attached that is Exhibit 95, Bates No. DHHRBMS016178, containing claims for Diagnoses codes: F64.0, F64.2, F64.8 and F64.9. Please note that, for all "MCO" claims as reflected in column "A," an entry of "denied" in column "X" simply means that such claim was presented to the MCO, and BMS does not have information about the outcome of that claim, and it would need to be obtained from the particular MCO. BMS only has outcomes for claims that are "fee for service," as indicated as "FFS" in column "A."

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 3rd day of February, 2022, a true and exact copy of **DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' THIRD SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
(404) 897-1880
(404) 506-9320 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson,
individually and on behalf of all others
similarly situated,

Exhibit
14

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Defendants.

DEFENDANTS' SECOND SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

SUPPLEMENTAL RESPONSE: Without waiving prior objections, and in addition to the individuals previously disclosed, these defendants state as follows:

Cynthia Beane, Commissioner for the Bureau for Medical Services;

Sarah Young, Deputy Commissioner for Policy Coordination and Operations; and

Brian Thompson, Director of Pharmacy Services

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esq. (WVSB #6558)
Roberta F. Green, Esq. (WVSB #6598)
Caleb B. David, Esq. (WVSB #12732)
Kimberly M. Bandy, Esq. (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson,
individually and on behalf of all others
similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 25th day of March, 2022, a true and exact copy of ***Defendants' Second Supplemental Response To Plaintiff's First Set Of Interrogatories To Defendants William Crouch, Cynthia Beane, And West Virginia Department Of Health And Human Resources, Bureau For Medical Services*** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
65 E. Wacker Pl, Suite 2000
Chicago, IL 60601
Counsel for Plaintiffs
(312) 663-4413
(312) 663-4307
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Exhibit 19

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS FIFTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE:

Please see documents obtained from Unicare regarding plaintiff, Christopher Fain which include an Excel Spreadsheet, marked as Exhibit 93, Bates No. DHHRBMS016080, and documents marked as Exhibit 94, Bates No. DHHRBMS016081 -016177. Please note, two Excel Spreadsheets were provided by Unicare that contained PHI for other participants which could not be redacted, and therefore, it is not being provided. The spreadsheets are titled, "West Virginia Member Claims—01/01/2016 through Current, Diagnosis F640 through F649 in any position" identified as "102721_Gender Dysphoria claims," and "West Virginia Member Claims—01/01/2016 through Current, Diagnosis F640 through F649 in any position" identified as "102721_Gender Dysphoria claim lines." This information can be obtained by Plaintiffs directly from Unicare.

3. Taking necessary steps to comply with applicable privacy laws and making all necessary

redactions to protect any personal health information. Documents in electronic, delimited, and importable format (e.g., excel spreadsheet) sufficient to show number of individuals who have requested coverage for Gender-Confirming Care, the number of claims each individual has made for Gender-Confirming Care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the Exclusion.

SUPPLEMENTAL RESPONSE:

Please see the Excel spreadsheet marked Exhibit 95, Bates No. DHHRBMS016178, containing claims for Diagnoses codes: F64.0, F64.2, F64.8 and F64.9. Please note that, for all "MCO" claims as reflected in column "A," an entry of "denied" in column "X" simply means that such claim was presented to the MCO, and BMS does not have information about the outcome of that claim, and it would need to be obtained from the particular MCO. BMS only has outcomes for claims that are "fee for service," as indicated as "FFS" in column "A."

7. If Defendants contend that the Exclusion of Gender-Confirming Care is supported by any governmental interest not encompassed in the Requests above, all Documents supporting that contention.

SUPPLEMENTAL RESPONSE: Please see information and communications from CMS regarding mandatory coverage, which does not include gender-confirming care, marked as Exhibit 96, Bates No. DHHRBMS016179 - 016223.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 3rd day of February, 2022, a true and exact copy of **DEFENDANTS FIFTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lambdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Ted Cheatham
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 19-003

Re: Changes to Modified Adjusted Gross Income (MAGI)-based Income Methodologies

Exhibit 20

August 22, 2019

Dear State Health Official:

The purpose of this letter is to provide guidance to explain several legislative changes to the modified adjusted gross income (MAGI)-based methodologies used for determining Medicaid and CHIP eligibility. These changes stem from the following pieces of legislation: the Tax Cuts and Jobs Act (Pub. L. No. 115-97, "TCJA"), enacted on December 22, 2017; the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123, "BBA of 2018"), enacted on February 9, 2018; and the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (Pub. L. No. 115-120, "HEALTHY KIDS Act"), enacted on January 22, 2018. This guidance provides states with information on how to implement these legislative requirements, consistent with titles XIX and XXI of the Social Security Act ("Act"), for individuals whose financial eligibility is determined using MAGI-based methodologies.

Background

Section 1902(e)(14) of the Act requires that state Medicaid agencies generally use "modified adjusted gross income" and "household income," as defined at section 36B(d)(2) of the Internal Revenue Code of 1986 (the IRC) to determine Medicaid eligibility. Section 2107(e)(1)(H) of the Act requires that MAGI and household income also be used to determine eligibility for the Children's Health Insurance Program (CHIP). For purposes of Medicaid and CHIP eligibility, we refer to these definitions collectively as "MAGI-based methodologies." MAGI-based methodologies for Medicaid and CHIP are implemented in the regulations at 42 CFR 435.603 and 457.315, respectively.[1]

In general, the calculation of MAGI-based income includes all taxable earned and unearned income minus certain expenses such as student loan interest or IRA contributions that are deductible in determining an individual's adjusted gross income (AGI) for federal income tax purposes. Three items must be added to adjusted gross income to determine an individual's MAGI (i.e., *modified* AGI): non-taxable foreign earned income, tax-free interest, and non-taxable Social Security benefits. There are a few discrete ways in which MAGI-based

[1] Certain individuals are exempt from application of MAGI-based financial methodologies. Generally, these include individuals whose eligibility is being determined on the basis of being age 65 or older, living with a disability or blindness or needing long-term services and supports; and individuals for whom the state does not apply an income test. A more detailed description of individuals for whom MAGI-based methodologies do not apply can be found in regulations at 42 CFR 435.603(j).

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DHHRBMS016179

methodologies used for Medicaid and CHIP differ from the definition of MAGI and household income in the IRC. For example, MAGI-based methodologies for treatment of irregular income received as a lump sum is different than the treatment of lump sum income under section 36B of the IRC. These differences are set forth in regulations at 42 CFR 435.603(e).

Identifying the members of an individual's household is important to determine the individual's total household income and family size. Under 42 CFR 435.603(f), for individuals intending to file a tax return as well as the individuals they claim as tax dependents, the MAGI-based household generally consists of the tax filer and his or her tax dependents. For individuals who are not tax filers or tax dependents, "non-filer" rules set forth in 42 CFR 435.603(f)(3) are used to determine the MAGI-based household. Under the non-filer rules, an individual's household generally consists of the family members, if living with the individual: the individual; the individual's spouse, if married; the individual's children (including step children); and, if the individual is a child, his/her parent(s) and sibling(s). The non-filer rules also are used for children and tax dependents in certain living situations, as described in 42 CFR 435.603(f)(2)(i)-(iii).

Once the composition of an individual's household has been established, additional rules are applied to determine whose income is counted in household income. Generally, the income of a tax dependent in a household is not counted unless it is expected that the dependent will be required to file a federal tax return – i.e., the income of the dependent is at or above the tax-filing thresholds for tax dependents under the IRC. Under regulations at 42 CFR 435.603(d)(2), the income of children in non-filing households also generally is excluded from household income unless a child's income meets the federal tax filing threshold.[2]

The TCJA, the BBA of 2018 and the HEALTHY KIDS Act each amended the Act as well as tax rules under the IRC in several ways, which impact the MAGI-based methodologies for Medicaid and CHIP. The following discussion explains the changes brought about by these new laws.

Changes to Tax Filing Thresholds

In 2017, a single tax dependent under age 65 and not blind met the federal tax filing threshold if he or she had $6,350 or more of gross income or $1,050 or more of unearned income. Gross income includes both earned and unearned income. This meant that, generally, for a child with unearned income below $1,050 and gross income below $6,350, none of the child's income would be included in determining household income. In contrast, all of the income of a child with unearned income equal to or greater than $1,050 or total gross income equal to or greater than $6,350 generally would be counted in household income.

[2] Under MAGI-based methods, a child's income is always counted when the child is the only person in his/her MAGI-based household (or is living with his/her sibling(s)), regardless of whether or not the child's income exceeds the filing threshold. For example, the child's income is counted in the case of a child living with his or her grandparent(s) and neither parent is living with them nor claiming the child as a tax dependent. 42 CFR 435.603(d)(1)

The TCJA modified the tax filing threshold for most individuals. For tax year 2018, single tax dependents who are under age 65 and not blind must file a federal tax return if any of the following apply for the tax year:[3]

1. Unearned income is more than $1,050;
2. Earned income is more than $12,000;
3. Gross income is more than the larger of –
    a. $1,050; or
    b. Earned income (up to $11,650) plus $350.

Further, the filing threshold is increased for tax dependents who are age 65 or older or who are blind. For tax year 2018, single tax dependents who are age 65 or older and/or who are blind must file a federal tax return if any of the following apply for the tax year:

1. Unearned income is more than $2,650 ($4,250 if 65 or older and blind);
2. Earned income is more than $13,600 ($15,200 if 65 or older and blind);
3. Gross income is more than the larger of –
    a. $2,650 ($4,250 if 65 or older and blind); or
    b. Earned income (up to $11,650) plus $1,950 ($3,550 if 65 or older and blind).

Attachment A includes a table comparing the 2017 and 2018 tax filing thresholds. The IRS updates the standard deduction and filing thresholds annually for inflation.

Impact on Household Composition

For years prior to 2018, tax filers were allowed a deduction for each of their personal exemptions, including their tax dependents. The TCJA reduced the personal exemption deduction amount to $0 for tax years 2018 through 2025, meaning that tax filers will no longer claim a deduction for their tax dependents on their federal tax return. Although taxpayers will no longer claim personal exemption deductions, they must still claim their dependents on their tax return by putting the name and Social Security Number of the dependent on the return to be eligible for certain tax benefits such as the dependent care credit and the premium tax credit for the child's health insurance coverage. Claiming dependents also remains relevant for determining household composition under the MAGI-based methodologies used by Medicaid and CHIP. Thus, there is no change to the rules governing household composition under 42 CFR 435.603(f) for purposes of making MAGI-based eligibility determinations.[4]

Changes to Countable Income

In addition to the changes noted above, the BBA of 2018 and TCJA made several changes to the taxability of certain items, which similarly impact MAGI-based methodologies.

[3] See IRS Publication 501, Table 2. https://www.irs.gov/pub/irs-pdf/p501.pdf.
[4] See: https://www.irs.gov/pub/irs-drop/n-18-84.pdf.

Counting of Qualified Lottery and Gambling Winnings in MAGI-based Methods

Under 42 CFR 435.603(e)(1) of the current regulations describing the MAGI-based methodologies, non-recurring income received as a lump sum is generally counted (if it is taxable) as income only in the month received; if not spent, the money converts to savings, which is a resource.[5] Section 53103 of the BBA of 2018 supersedes this regulatory rule in the case of "qualified lottery winnings" and "qualified lump sum income" (i.e., gambling) of $80,000 or greater. Specifically, section 53103, which added paragraph (K) to section 1902(e)(14) of the Act, requires that covered lottery and gambling winnings of $80,000 or greater, which are received in a single payout, be counted not only in the month received, but over a period of up to 120 months. The statute provides a formula for determining this period, depending on the amount of the winnings. States must apply this formula to qualified lottery or gambling winnings received beginning on or after January 1, 2018.

Qualified Lottery Winnings. Under section 1902(e)(14)(K)(v) of the Act, the term "qualified lottery winnings" is defined as "winnings from a sweepstakes, lottery, or pool" described in section 4402 of the IRC (which generally requires that these particular activities be conducted by a state agency or under the authority of state law), or winnings from "a lottery operated by a multistate or multijurisdictional lottery association." Multijurisdictional lotteries include those that include multiple entities of government.

While lottery winners generally have a choice between receiving a single payment or an annuity that pays out in installments over a period of time (often in annual payments over 20 or 30 years), the definition of "qualified lottery winnings" in section 1902(e)(14)(K)(v) by its own terms applies to the single payout option. Lottery winnings paid out in installments are not required to be considered "qualified lottery winnings" under the statute, and we do not think that interpreting the term to include such winnings would be consistent with the purpose of the statute. In our analysis of the potential impact of the formula for qualified lottery winnings on an annuity paid in installments, we found through many permutations of winnings that some individuals could have winnings counted for a shorter time and others for a longer time under the formula as compared to existing MAGI-based income counting. Due to the complexity of various lotteries, payment amounts and scenarios, and in the absence of rulemaking to implement this law, at this time we are not interpreting the definition of "qualified lottery winnings" beyond the plain language of the statute. Therefore, lottery winnings paid out in installments would be treated the same as other types of recurring income under 42 CFR 435.603(e).[6]

With respect to non-cash prizes, like a car or boat, the statute does not clearly specify whether such prizes are considered "qualified lottery winnings" under section 1902(e)(14)(K)(v) of the Act. As an example, the winner of a sweepstakes may be awarded a boat, which is appraised at a value of $110,000. Unlike a cash prize, however, a non-cash prize like the boat will begin to depreciate immediately. Depending on the length of time that elapses between receipt and sale

[5] There is one exception to this rule in the case of beneficiaries who receive lump sum income in a state that has elected the option to use projected annual household income for current beneficiaries under 42 CFR 435.603(h)(2).
[6] To address the fluctuations in monthly income of a lottery winner receiving annual annuity payments, under MAGI-based rules at 42 CFR 435.603(h)(3), states currently may elect an option to account for "reasonably predictable future income" by prorating lottery payments over a 12-month period to determine an average current monthly income for Medicaid and CHIP.

of the item, the fair market value could be considerably less than the original appraised value. Therefore, we believe that non-cash prizes should continue to be counted as lump sum income in the month in which they are received and not counted as "qualified lottery winnings".

Qualified Lump Sum Income. Section 1902(e)(14)(K)(vi) of the Act defines "qualified lump sum income" as "income that is received as a lump sum from monetary winnings from gambling." Under this statute, the Secretary has discretion to define "gambling," except that the activities described in 18 U.S.C 1955(b)(4) must be included in the definition. These activities include: betting pools; wagers placed through bookmakers; slot machines; roulette wheels; dice tables; lotteries; and bolita or numbers games, or the selling of chances therein. The Secretary will consider other activities proposed by one or more states to be included in the definition of gambling. Absent a determination by the Secretary that inclusion of other activities in the definition of gambling is appropriate, states may not include any other activities. Because the statute specifically defines qualified lump sum income as "*monetary* winnings from gambling" (emphasis added), non-cash prizes are not counted as qualified lump sum income for the purposes of section 1902(e)(14)(K) of the Act

Formula for Counting Qualified Winnings. For qualified winnings from lotteries or gambling activities occurring on or after January 1, 2018, states must count the winnings according to the following formula:

Winnings less than $80,000 are counted in the month received;

- Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and
- For every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income.

The maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. A table showing the amount of monthly income attributed to increasing amounts of qualified winnings and the number of months over which the winnings is counted appears in Attachment B.

Treatment of Winnings for Other Household Members. Under section 53103(b)(2) of the BBA of 2018, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individuals receiving the winnings. The determination of household income for other members of the individual's household are not affected. Thus, for example, the total amount of qualified lottery or gambling winnings of a spouse or parent continues to count only in the month received in determining the eligibility of the other spouse and children.

Verification of lottery and gambling winnings. Under regulations at 42 CFR 435.940 through 435.952 and 457.380, states may accept self-attestation or require other verification of lottery and gambling winnings. If a state requires other verification, per regulations at 42 CFR 435.952(c), the agency must first access available electronic data sources (such as a state lottery winner database, if available) and may accept self-attestation of lottery and gambling winnings before requesting documentation from the individual.

Hardship exemption. Section 1902(e)(14)(K)(iii) of the Act requires that states establish an "undue medical or financial hardship" exemption, through a procedure and based on a standard established by the state, in accordance with guidance provided by the Secretary, for individuals impacted by the new treatment of lottery and gambling winnings. Pending further guidance from the Secretary, states should develop a procedure and establish a reasonable standard for this hardship exemption.

State responsibilities to ineligible applicants and beneficiaries. Applicants and beneficiaries affected by the counting of lottery or gambling winnings maintain the ability to request a determination on a non-MAGI basis, as described at 42 CFR 435.911. Individuals determined financially ineligible for Medicaid or CHIP due to lottery or gambling winnings also have the right to purchase health coverage through a Qualified Health Plan (QHP) on the Exchange and, if eligible, claim a premium tax credit (PTC) for such purchase. Section 1902(e)(14)(K)(iv) of the Act addresses certain state responsibilities to such applicants and beneficiaries, related to notices and technical assistance. The Act specifies that the state agency provide notice to affected individuals of the date on which the lottery or gambling winnings no longer will be counted for the purpose of Medicaid or CHIP eligibility. States also must notify affected individuals of the hardship exemption. In addition, the Act requires states to "inform the individual of the individual's opportunity to enroll in" a QHP on the Exchange, which states meet through implementation of notices regulations at 42 CFR 435.917, 435.1200(e) and 457.340(e).

Section 1902(e)(14)(K)(iv)(II) requires states to "provide technical assistance to the individual seeking to enroll in" a QHP. Consistent with coordination regulations at 42 CFR 435.1200(e) and 42 CFR 457.350(i), the state agency takes appropriate action to transfer the electronic account of an individual financially ineligible for Medicaid or CHIP to the Exchange.[7] Inasmuch as the existing account transfer procedures that states use under the coordination regulations afford individuals needed assistance and provide the opportunity to enroll in appropriate coverage, such existing procedure satisfy the requirement to provide technical assistance.

MAGI Exclusion of Parent Mentor Compensation

Section 3004 of the HEALTHY KIDS Act extended the outreach and enrollment grant program for children who are eligible for, but not enrolled in, Medicaid or CHIP. Section 2113(f)(1)(E) of the Act provides that national, state, local, or community-based public or nonprofit private organizations that use parent mentors, are eligible to receive such grants. A "parent mentor," defined in section 2113(f)(5) of the Act, is a parent or guardian of a Medicaid or CHIP-eligible child who is "trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children."

[7] Qualified lottery and gambling winnings are subject to federal income taxation in the year received. Because PTC for subsidized purchase of a QHP is based on taxable income during the tax year, if the amount of winnings results in individuals losing Medicaid or CHIP eligibility and their household income, including the lottery or gambling winnings, exceeds the income limit for PTC (400 percent of the federal poverty level (FPL)), those individuals will not qualify for a subsidized health plan for the year in which the winnings are received. However, because section 1902(e)(14)(K) of the Act applies only to MAGI-based methods for Medicaid and CHIP, such winnings will not be counted in subsequent years for purposes of eligibility for the PTC for purchase of coverage through the Exchange.

In order to protect parent mentors from losing eligibility for Medicaid, section 3004 of the HEALTHY KIDS Act amends section 1902(e)(14) of the Act to exclude parent mentor compensation from their MAGI-based household income. New paragraph (J) provides that "[a]ny nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor" in a grant-funded program under section 2113 of the Act "shall be disregarded for purposes of determining income eligibility of such individual for medical assistance." The disregard of parent mentor income applies only in the case of parent mentors working with a grantee organization under section 2113 of the Act.

Nominal amounts paid as a stipend to a parent mentor are excluded from income. For payments received as wages or other compensation, states have discretion to determine the threshold of a "nominal amount." CMS will alert states if a grant is awarded under section 2113 of the Act in which the grantee plans to use parent mentors. We will be available to work with those states and grantees to establish a process for applicants and beneficiaries to identify parent mentor income that is not counted in determining eligibility under section 1902(e)(14)(J) of the Act.

Alimony Received

Prior to enactment of the TCJA, alimony as defined in IRC section 71 was considered taxable income to the recipient. Section 11051 of the TCJA modified the alimony rules. Under the TCJA, alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not included in the income of the recipient. For individuals with alimony agreements finalized on or before December 31, 2018, alimony continues to be included in the income of the recipient for the duration of the agreement unless or until the agreement is modified. Treatment of alimony paid is discussed below. The treatment of child support is unchanged: child support is not included in the income of the recipient and thus not counted in MAGI-based income.

Discharged Student Loan Debt

Student loan debt that is discharged, forgiven or cancelled is generally treated as taxable income to the borrower, and therefore the amount of discharged debt is included in MAGI-based income.[8] However, section 11031 of the TCJA amended section 108(f) of the IRC to provide an exception for tax years 2018 through 2025 in cases of discharged debt on account of the death or permanent and total disability of the student. Under the amendment, discharged student loan debt is not included in income (and not counted in the MAGI-based income) of a borrower if the debt is discharged on account of the death or the permanent and total disability of the student. (The borrower and the student may or may not be the same person.) Student loan debt discharged under the foregoing circumstances is not counted as income in determining household income for other members of the borrower's household.

Changes to Deductions

[8] A notable exception is the Public Service Loan Forgiveness program and certain teacher loan/healthcare loan forgiveness programs, which do not lead to taxable income (26 USC 108(f)(1)).

As noted above, certain deductions are allowed under the IRC in determining adjusted gross income, upon which MAGI is based. The TCJA eliminated several of these deductions.

Moving Expenses

Section 11049 of the TCJA, amending section 217 of the IRC, eliminated the deduction for qualified moving expenses for tax years 2018 through 2025. Moving expenses, including expenses incurred by the individual as well as reimbursements from an employer, should no longer be deducted in calculating MAGI. This change does not apply to active duty members of the military who are ordered to move or change duty station.

Alimony Paid

Under the TCJA, alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not deductible by the payer. For individuals with alimony agreements finalized on or before December 31, 2018, alimony payments continue to be deductible. Child support payments remain non-deductible.

Tuition and Fees Deduction

The payment of tuition and fees for qualified education expenses for postsecondary education had been an allowable deduction. Amounts paid for these expenses for the taxpayer, spouse or tax dependent typically could be deducted in computing adjusted gross income. Section 40203 of the BBA of 2018 amended section 222(e) of the IRC to eliminate this deduction, effective January 1, 2018. Such tuition and fees paid are no longer deductible in calculating MAGI, effective January 1, 2018.

The tuition and fees deduction is separate and distinct from the exclusion of scholarships, awards or fellowships used solely for educational purposes from MAGI for purposes of Medicaid and CHIP eligibility. This exclusion, which also applies for determining MAGI under the IRC, remains in effect under the Medicaid regulations at 42 CFR 435.603(e)(2) and CHIP regulations at 42 CFR 457.315.

State Requirement to Report Enrollment in MEC

Under Section 6055 of the IRC, states are required to provide Medicaid and CHIP beneficiaries with IRS Form 1095-B, indicating that the beneficiary had minimum essential coverage (MEC) for the tax year. States also must provide this information to the IRS. Under section 5000A of the IRC, individuals not enrolled in MEC and not exempt are subject to a "shared responsibility payment." The TCJA reduced the shared responsibility payment to $0 beginning in tax year 2019. However, it did not eliminate the requirement for states to furnish Form 1095-B or to provide information about Medicaid and CHIP enrollment to IRS. Therefore, states must continue to send Forms 1095-B for Medicaid and CHIP coverage for tax year 2019 and beyond. If there is any change to these reporting requirements, CMS will communicate the changes to states.

Operational Considerations

In order to implement the changes to MAGI-based methods described in this letter, states may need to make updates to eligibility policies and procedures and changes to eligibility systems logic. In addition, states will need to be able to collect the relevant application information in order to make accurate Medicaid and CHIP determinations. Capturing the information may involve changes to applications and other forms, additional instructions or help text, or new application questions. In order to implement needed systems changes, and in accordance with 42 CFR 433.112(b)(14), states may request enhanced 90 percent federal financial participation for eligibility technology investments funded through an approved Advanced Planning Document. CMS remains available to provide technical assistance to states on implementation of such changes to ensure that states are able to make the changes as soon as possible.

We hope this information will be helpful. Questions and comments about the changes to MAGI-based methodologies discussed in this bulletin may be directed to Stephanie Kaminsky, Director, Division of Medicaid Eligibility Policy, CMCS, at Stephanie.Kaminsky@cms.hhs.gov. Requests for technical assistance on revisions to the state's application and renewal processes needed to implement the changes to MAGI-based methodologies may be directed to Jessica Stephens, Director, Division of Enrollment Policy and Operations, CMCS, at Jessica.Stephens@cms.hhs.gov.

Sincerely,

Calder Lynch
Deputy Administrator and Director

Enclosures

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Attachment A –
Tax Filing Thresholds

	2017 Tax Filing Thresholds	2018 Tax Filing Thresholds
Personal Exemption Amount	$4,050[9]	$0
Standard Deduction for most people[10]	$6,350 (gross) - single	$12,000 (gross) - single[11]
Tax filing threshold for single tax dependent[12]	$1,050 unearned; or $6,350 earned; or Gross income is more than the larger of: • $1,050; or • Earned income (up to $6,000) plus $350	$1,050 unearned; or $12,000 earned; or Gross income is more than the larger of: • $1,050; or • Earned income (up to $11,650) plus $350
Tax dependents > 65 or blind	$2,600 unearned; or $7,900 earned; or Gross income is more than the larger of: • $2,600; or • Earned (up to $6,000) plus $1,900	$2,650 unearned; or $13,600 earned; or Gross income is more than the larger of: • $2,650; or • Earned income (up to $11,650) plus $1,950
Tax dependent > 65 and blind	$4,150 unearned; or $9,450 earned; or Gross income is more than the larger of: • $4,150; or • Earned (up to $6,000) plus $3,450	$15,200 earned $4,250 unearned income Gross income is more than the larger of: • $4,250; or • Earned income (up to $11,650) plus $3,550

[9] See IRS Pub 17, Chapter 3; and Pub 501.
[10] For individuals who are under age 65, not blind, not head of household and no one else can claim individual as a dependent. See IRS Pub 17, Table 20-1 (2017) and Table 21-1 (2018); and IRS Pub 501, Table 6.
[11] To be increased annually for inflation. See Internal Revenue Bulletin 2018-10 (March 5, 2018).
[12] For individuals under age 65 and not blind. See IRS Pub 501, Table 2.

Attachment B –
Lottery and Gambling Winnings:
Months over which Income is Counted by Income Increment

From $	Up To $	# Months Counted for Medicaid
1	79,999	1
80,000	89,999	2
90,000	99,999	3
100,000	109,999	4
110,000	119,999	5
120,000	129,999	6
130,000	139,999	7
140,000	149,999	8
150,000	159,999	9
160,000	169,999	10
170,000	179,999	11
180,000	189,999	12
190,000	199,999	13
200,000	209,999	14
210,000	219,999	15
220,000	229,999	16
230,000	239,999	17
240,000	249,999	18
250,000	259,999	19
260,000	269,999	20
270,000	279,999	21
280,000	289,999	22
290,000	299,999	23
300,000	309,999	24
310,000	319,999	25
320,000	329,999	26
330,000	339,999	27
340,000	349,999	28
350,000	359,999	29
360,000	369,999	30
370,000	379,999	31
380,000	389,999	32
390,000	399,999	33
400,000	409,999	34
410,000	419,999	35

From $	Up To $	# Months Counted for Medicaid
420,000	429,999	36
430,000	439,999	37
440,000	449,999	38
450,000	459,999	39
460,000	469,999	40
470,000	479,999	41
480,000	489,999	42
490,000	499,999	43
500,000	509,999	44
510,000	519,999	45
520,000	529,999	46
530,000	539,999	47
540,000	549,999	48
550,000	559,999	49
560,000	569,999	50
570,000	579,999	51
580,000	589,999	52
590,000	599,999	53
600,000	609,999	54
610,000	619,999	55
620,000	629,999	56
630,000	639,999	57
640,000	649,999	58
650,000	659,999	59
660,000	669,999	60
670,000	679,999	61
680,000	689,999	62
690,000	699,999	63
700,000	709,999	64
710,000	719,999	65
720,000	729,999	66
730,000	739,999	67
740,000	749,999	68
750,000	759,999	69
760,000	769,999	70

From $	Up To $	# Months Counted for Medicaid
770,000	779,999	71
780,000	789,999	72
790,000	799,999	73
800,000	809,999	74
810,000	819,999	75
820,000	829,999	76
830,000	839,999	77
840,000	849,999	78
850,000	859,999	79
860,000	869,999	80
870,000	879,999	81
880,000	889,999	82
890,000	899,999	83
900,000	909,999	84
910,000	919,999	85
920,000	929,999	86
930,000	939,999	87
940,000	949,999	88
950,000	959,999	89
960,000	969,999	90
970,000	979,999	91
980,000	989,999	92
990,000	999,999	93
1,000,000	1,009,999	94
1,010,000	1,019,999	95
1,020,000	1,029,999	96
1,030,000	1,039,999	97

From $	Up To $	# Months Counted for Medicaid
1,040,000	1,049,999	98
1,050,000	1,059,999	99
1,060,000	1,069,999	100
1,070,000	1,079,999	101
1,080,000	1,089,999	102
1,090,000	1,099,999	103
1,100,000	1,109,999	104
1,110,000	1,119,999	105
1,120,000	1,129,999	106
1,130,000	1,139,999	107
1,140,000	1,149,999	108
1,150,000	1,159,999	109
1,160,000	1,169,999	110
1,170,000	1,179,999	111
1,180,000	1,189,999	112
1,190,000	1,199,999	113
1,200,000	1,209,999	114
1,210,000	1,219,999	115
1,220,000	1,229,999	116
1,230,000	1,239,999	117
1,240,000	1,249,999	118
1,250,000	1,259,999	119
1,260,000	or higher	120

Attachment C –
Frequently Asked Questions:
Changes to Modified Adjusted Gross Income (MAGI)-based Income Methodologies

Lottery and Gambling Winnings

Q1. Can you provide some examples of how lottery and gambling winnings would impact individual applicants and beneficiaries?

A1. Consider the following examples:

1. Sally is enrolled in Medicaid with MAGI-based household income of $1,200 per month. She is single and has no dependents. On New Year's Eve 2018, Sally wins $192,000 playing roulette. How do Sally's gambling winnings impact her MAGI-based income and eligibility for Medicaid?
    a. Using the chart in Attachment B, we see that Sally's winnings of $192,000 are counted in her MAGI-based income for 13 months, including the month in which she receives the winnings. So they are counted in December 2018 through December 2019.
    b. An equal amount of $14,769 is counted in each month ($192,000/13 months = $14,769 per month).
    c. Sally's MAGI-based monthly income for December 2018 through December 2019 is $15,969 ($14,769 gambling winnings + $1,200 other MAGI-based income) assuming no changes to her other MAGI-based income.
    d. Because Sally's income exceeds the state's MAGI-based income standard, the agency would provide Sally with a notice alerting her that she is no longer eligible for Medicaid and her coverage will be terminated following the advance notice period. The notice will also tell Sally that beginning January 1, 2020, her gambling winnings will no longer be counted in her MAGI-based income.
    e. The Medicaid agency will transfer Sally's account to the Exchange. Because she is losing eligibility for Medicaid, she qualifies for a special enrollment period and the Exchange will determine if she is eligible for advanced payments of the premium tax credit.

2. Joe is a single individual who has no dependents. He earns $700 per month and has no other income or deductions. Joe wins a scratch-off ticket paying out $50,000 on May 15, 2019. The following month, Joe applies for Medicaid. How do his lottery winnings impact his MAGI-based income and eligibility for Medicaid?
    a. Using the chart in Attachment B, we see that Joe's lottery winnings are counted in MAGI-based methods for only one month. Because his winnings are less than $80,000, they are counted only in the month received. So the full amount of $50,000 is counted in May of 2019.
    b. When Joe applies for Medicaid in June, his MAGI-based income will be $700 and that will be used to determine his financial eligibility for Medicaid.

Q2. How do lottery and gambling winnings received by parents impact their children's eligibility for Medicaid?

A2. The changes to section 1902(e)(14) of the Act made by the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123, "BBA of 2018") only impact the MAGI-based household income of the individuals who themselves receive the lottery or gambling winnings. Therefore, when determining Medicaid eligibility for a child who lives with a parent, the parent's qualified lottery or gambling winnings would be treated the same as any other lump sum income received and included in the child's MAGI-based income only in the month received, as described at 42 CFR 435.603(e)(1). Consider the following example.

Justine is a single parent who lives with her son, Oscar, who is age 7. Justine and Oscar have monthly MAGI-based income of $2,000 from Justine's job. On April 14, 2019, Justine submits a Medicaid application for Oscar. The following week Justine wins the state lottery and receives a lump sum payment of $755,000. How do Justine's lottery winnings impact Oscar's MAGI-based income and eligibility for Medicaid?

For the month of April, Oscar's MAGI-based household income will be calculated as $755,000 in lottery winnings, plus $2,000 in the other MAGI-based income, for a total monthly income of $757,000 for a family of two. For the month of May, Oscar's MAGI-based income will be $2,000. Justine's lottery winnings would count toward Oscar's MAGI-based income only in the month of April. If Justine applies for Medicaid, using the chart in Attachment B, her winnings of $755,000 would be counted in her MAGI-based income for 69 months (or, 5 years and 9 months), beginning in the month in which she receives the winnings. That is, Justine's winnings would be counted in her MAGI-based income in April 2019 through December 2024. An equal amount of $10,942 would be counted in each month ($755,000/69 months = $10,942 per month).

Q3. Do winnings from any state count under the lottery and gambling winnings methodology?

A3. Yes. Lottery and gambling winnings are treated the same regardless of the state in which they were won. The methodology in section 1902(e)(14)(K) of the Act applies to winnings an individual receives from any state.

Q4. How are multiple instances of gambling winnings counted under the lottery and gambling winnings methodology?

A4. If a Medicaid or CHIP applicant or beneficiary wins monetary winnings from gambling multiple times, the lottery and gambling winnings methodology is applied separately to each instance of winning. Where the amount of months over which winnings are counted overlap, those months are counted concurrently (each instance beginning and ending as per the formula) and the countable income attributed to each month is added together for each month.

Q5. Are gambling losses subtracted from gambling winnings for the purposes of the lottery and gambling winnings methodology?

A5. No. Although there are circumstances in which gambling losses may be deducted from income for the purpose of federal income taxes, gambling losses are not deducted from winnings for the purposes of the lottery and gambling winnings methodology under MAGI-based income methodologies for Medicaid and CHIP.

Q6. How should the "gap-filling" rule at 42 CFR 435.603(i) apply to individuals whose income is counted under the lottery and gambling winnings methodology?

A6. The Medicaid "gap-filling" rule at 42 CFR 435.603(i), promulgated in March 2012, was designed to prevent a potential gap in coverage for low-income individuals caused by the slight differences in the MAGI methodologies used for purposes of premium tax credit (PTC) eligibility and the MAGI-based methodologies used for purposes of Medicaid and CHIP eligibility. Under the gap-filling rule, if an individual's MAGI-based monthly household income for purposes of Medicaid eligibility is above the applicable Medicaid income standard and the individual's MAGI-based annual household income for purposes of PTC eligibility is under 100 percent of the FPL (and ineligible for a PTC due to too little income) the state is required to apply the MAGI methodologies generally used for purposes of PTC eligibility in determining the individual's eligibility for Medicaid.

The different treatment of lottery and gambling winnings under the MAGI methodologies for PTC eligibility versus the MAGI-based methodologies used for Medicaid and CHIP may result in a situation in which an individual's household income for purposes of PTC eligibility in a given year will be under 100 percent FPL, but his or her income applying MAGI-based methodologies (for purposes of Medicaid and CHIP eligibility) will be over the Medicaid and CHIP eligibility thresholds. If applied in this situation, the gap filling rule would result in approval of Medicaid or CHIP eligibility in the year after receipt of the winnings. If applying the lottery and gambling methodology would result in income over the Medicaid eligibility standard, applying the gap-filling rule and determining such an individual eligible would not be consistent with the intended result under the BBA of 2018. We believe that the new statutory provision supersedes the regulatory policy in this situation. Thus, we have determined that states should not apply the gap-filling regulation at 42 CFR 435.603(i) if doing so would result in a determination contrary to the determination reached after applying the lottery and gambling methodology added at section 1902(e)(14)(K) of the Act by the BBA.

Q7. Are states required to keep a record of individuals found ineligible for a period of time due to lottery or gambling winnings?

A7. Per regulations at 42 CFR 431.17 and 435.914(a), states are required to maintain case records on each applicant and beneficiary containing, among other things, facts essential to supporting the agency's denial or termination of eligibility. States are expected to follow their standard recordkeeping protocol when an individual is denied or terminated

due to lottery or gambling winnings, including the period of time such records are maintained. States are not required to establish a separate process specific to individuals denied or terminated from coverage due to lottery or gambling winnings.

When an individual previously denied or terminated from coverage subsequently reapplies for coverage, states typically are able to identify the individual's previous application or enrollment in the state's program. Some states may have ready access to the record of the individual's prior winnings, and such states would be expected to take this information into account in processing the individual's new application. Other states may want to establish a process to maintain a record of the monthly amount of winnings of former applicants and beneficiaries to be counted as income as well as the duration for which that amount is counted.

Other Questions

Below we answer frequently asked questions which are not related to the lottery and gambling winnings methodology discussed in this letter.

Q8. Now that alimony payments are treated differently under MAGI-based methodologies depending on the date that the agreement was consummated or last revised, how can states verify the date of execution of separation or divorce agreements that include provision for alimony?

A8. Under the general verification regulations at 42 CFR 435.945(a) and 435.952(c), states have the flexibility to accept attestation of the date of the finalization or modification of a separation or divorce agreement or to require paper documentation, provided that electronic verification is not available or is inconsistent with the individual's attestation.

Q9. Does the change to the treatment of alimony affect or render obsolete the mandatory eligibility group for extended Medicaid due to increased collection of spousal support (42 CFR 435.115)?

A9. No. The discussion of including alimony in income relates only to MAGI-based methods, and not to any particular MAGI-based eligibility group. In particular, the group for extended Medicaid eligibility based on the increased collection of spousal support remains in effect as described under 42 CFR 435.115.

As noted in the SHO letter, if a separation or divorce agreement (or a modification to a pre-existing agreement) was finalized after December 31, 2018, the alimony payments under the agreement would not be counted in MAGI income and an increase would not trigger the four-month extension of Medicaid eligibility. However, if a separation or divorce agreement was finalized on or before December 31, 2018 (and is not modified thereafter), the alimony payments under the agreement must be included in the income of the recipient. In circumstances in which such alimony income meets the definition of "spousal support" under title IV-D of the Act, and the recipient has an increased collection of such support (e.g., through a scheduled increase, payment of arrears, or

through new collection on an existing support obligation) through the IV-D agency, the family may qualify for the four-month extension of Medicaid eligibility group under 42 CFR 435.115.

Spousal support that does not meet the IRS definition of alimony is not included in income and therefore an increased collection of such support would not trigger the extension under 42 CFR 435.115. The five requirements for spousal support to be alimony are:

1. Payment must be in cash;
2. Payment is received by (or on behalf of) a spouse under a divorce or separation agreement;
3. The divorce or separation instrument does not designate such payment as a payment not includable in gross income and not allowable as a deduction;
4. The payee spouse and the payer spouse are not members of the same household at the time such payment is made; and
5. There is no liability to make any such payment (in cash or property) as a substitute for such payments after the death of the payee spouse.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail
Stop S2-26-12
Baltimore, Maryland21244-1850

SHO# 20-005

RE: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment

December 30, 2020

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance about section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. No. 115-271). To increase access to medication-assisted treatment (MAT) for opioid use disorders (OUD), section 1006(b) of the SUPPORT Act requires states to provide Medicaid coverage of certain drugs and biological products, and related counseling services and behavioral therapy.[1] This State Health Official Letter (SHO Letter) also describes available opportunities for increasing treatment options for substance use disorders (SUD) generally. CMS encourages states to consider these opportunities when implementing the mandatory MAT coverage under section 1006(b) of the SUPPORT Act. The new required benefit is limited to the use of MAT for the treatment of OUD, and thus this SHO Letter is generally focused on that topic, not on treatment services for other SUDs, including alcohol use disorders.

Background

Section 1006(b) of the SUPPORT Act, signed into law on October 24, 2018, amends section 1902(a)(10)(A) of the Social Security Act (the Act) to require state Medicaid plans to include coverage of MAT for all eligible to enroll in the state plan or waiver of state plan. Section 2601 of the Continuing Appropriations Act, 2021 and other Extensions Act, Pub. L. No. 116-159, amended the SUPPORT Act to specify that the rebate requirements in section 1927 shall apply to any MAT drug or biological described under the mandatory benefit to the extent that the MAT drug or biological is a covered outpatient drug. (More information on section 2601 is in the section below entitled, "MAT Drug Coverage and Section 1927 Manufacturer Rebates.") Section 1006(b) also adds a new paragraph 1905(a)(29) to the Act to add the new required benefit to the definition of "medical assistance" and to specify that the new required benefit will be in effect for the period beginning October 1, 2020, and ending September 30, 2025.

In addition, section 1006(b) adds section 1905(ee)(1) to the Act to define MAT, for purposes of the new required coverage, as:

> . . . all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section

[1] SUPPORT for Patients and Communities Act, Pub. L. No. 115–271 (2018), https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf.

351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and[,] . . . with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

CMS interprets section 1905(ee)(1) of the Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. Currently, the FDA has approved the following drugs used for MAT to treat OUD: methadone, buprenorphine, and naltrexone.[2] Only those formulations of drugs or biologicals that are approved or licensed by the FDA for MAT to treat OUD must be covered under the new mandatory Medicaid benefit. There are currently no FDA-licensed biological products to treat OUD.[3]

Medication-Assisted Treatment

While states are required to cover all drugs and biologicals approved or licensed by the FDA used for MAT to treat OUD under the new mandatory benefit, various considerations affect which medication should be provided to a particular patient.[4]

- Methadone is a long-acting synthetic opioid agonist medication with a long history of use in treatment of OUD in adults. Methadone is indicated for the detoxification treatment of opioid addiction as well as maintenance treatment of opioid addiction in conjunction with appropriate social and medical services.[5]

  Methadone for treatment of OUD must be administered by an Opioid Treatment Program (OTP). Currently, solid (non-dispersible) and dispersible tablets, as well as the liquid concentrate, are labeled for use in such outpatient OUD therapy. These products cannot be dispensed from a pharmacy for the purpose of treating OUD. OTPs must have a current, valid certification from the Substance Abuse and Mental Health Services Administration (SAMHSA) and be accredited by an independent, SAMHSA-approved accrediting body.[6] Effective January 1, 2020, the Medicare program began covering and reimbursing OUD treatment services furnished by an OTP.[7]

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[2] U.S. Food and Drug Administration (FDA). Information about Medication-Assisted Treatment (MAT). FDA web site. https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat; Substance Abuse and Mental Health Services Administration (SAMHSA). Medication-Assisted Treatment. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment

[3] "Information about Medication-Assisted Treatment (MAT)," U.S. Food and Drug Administration, last modified February 14, 2019, https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[4] SAMHSA. Office of the Surgeon General. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington (DC). U.S. Department of Health and Human Services. 2016 Nov. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. Available from: https://www.ncbi.nlm.nih.gov/books/NBK424859/.

[5] FDA. Dolophine Highlights of Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/006134s045lbl.pdf

[6] SAMHSA. Certification of Opioid Treatment Programs. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs.

[7] SUPPORT Act, Section 2005, Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs. See also CMCS Informational Bulletin, "Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020" (Dec. 17, 2019), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf

- Buprenorphine is a synthetic opioid medication that acts as a partial agonist, blocking and only weakly activating the opioid receptor, thus blunting the euphoric effects of other opioids for the treatment of OUD.[8]

  Buprenorphine is currently available in several dosage forms, including an oral dissolvable film, sublingual tablet, and injection. It is available as a single ingredient or in combination with naloxone, an antagonist (or blocker) of opioid receptors to prevent attempted misuse by injection. For more information on the FDA approved medications for treatment of OUDs, see SAMHSA's Treatment Improvement Protocol 63 as well as the FDA web site: https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm.[9]

  Long-acting buprenorphine injections are a route of administration that may help to improve patient adherence, may reduce the risk of accidental exposures, theft, or deliberate misuse, and may reduce risks associated with office visits during the COVID-19 pandemic.[10] Sublocade is a once-monthly injection designed to deliver buprenorphine at sustained levels of medication throughout the month.[11]

- Naltrexone is a synthetic opioid antagonist – it blocks opioids from binding to receptors and is FDA-approved for the prevention of relapse to opioid dependence, following opioid detoxification. Naltrexone is well-tolerated following detoxification. It has no potential for abuse, and it is not addictive.[12] Long-acting injectable naltrexone is FDA-approved with recommended dosing once every four weeks[13] for maintenance of abstinence.[14] Naltrexone can be prescribed by any clinician who is licensed in the state to prescribe medications.[15,16]

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[8] FDA. Subutex Highlights of Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020732s018lbl.pdf

[9] SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020. https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

[10] Volkow ND. Collision of the COVID-19 and Addiction Epidemics. Ann Intern Med. 2020; 173(1):61-62. doi:10.7326/M20-1212

[11] Crist, Richard C et al. Pharmacogenetics of Opioid Use Disorder Treatment. *CNS drugs*. 2018; vol. 32 (4): 305-320. doi:10.1007/s40263-018-0513-9.

[12] National Institute on Drug Abuse. (2018, January 17). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies.

[13] FDA. ReVia Highlights of Prescribing Information.https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf

[14] Tanum L, Solli KK, Latif ZE, Benth JŠ, Opheim A, Sharma-Haase K, Krajci P, Kunøe N. Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial. JAMA Psychiatry. 2017 Dec 1;74(12):1197-1205. doi: 10.1001/jamapsychiatry.2017.3206. Erratum in: JAMA Psychiatry. 2018 Mar 14;75(5):530. PMID: 29049469; PMCID: PMC6583381.

[15] SAMHSA. Naltrexone. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone.

[16] We note that in addition to the MAT drugs listed here that are required to be covered for management of opioid dependency under the new benefit at section 1905(a)(29) of the Act, states that provide optional coverage of prescribed drugs under section 1905(a)(12) must do so consistent with sections 1902(a)(54) and 1927, which require coverage of all drugs and biologicals that satisfy the definition of a covered outpatient drug at sections 1927(k)(2)-(4), if the manufacturer has a national drug rebate agreement in effect. In that some medications not defined as MAT

To address the full scope of patients' treatment needs, section 1905(ee)(1) defines the required MAT benefit as including counseling services and behavioral therapy related to the drugs and biologicals covered under the new mandatory benefit. While states have flexibility to specify which counseling services and behavioral therapy they will include in the new mandatory benefit, states that already cover MAT successfully often cover a range of effective behavioral health services for beneficiaries with OUD receiving MAT, including the following:

- Individual/Group Therapy generally helps patients identify treatment goals and potential solutions to problems that cause emotional stress; seeks to restore communication and coping skills; strengthens self-esteem; and promotes behavior change and optimal mental health. Cognitive behavioral therapy is a type of therapy that has been shown to be successful in treating individuals with OUD.

- Peer Support Services are typically understood to be services in which a qualified peer support provider (also called a recovery coach or peer recovery support specialist) assists individuals with their recovery from substance use disorders, including OUD. Peer support services can also be offered in relation to co-occurring mental disorders and OUD. Services can include counseling on coping with symptoms and navigating early stages of the recovery process; modeling appropriate behavior, skills, and communication; engagement with a supportive community of recovering peers; and helping the person access community resources. CMS has issued guidance that addresses requirements for peer support providers.[17]

- Crisis Intervention Services are typically provided to immediately reduce or eliminate the risk of physical or emotional harm. Services can include evaluation, triage, and access to services; and treatment to effect symptom reduction, harm reduction, and/or safe transition of individuals in acute crisis to the appropriate level of care for stabilization.

MAT Provider Landscape

Section 3502 of the Drug Addiction Treatment Act of 2000[18] amended the Controlled Substances Act (CSA) to permit qualified physicians to receive a waiver of the CSA's separate registration requirements for prescribing and dispensing certain opioid medications, such as buprenorphine, to treat OUD. Because of concerns about the lack of access to OUD treatment, Congress expanded the types of practitioners who are eligible for a waiver to prescribe and dispense buprenorphine to treat OUD. The Comprehensive Addiction and Recovery Act of 2016 allowed nurse practitioners and physician assistants to qualify for a waiver.[19] Additionally,

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may be used to assist in short or long-term treatment success for beneficiaries with OUD, such as medications to treat opioid withdrawal symptoms, CMS would encourage states to focus on optimal patient outcomes in decisions that impact coverage and access.

[17] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf.

[18] Children's Health Act of 2000, Section 3501, Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (2000). https://www.govinfo.gov/content/pkg/PLAW-106publ310/pdf/PLAW-106publ310.pdf.

[19] Comprehensive Addiction and Recovery Act of 2016, Section 303, Medication-assisted Treatment for Recovery from Addiction, Pub. L. No. 114–198, 130 Stat. 69, (2016). https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

section 3201 of the SUPPORT Act[20] extends eligibility for prescribing buprenorphine for the treatment of OUD to clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives until October 1, 2023.

Section 3201 of the SUPPORT Act also expands the eligibility of certain physicians and other qualifying practitioners to treat up to 100 patients in the first year of waiver receipt if they satisfy one of the following two conditions found in regulation:[21]

1) The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology; or

2) The practitioner provides MAT in a "qualified practice setting." A qualified practice setting is one that:

a. Provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
b. Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
c. Uses health information technology systems such as electronic health records in accordance with practice setting requirements;
d. Registers for their state prescription drug monitoring program where operational and in accordance with federal and state law; and
e. Accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

After one year at the 100-patient limit, physicians and qualifying other practitioners who meet the above criteria can apply to increase their patient limit to 275.[22]

Current MAT State Plan Coverage

Currently, all state Medicaid programs cover some form of buprenorphine and extended-release naltrexone for treatment of OUD. In addition, most states also cover some form of the counseling and behavioral therapies that are necessary to provide evidence-based MAT. Methadone is indicated for use as part of an MAT protocol for treating OUD, but also for pain management. When used for treating OUD, methadone can only be administered by OTPs, which must be certified by SAMHSA and registered with the Drug Enforcement Administration (DEA).[23] OTPs must be licensed in the state in which they operate and accredited by a

[20] SUPPORT Act, Section 3201, Allowing for More Flexibility with Respect to Medication-Assisted Treatment for Opioid Use Disorders.
[21] 21 U.S.C. 823(g)(2)(B)(II)(bb) – (cc); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610, 42 C.F.R. 8.615.
[22] 21 U.S.C. 823(g)(2)(B)(II)(dd); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610 – 655.
[23] We note that in contrast, when methadone is used for the treatment of pain, it can be dispensed from pharmacies, which are not able to dispense methadone for OUD unless they are also certified as OTPs.

SAMHSA-approved accrediting body.[24] Additionally, federal regulations at 42 C.F.R. part 8 impose standards governing, for example, required services, staff credentials, patient admission criteria, and patient confidentiality criteria.[25] In a report on the use of medications to treat OUD in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, SAMHSA found that methadone is covered for MAT to treat OUD by Medicaid in 42 of the 53 states and territories included in the report.[26]

Institution for Mental Diseases (IMD) Exclusion

Frequently, MAT-related counseling and behavioral therapy are provided on-site at clinics and health centers where buprenorphine and/or naltrexone are dispensed. Primary care providers who prescribe MAT drugs often partner with local substance use disorder treatment or mental health care agencies to connect individuals to counseling. Federal regulation requires patients who receive treatment in an OTP to receive access to[27] medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication.[28] Medications for MAT, as well as the counseling and behavioral therapies, can also be furnished in inpatient and residential settings such as psychiatric hospitals, inpatient units, or residential treatment programs, including in IMDs, but Medicaid coverage is generally not available unless the setting is not an IMD or an exception to the IMD exclusion applies, as discussed below.

An IMD is defined in section 1905(i) of the Act as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual under age 65 who resides in an IMD. This is commonly known as the "IMD exclusion." The IMD exclusion applies to any care or services provided inside or outside of the facility or hospital to a Medicaid beneficiary residing in an IMD, unless an exception to the IMD exclusion applies. As specifically relevant here, MAT and counseling and behavioral therapies provided in an IMD would not be covered by Medicaid unless an exception to the IMD exclusion applies.

Currently, there are several exceptions to the IMD exclusion and other authorities that permit short-term stays in IMDs. First, Medicaid payment is permitted for inpatient hospital services, nursing facility services, and intermediate care facility services provided in IMDs to individuals age 65 and older.[29] Second, Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the "psych under 21 benefit," furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility."[30]

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[24] SAMHSA. Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose. HHS Publication No. SMA-18-5093, page 39.
[25] 42 C.F.R. 8.12.
[26] SAMHSA. HHS Publication No. SMA-18-5093, page 39. Published November, 2018
[27] SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020. https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
[28] 42 C.F.R 8.12(f)
[29] 42 C.F.R. 440.140
[30] 42 C.F.R. 440.160

Third, section 1012 of the SUPPORT Act, entitled "Help for Moms and Babies," added a new limited exception to the IMD exclusion. For more information, see the CMCS Informational Bulletin, "State Guidance for the New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women, July 26, 2019."[31] Fourth, section 5052 of the SUPPORT Act, entitled, "State option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases," amended the IMD exclusion and established a new section 1915(*l*) of the Act. This provision permits states to cover a state plan option to provide services to Medicaid beneficiaries age 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD. The period of this state plan option is from October 1, 2019 through September 30, 2023. For more information, see State Medicaid Director Letter (SMDL) # 19-0003, Re: Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(*l*) of the Social Security Act, November 6, 2019.[32]

Other authorities that permit short-term stays in IMDs include section 1115 demonstrations. CMS announced a section 1115 demonstration initiative where states can receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids or other substances, including services provided to beneficiaries residing in IMDs. For more information, see section 1115 SUD Demonstrations, SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017.[33] Finally, states may receive FFP for monthly capitation payments for beneficiaries age 21 through 64 receiving SUD treatment in an IMD for a short-term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the managed care regulation are met.[34]

SUPPORT Act Section 1006(b) Coverage

Section 1006(b) of the SUPPORT Act requires states to begin implementing MAT as a mandatory Medicaid state plan benefit for categorically needy populations for the 5-year period beginning October 1, 2020. Under the definition of the new mandatory benefit at section 1905(ee)(1) of the Act, states are required to cover all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat OUDs. CMS interprets the statute to require coverage of all forms of the drugs and biologicals that the FDA has approved or licensed for treatment of OUD. States are also required to cover counseling services and behavioral therapies associated with provision of the required drug and biological coverage.

Exception for Provider Shortage

Section 1905(cc)(2) of the Act provides that states may be excused from the mandatory coverage requirement if, before the requirement takes effect on October 1, 2020, the state "certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of

[31] https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf.
[32] https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf.
[33] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.
[34] 42 C.F.R. 438.6(e)

a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3)."

In CMS's view, the purpose of the new requirement is to increase access to MAT to treat OUD for Medicaid beneficiaries, and this can only be accomplished by increasing the enrollment in Medicaid of OTPs and other MAT providers and practitioners. CMS therefore expects states to conduct provider outreach and enrollment as they prepare to meet the new requirements. As discussed above, because methadone for treatment of OUD can only be provided in OTPs, states that do not already enroll OTPs as Medicaid providers will be expected to take action to do so. Additionally, if a state has MAT providers operating in the state that are not currently enrolled in the Medicaid program, states are expected to permit any willing and qualified provider to become a Medicaid provider for the newly required MAT benefit, so that beneficiaries may receive these services from the qualified and willing provider of their choice, consistent with section 1902(a)(23) of the Act and 42 C.F.R. 431.51.

CMS expects a state seeking the exception under section 1905(ee)(2) to document in its exception request that it has made a good faith effort toward enrolling providers of MAT for the Medicaid fee-for-service program, Medicaid managed care organizations (MCOs), and primary care case managers (PCCMs). Such documentation would include information about state review of MCO demonstrations of adequate capacity to furnish services under 42 C.F.R. 438.207; state standards for uniform credentialing policies that MCOs must use in accordance with 42 C.F.R. 438.214(b); and MCO policies and procedures for credentialing and re-credentialing network providers, required under 42 C.F.R. 438.214. A state requesting an exception should conduct a detailed accounting of the current MAT providers in the state, both those that are enrolled in the Medicaid program and those that are not, and should detail in its exception request the process that the state has undertaken to contract with MAT providers (and/or to encourage that MAT providers contract with the state's Medicaid MCOs and/or PCCMs) and the reasons why the providers are not willing to enroll.

We recognize that there may be state-specific administrative challenges with providing CMS with the information necessary for the Secretary to determine that the state has satisfactorily certified to the existence of a shortage of providers, especially in light of the fact that this guidance is being issued after October 1, 2020, the effective date of the new MAT coverage requirement. Therefore, CMS will not require states seeking this exception to have submitted a request for the exception before October 1, 2020. Instead, CMS will accept state requests for this exception on or before January 14, 2021. The request for the exception should be submitted at the same time as a request for flexibility under section 1135 of the Act with respect to state plan amendment (SPA) submission and notice timelines (as described further below). If a state is not granted an exception based on a shortage of providers or facilities, then the state will need to submit a SPA, and requesting flexibility with respect to SPA submission and notice timelines could help the state to safeguard a SPA effective date of October 1, 2020 if the exception request is denied. For further detail, please refer to the "SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines" section below.

CMS remains committed to providing technical assistance to states and other stakeholders in understanding the mandatory MAT benefit and developing implementation approaches that result in the provision of Medicaid services in a manner compliant with program requirements.

States that seek an exception based on a shortage of providers or facilities should submit their request on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new "One CMS Portal," the request for the exception based on a shortage of providers or facilities should be submitted via the portal. The information detailed below should be included with the request, which should include the state's certification that it cannot come into compliance with the new requirement due to a shortage of providers. States may, but are not required to, use the following format.

_____ [Insert name of state] certifies that implementing the MAT benefit specified in section 1905(a)(29) of the Act is not feasible due to a shortage of qualified providers or facilities that will enroll in the state Medicaid program or contract with a Medicaid managed care organization (MCO) or Primary Care Case Manager to furnish one or more of the required MAT benefit components, and requests an exception from the requirement to provide this benefit for this reason.

The state's request should include all of the following information:

a. A description of the state's current qualified provider and facility status, including the number, type, and location of qualified providers and facilities that furnish MAT.
b. A brief description of the process that the state has undertaken to contract with all qualified MAT providers and facilities and reasons why the providers did not contract with the state or a managed care organization or Primary Care Case Manager.
c. For all Medicaid MCOs in the state, the written policies and procedures for selection and retention of network providers required by 42 C.F.R. 438.214, and copies of the assurances of adequate capacity and supporting documentation required by 42 C.F.R. 438.207(b), along with the state's certification and supporting documentation required by 438.207(d).
d. A description of the unmet need caused by the shortage of qualified providers or facilities among eligible children and adults whom the state identifies as individuals with OUD who could benefit from MAT.
e. A description of the state's plan to enroll additional qualified providers or facilities to ensure that all individuals eligible for MAT under the state plan (or a waiver of the state plan) are able to access it, and the date when the state thinks it will resolve the qualified provider or facilities shortage.

All exceptions approved under section 1905(ee)(2) will be for the full five-year period that the new MAT benefit is required. However, if a state decides to come into compliance with the MAT benefit requirement after receiving an exception under section 1905(ee)(2), CMS will be available to provide technical assistance to the state.

Extension of Compliance Deadline Due to Legislative Delay

Section 1006(b)(4)(B) of the SUPPORT Act (which was not codified in any provision of the Social Security Act) provides for an "exception" to the October 1, 2020 effective date of the new MAT benefit "for state legislation." Essentially, this provision provides for an extension to the required start date of the new coverage requirement if the only reason the state cannot come into compliance by October 1, 2020 is due to lack of state legislation that is needed to meet the requirement. Not all states will be able to seek this extension, because it depends on the timing of the state's first regular legislative session that began after the date of enactment of the SUPPORT Act (October 24, 2018). If the Secretary of Health and Human Services determines that state legislation is needed to bring the state plan into compliance with the new coverage requirement, the Secretary will not consider the state to be out of compliance with the new coverage requirement solely on the basis of a failure to enact the required state legislation before the first day of the first calendar quarter beginning after the close of the first regular session of the state's legislature that begins after October 24, 2018. If a state's first regular legislative session beginning after October 24, 2018 was the calendar year that began on January 1, 2019 and ended on December 31, 2019, the state would not be able to seek this extension because it would have had only until December 31, 2019 to enact any required legislation, and the first day of the first calendar quarter that begins after that date is January 1, 2020 – well before October 1, 2020.

If, however, a state's first regular legislative session beginning after October 24, 2018 does not end until on or after October 1, 2020, and the Secretary determines that legislation was necessary to meet the new coverage requirement, but the necessary legislative authorization was not obtained, the state could seek to delay compliance with the new coverage requirement until the first day of the first calendar quarter after the legislative session ends. Such a state is expected to come into compliance with the new coverage requirement by the first day of the first calendar quarter after the end of the legislative session, unless the exception in section 1905(ee)(2) applies. If a state has a two-year legislative session, each year of the session shall be considered to be a separate regular session of the state legislature for purposes of this extension. This means that a state would not have a longer extension if it has a two-year legislative session; such a state is treated like a state with a one-year legislative session, and any applicable extension ends on the first day of the first calendar quarter following the end of the first year of the two-year session.

CMS will grant an extension based on legislative delay only if a legislative delay is the only reason that a state cannot meet the requirement, and only when the first regular legislative session that began after October 24, 2018 ends on or after October 1, 2020, as discussed above. States should submit requests for the legislative delay extension on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new "One CMS Portal," the request for the legislative delay extension should be submitted via the portal. The request should include documentation to support that the state's first regular legislative session that began after October 24, 2018 did not end until on or after October 1, 2020, that state legislation is needed to come into compliance with the new coverage requirement, and that the legislative delay is the only reason the state cannot come into compliance as of October 1, 2020. States are encouraged to submit a request for flexibility under section 1135 of the Act with respect to SPA submission and notice timelines,

as discussed below under "SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines," at the same time as the request for the legislative delay extension, in order to help safeguard a SPA effective date of October 1, 2020 if the state's request for a legislative delay extension is not granted. States may, but are not required to, use the following format for their legislative delay extension submission:

_____ [Insert name of state] requests an exception based on the need for legislative authority to cover the benefit described in section 1905(a)(29) of the Social Security Act, and submits documentation to support that the state's first regular legislative session that began after October 24, 2018 will not end until on or after October 1, 2020. [Describe the documentation that is attached or that accompanies the request and include information about the state's legislative calendar so CMS can determine the state's compliance date.]

States that are granted an extension due to legislative delay will still need to follow the SPA submission requirements below and submit a SPA consistent with the extended compliance deadline.

SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines

SPA effective date requirements outlined at 42 C.F.R. 430.20 provide for an effective date retroactive to the first day of the quarter in which the SPA was submitted. In addition, the public notice requirements at 42 C.F.R. 447.205 require states to publish notice of proposed changes in methods and standards for setting payment rates for services before the proposed effective date of the change. Accordingly, under these rules, states have only until December 31, 2020 to submit a SPA establishing coverage or payment for the new MAT benefit that would take effect October 1, 2020. Additionally, any SPA setting payment rates for the new benefit could take effect only after the state issues public notice of the proposed payment changes. Thus, states would have had to publish notice of their payment rate changes by September 30, 2020, for changes to take effect October 1, 2020.

CMS is aware that most states have been unable to submit a SPA for the new MAT benefit that meets these submission and notice timing requirements because they have had to focus almost exclusively on responding to the COVID-19 pandemic throughout much of 2020. At the same time, the opioid crisis has only been exacerbated by the COVID-19 pandemic. During the COVID-19 public health emergency (PHE), disruptions in treatment have resulted in a resurgence of relapses and fatal overdoses among individuals with OUD.[35]

Consequently, in order to help ensure that beneficiaries can access coverage for the new MAT benefit effective retroactively to October 1, 2020, CMS is giving states the opportunity to request that CMS exercise its section 1135 authority to modify the regulatory deadlines associated with SPA submission and public notice for coverage and payment SPAs for the new MAT benefit while the COVID-19 PHE is still in effect.[36] CMS strongly recommends that states submit these

[35] https://qz.com/1889798/covid-19-is-making-the-opioid-crisis-much-worse/

[36] Section 1135 authority permits the Secretary to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements during a PHE, in order to ensure, to the maximum extent feasible, that sufficient health care items and services are available to meet the needs of individuals enrolled in those programs.

requests on or before January 14, 2021. Specifically, if responding to the COVID-19 pandemic has delayed a state's ability to submit a coverage or payment SPA for the new MAT benefit or provide public notice of payment rate changes related to the new MAT benefit under the time frames set forth at 42 C.F.R. 430.20 and 447.205, the state may request flexibility regarding the timing of the SPA public notice and submission process for these SPAs, so that it can submit SPAs adding coverage and payment for the new mandatory MAT benefit at section 1905(a)(29) of the Act in the first quarter of 2021 that would be effective October 1, 2020. If a state does not submit a request for section 1135 flexibility as described herein and submits a SPA after December 31, 2020 to add the new mandatory MAT benefit, then the SPA's effective date would be on (or sometime after) January 1, 2021, beneficiaries might not be able to access all available MAT coverage before that date, and the state would not be in timely compliance with the new coverage requirement.

CMS will provide states with this flexibility only if they meet the following conditions. First, all state requests for modification of the deadlines for MAT SPA submission and public notice under section 1135 must be submitted and approved during the COVID-19 PHE, and all MAT SPAs must be submitted on or before March 31, 2021. Second, states must solicit and should consider public comments and comments received through tribal consultation before finalizing the SPAs that will take effect. States must conduct tribal consultation if required under section 1902(a)(73)(A) before submission of their MAT SPAs, even if CMS approves a modification under section 1135 of the 42 C.F.R. 447.205 notice timelines. Additionally, CMS strongly recommends that states conduct any public notice required under 42 C.F.R. 447.205 before submitting their MAT SPAs, even if CMS approves a modification under section 1135 of the timeline for that notice. If states have had to put in place interim coverage or rate policies for the new MAT benefit while preparing their SPAs for submission and finalizing them for approval, they would be expected to give effect to the rates and coverage policies that are ultimately approved retroactive to the effective date of October 1, 2020. States seeking these section 1135 flexibilities should submit a letter to Jackie Glaze at Jackie.Glaze@cms.hhs.gov by January 14, 2021. In addition to a statement explaining that the state's response to the COVID-19 pandemic has delayed its ability to submit coverage and/or payment SPAs for the new MAT benefit according to the regulatory SPA submission and notice timelines, the letter should include the following language (as applicable):

Request for Modifications under Section 1135

> Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of SPA submission requirements at 42 C.F.R. 430.20, in order to submit a SPA implementing section 1905(a)(29) of the Act by March 31, 2021 that would take effect on October 1, 2020.
>
> Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of the public notice time frames set forth at 42 C.F.R. 447.205, in order to obtain an effective date of October 1, 2020 for its SPA implementing statewide methods and standards for setting payment rates for the benefit described at section 1905(a)(29) of the Act. The state will issue public notice as soon as possible, and in no event later than February 28, 2021.

With respect to SPA submissions related to coverage and payment for the new MAT benefit, states should take the following steps.

States should submit an amendment to their Medicaid state plans (including to Alternative Benefit Plans, if applicable), no later than December 31, 2020 (or March 31, 2021, if CMS has approved section 1135 flexibility as discussed above) after having conducted public notice and tribal consultation, as needed, to cover, under the new mandatory benefit at section 1905(a)(29) of the Act, all FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, as well as all forms of the drugs and biologicals approved or licensed by the FDA for MAT to treat OUD, and associated counseling services and behavioral therapies. States should submit their SPAs to the Regional SPA/Waiver mailbox that is currently used for other Medicaid SPA submissions. If a state is participating in the pilot for the new "One CMS Portal," the SPA should be submitted via the portal.

States that already use existing Medicaid authorities to cover items and services that will now be covered under the new mandatory MAT benefit, including FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, and associated counseling services and behavioral therapies, are expected to submit a SPA to move their coverage of these items and services to a new page in their Medicaid state plans for the new mandatory benefit at section 1905(a)(29) of the Act.

In addition to submitting SPAs to add the mandatory MAT benefit to the state plan, states will need to propose associated changes to the payment section of the state plan. States will need to submit a new Attachment 4.19-B page for the mandatory benefit at section 1905(a)(29) that describes the rate-setting methodology used to pay for the services covered under the mandatory MAT benefit. The rate-setting methodology for the new MAT benefit must be consistent with section 1902(a)(30)(A) of the Act, which requires Medicaid payments to be "consistent with efficiency, economy, and quality of care" and to be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." States may include all medical service costs associated with furnishing the MAT benefit services to Medicaid beneficiaries (such as salaries, fringe benefits, supplies, and equipment) in their rate-setting methodology for the new MAT benefit, and the methodology must be a comprehensive description within the state plan consistent with 42 C.F.R. 430.10. As states have a variety of options to choose from in how they pay for MAT services, CMS is available to provide assistance to states as they develop SPA proposals. We encourage states to reach out to their state lead in the Medicaid and CHIP Operations Group for technical assistance.

As with any SPA submission, CMS expects states to comply with all SPA requirements that are not waived or modified, including those found in 42 C.F.R. 440.200, et seq., and to provide information on the source of the non-federal share of the service payments and information on the rate-setting methodology. Specific guidance related to SPA submission procedures may be found on the Medicaid.gov web page.

MAT Drug Coverage and Section 1927 Manufacturer Rebates

CMS interprets section 1905(ee)(1) of the SUPPORT Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the FDA has approved or licensed for MAT to treat OUD. More specifically, under the new mandatory MAT benefit, states are required to cover such FDA approved or licensed drugs and biologicals used for indications for MAT to treat OUD.

Statutory amendments were made to the original language at sections 1905(a)(29) and 1905(ee) by Section 2601 of the Continuing Appropriations Act, 2021 and Other Extensions Act (Pub. L. No. 116-159) to specify that the rebate requirements in section 1927 shall apply to any MAT drugs or biologicals described under the mandatory benefit at section 1905(ee)(1)(A), that are furnished as medical assistance under sections 1905(a)(29) and section 1902(a)(10)(A), and are covered outpatient drugs, as that term is defined at section 1927(k)(2). In determining whether such a MAT drug or biological satisfies the definition of a covered outpatient drug, such MAT drugs or biologicals are deemed prescribed drugs for such purposes. More specifically, these amendments ensure that MAT drugs and biologicals can be included in the Medicaid Drug Rebate Program (MDRP). Additionally, for MAT drugs or biologicals that are also covered outpatient drugs, the amendments also ensure a state's ability to seek section 1927 rebates and apply drug utilization management mechanisms (such as preferred drug lists and prior approval), and establish a manufacturer's obligation to pay appropriate rebates and comply with all applicable drug product and drug pricing reporting and payment of rebates. The change in law is effective as if included in the enactment of the SUPPORT Act, which was October 24, 2018.

CMS expects that most manufacturers of MAT drugs and biologicals currently have in effect a rebate agreement with the Secretary and pay rebates to states for all drugs and biologicals that meet the definition of covered outpatient drug (COD) in section 1927(k) of the Act, and if not, that manufacturers of these drugs and biologicals will likely enter into a rebate agreement with the Secretary and pay rebates to states. Should an FDA-approved MAT drug or biological for OUD not meet the definition of a covered outpatient drug, or if the drug is a covered outpatient drug, but the manufacturer does not have a rebate agreement in effect with the Secretary, the state would still be required to cover the drug or biological under the MAT mandatory benefit, and the drug or biological would be eligible for FFP, but not rebates. States could subject MAT drugs or biologicals that are not covered outpatient drugs to prior approval or other utilization management mechanisms under 42 C.F.R. 440.230 as described below, including in order to prioritize coverage of those drugs that are covered outpatient drugs, but the state still must provide coverage for MAT drugs that are not covered outpatient drugs if they are medically indicated for the beneficiary, consistent with 42 C.F.R. 440.230(b).

State Use of Utilization Management Mechanisms

As a reminder, states may use utilization management controls to promote the efficient delivery of care and to control costs.[37] States can use the Section 1927 utilization management mechanisms for MAT drugs used for OUD that are covered outpatient drugs, such as

[37] Medicaid and CHIP Payment and Access Commission's (MACPAC) October 2019, Report to Congress: Utilization Management of Medication-Assisted Treatment in Medicaid, https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf

encouraging the use of generic products, creating a preferred drug list, or choosing to implement prior authorization to manage drug classes that may require additional monitoring.

For MAT drugs that are covered outside of a rebate agreement, or would be covered outpatient drugs, except that they are subject to the limiting definition at section 1927(k)(3) (e.g. those that are paid as part of a bundle), states may use the utilization management mechanisms authorized under 42 C.F.R. 440.230. In these cases, states may propose limits on the amount, duration, and scope of these drugs under the MAT benefit, including to encourage the use of the most cost-effective MAT drugs and biologicals.

Support to States for Increasing SUD Treatment Options

Well-supported scientific evidence demonstrates that treatment for substance use disorders – including inpatient, residential, and outpatient treatment – is cost-effective compared with no treatment.[38] Existing Medicaid authorities, as well as new opportunities afforded by the SUPPORT Act, are available to help states expand their SUD service continuum, which can include MAT.

Section 1115 demonstration projects – In November 2017, CMS announced a section 1115 initiative that affords states the opportunity to receive federal financial participation (FFP) for expenditures on the continuum of services to treat SUD, including expenditures on treatment while Medicaid enrollees are residing in residential treatment facilities that are IMDs. Such expenditures can generally not be federally matched under Medicaid due to the IMD exclusion. As part of this initiative, states may develop innovative approaches to inpatient and residential care for individuals with SUDs that are expected to supplement and coordinate with community-based care to provide a robust continuum of care in the state. Participating states are required to ensure residential settings included in these demonstrations are either offering beneficiaries access to MAT on-site or facilitating beneficiaries' access to MAT off-site.[39]

Section 1003 of the SUPPORT Act – Section 1003 requires the Secretary to conduct a demonstration project to increase Medicaid SUD provider capacity. In 2019, CMS awarded planning grants to 15 states to conduct an assessment of SUD treatment and recovery needs of the state. The planning grants may also support activities to recruit, train, and provide technical assistance for providers; to improve reimbursement; and to expand the number or treatment capacity of Medicaid providers. Up to five of the states that received planning grants will be selected to implement demonstrations and receive enhanced federal reimbursement for increases in Medicaid SUD treatment and recovery services expenditures. For more information on this demonstration project, and the 15 states that were awarded planning grants, see the Medicaid.gov web page.[40]

Section 1006(a) of the SUPPORT Act – Section 1006(a) of the SUPPORT Act permits CMS to extend, at state request, the period of 90% federal match from eight to 10 fiscal year quarters for

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[38] Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[39] SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[40] https://www.medicaid.gov/medicaid/benefits/bhs/support-act-provider-capacity-demos/index.html

health home services provided to SUD-eligible individuals under a SUD-focused Medicaid health home SPA approved on or after October 1, 2018. The Medicaid health home state plan option (authorized under section 1945 of the Act) promotes coordination of primary and acute physical and behavioral health services and long-term services and supports. Specific guidance related to the health home Medicaid state plan option, including guidance on health home services, health home providers, state reporting, and developing payment methodologies, can be found on the Medicaid.gov web page.[41] Information on section 1006(a) of the SUPPORT Act is also available in the policy guidance tab on the Medicaid.gov web page.[42]

Section 7181 of the SUPPORT Act – Section 7181 of the SUPPORT Act reauthorized and modified the "State and Tribal Response to the Opioid Crisis" grants established under section 1003 of the 21st Century Cures Act. Section 7181 requires the grants to be awarded to Indian tribes in addition to states and territories. This provision also expands the types of activities that grants may support to include the establishment of prescription drug monitoring programs and training for health care practitioners in preventing diversion of controlled substances. It also emphasizes flexibility with use of funds by permitting resources to be directed "in accordance with local needs related to substance use disorders."[43]

Section 7181 authorizes $500 million for each of Fiscal Years 2019-2021, which would remain available until expended. It authorizes a set-aside of up to 15% for states with the highest age-adjusted rate of drug overdose death based on the ordinal ranking of states according to the Centers for Disease Control and Prevention (CDC)[44]. SAMHSA will provide state agencies and Indian tribes with technical assistance on grant application and submission procedures, award management activities, and enhancing outreach and direct support to rural and underserved communities and providers in addressing the opioid crisis.

Telehealth – HHS developed materials to help clarify how clinicians can use telemedicine as a tool to expand buprenorphine-based MAT for OUD treatment under current DEA regulations. This information includes a clinical practice example that is consistent with applicable DEA and HHS administered authorities. It is hoped that the materials help expand providers' ability to prescribe MAT to patients, including remote patients under certain circumstances. This information can be found on the HHS.gov web page.[45]

Telehealth could be especially helpful in supporting access to buprenorphine in rural areas, where there may be a smaller number of waivered providers able to prescribe buprenorphine for the treatment of OUD in settings other than federally regulated opioid treatment programs.[46]

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[41] https://www.medicaid.gov/medicaid/ltss/health-homes/index.html.
[42] CMCS Informational Bulletin, Guidance for States on the Availability of an Extension of the Enhanced Federal Medical Assistance Percentage (FMAP) Period for Certain Medicaid Health Homes for Individuals with Substance Use Disorders (SUD), May 7, 2019, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib050719.pdf.
[43] https://www.govinfo.gov/content/pkg/PLAW-115publ271/html/PLAW-115publ271.htm
[44] https://www.cdc.gov/drugoverdose/data/statedeaths.html
[45] https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf.
[46] U.S. Department of Health and Human Services. Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder. DHHS web site. September 2018. https://www.hhs.gov/blog/2018/09/18/using-telemedicine-combat-opioid-epidemic.html.

CMS also released a State Medicaid Director Letter (SMDL) in June 2018, "Leveraging Medicaid Technology to Address the Opioid Crisis,"[47] that includes a section on how states can leverage telehealth technologies to improve access to SUD treatment. This SMDL also discusses the potential availability of enhanced federal funding to support telehealth-enabling technologies. Additionally, consistent with section 1009(b)(1) of the SUPPORT Act, CMS issued guidance on federal Medicaid reimbursement for services to treat SUD furnished via telehealth, including in School-Based Health Centers.[48] Services discussed in this guidance include assessment, MAT, counseling, medication management, and medication adherence with prescribed medication regimes.

Conclusion

MAT is an effective, comprehensive, and evidence-based treatment that is integral to addressing the nation's opioid crisis. Section 1006(b) of the SUPPORT Act amended the Social Security Act to require states to cover MAT for all eligible to enroll in the state plan or waiver of state plan. The new mandatory MAT benefit includes all FDA-approved drugs and licensed biologicals used for MAT to treat OUD, as well as associated counseling and behavioral therapies. CMS interprets the statute to require coverage of all forms of drugs and biologicals approved or licensed by the FDA for use as MAT to treat OUD. CMS is available to provide technical assistance and looks forward to working with states to ensure Medicaid beneficiaries with OUD receive the services they need. If you have any questions, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Sincerely,

/s/

Anne Marie Costello
Acting Deputy Administrator and Director

cc: State Mental Health Directors
State Substance Use Directors
State Opioid Treatment Authorities
State Budget Officers
State Pharmacy Directors
National Association of Medicaid Directors
National Association of State Mental Health Program Directors
National Association of State Alcohol and Drug Abuse Directors
Association of State and Territorial Health Officials
National Association of State Budget Officers
National Conference of State Legislatures

[47] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf.

[48] CMCS Informational Bulletin, April 2, 2020. Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf

Disclaimer Language: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard Mailstop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 21-003

RE: Medicaid and CHIP Coverage and Reimbursement of COVID-19 Testing under the American Rescue Plan Act of 2021 and Medicaid Coverage of Habilitation Services

August 30, 2021

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance on Medicaid and Children's Health Insurance Program (CHIP) coverage and reimbursement of COVID-19 testing under the American Rescue Plan Act of 2021 (ARP) (Pub. L. No. 117-2). Additionally, CMS is issuing this guidance to clarify that, only during the COVID-19 public health emergency (PHE), states may cover habilitation services provided to children under section 1915(c) and section 1915(i) of the Social Security Act (the Act) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program.

CMS will apply the interpretations of statute in this guidance on a prospective basis beginning with the date of issuance of this letter.

Mandatory COVID-19 Testing Coverage under the American Rescue Plan Act of 2021

Overview

CMS interprets the ARP to require state Medicaid and CHIP programs to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA)-authorized COVID-19 tests, without cost-sharing obligations, for a period of time that begins March 11, 2021, and generally extends beyond the end of the COVID-19 PHE. In meeting these ARP requirements, states must continue to apply normal third-party liability rules and may continue to apply utilization management techniques, as further described later in this letter.[1]

ARP Sections 9811 and 9821

The ARP was enacted on March 11, 2021 and included COVID-19 testing coverage mandates specific to Medicaid and CHIP. Section 9811(a) of the ARP added a new mandatory Medicaid

[1] Use of the term "state" in this letter includes the territories, as applicable.

benefit at section 1905(a)(4)(F) of the Act. Section 9821 of the ARP added the same mandatory benefit for all CHIP enrollees at section 2103(c)(11)(B) of the Act. Sections 1905(a)(4)(F) and 2103(c)(11)(B) of the Act require states to cover testing for COVID-19 for the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. In addition, section 9811(a)(2)(E) of the ARP amended the statutory language following section 1902(a)(10)(G) of the Act to require coverage of additional testing for COVID-19 for individuals eligible for the optional Medicaid eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Act (the group CMS previously referred to as the "optional COVID-19 testing group").[2]

ARP sections 9811 and 9821 also amended sections 1916, 1916A, and 2103(e)(2) of the Act to specify that states cannot impose cost-sharing with respect to the COVID-19 testing coverage required under the ARP and described in sections 1905(a)(4)(F) and 2103(c)(11)(B). ARP section 9811(a)(5) also amended section 1937(b) of the Act to require states to include the same COVID-19 testing coverage in Medicaid alternative benefit plans, without any deduction, cost-sharing, or similar charge.

CMS interprets the amendments made by sections 9811 and 9821 of the ARP to require states to cover both diagnostic and screening tests for COVID-19 (which includes their administration), consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19. CMS is aligning its interpretation of these ARP amendments with applicable CDC recommendations because the CDC recommendations provide a national reference point for who should be tested during the COVID-19 pandemic and evolve as science evolves.[3] CMS interprets these amendments to require states to cover, without cost sharing, all diagnostic and screening testing that would be consistent with the CDC recommendations. This includes, for example, coverage of screening testing to return to school or work or to meet travel requirements. CMS is available for technical assistance as states design their testing coverage policy and as the COVID-19 pandemic evolves.

An individualized test result must be obtained for both diagnostic and screening testing covered under the amendments made by sections 9811 and 9821 of the ARP to support a Medicaid or CHIP claim. Additionally, all types of FDA-authorized COVID-19 tests must be covered under CMS's interpretation of the ARP COVID-19 testing coverage requirements, including, for example, "point of care" or "home" tests that have been provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider of COVID-19 tests. Home tests include those where a specimen is collected at home and then sent to a clinical laboratory or other certified testing site for testing, and those that are entirely performed at home, meaning the test system includes the ability to perform the test without involvement of a laboratory. States have

[2] Under section 1902(a)(10)(A)(ii)(XXIII) of the Act and the statutory language following section 1902(a)(10)(G) of the Act, states can provide coverage to the optional COVID-19 group (previously referred to as the optional COVID-19 testing group) only through the last day of the COVID-19 PHE. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 testing, after the PHE ends.

[3] See, e.g., https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/sars-cov2-testing-strategies.html.

discretion to condition coverage of a home test on a prescription as part of their utilization management (some FDA-authorized home tests require a prescription). As states establish utilization management techniques, including possible prescription conditions, they are encouraged to do so in ways that do not establish arbitrary barriers to accessing COVID-19 testing coverage, but that do facilitate linking the reimbursement of a covered test to an eligible Medicaid or CHIP beneficiary.

Finally, states may apply medical necessity criteria and other amount, duration, and scope parameters to COVID-19 testing covered under section 1905(a)(4)(F) of the Act and the other amendments made by section 9811 of the ARP, as they may do for all Medicaid services, as a utilization management control, provided that the benefit is sufficient to reasonably achieve its purpose (consistent with 42 CFR § 440.230(b)). States may also apply utilization controls to the COVID-19 testing covered in CHIP under section 2103(c)(11)(B), consistent with 42 CFR § 457.490.

Screening Testing in Schools

Schools can be Medicaid providers of COVID-19 screening testing covered under section 1905(a)(4)(F) and the other amendments made by section 9811 of the ARP. The vast majority of schools that render school-based services covered by Medicaid are reimbursed via a methodology associated with a Certified Public Expenditure (CPE) that requires reconciliation to actual cost via a uniform cost report. If the school obtains and administers a COVID-19 test and the state plan payment methodology is reconciled to cost, the cost of the test could be recorded on a cost report as a medical supply, and any accompanying cost of administering the test, such as the salary of the administering nurse, etc., would also be recorded in the cost report.

Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [Medicaid state] plan at least to the extent that such care and services are available to the general population in the geographic area." If the state plan payment methodology is a rate for school-based services, the cost of the test and any cost associated with administering the test should be factored into the rate. If the school contracts with an outside entity to administer the test, the school, not the outside entity, would be considered the billing provider of the test under Medicaid. If the state plan payment methodology is reconciled to cost, the contractual rate negotiated between the school and the outside entity would be recorded as contracted services in the provider's uniform cost report. If the state plan payment methodology is a rate, the above-contracted cost should be factored into the rate.

While there is no prohibition on Medicaid qualified providers billing for Medicaid covered services and items provided to Medicaid beneficiaries that may be provided free of charge to the general public, there may be sources of federal funding that are also available to cover the cost of testing in schools, which could potentially duplicate Medicaid payments. To avoid such duplication, states should ensure that Medicaid payments are appropriately considered along with other available sources of federal funds or revenue that may be used to fund testing in schools.

All third-party payer provisions continue to apply, and we remind states of the existence of additional funding streams for COVID-19 testing reimbursement not typically available.[4]

As indicated above, states may implement utilization management techniques in the coverage of screening testing in schools.

State Plan Amendments

States will need to submit Medicaid state plan amendments (SPAs) to add testing coverage and reimbursement as required under the ARP, including under the new mandatory benefit at section 1905(a)(4)(F) of the Act. CMS will provide additional information on submission of Medicaid SPAs to reflect ARP changes. CMS is available for technical assistance on SPA development.

States will also need to submit CHIP SPAs pursuant to CMS requirements at 42 CFR § 457.60(a). States will need to indicate that they are providing testing coverage without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. CMS will provide additional information on submission of CHIP SPAs to reflect ARP changes.

Medicaid Coverage of Individuals with Disabilities Education Act (IDEA) Services during Remote Learning

As discussed in State Health Official (SHO) letter 21-001, under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child's individualized education program (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP). These educational services can help children with disabilities achieve their educational goals. Medicaid reimbursement is available for covered services that are included in the child's IEP and IFSP provided to eligible beneficiaries by qualified Medicaid providers.[5] States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting if the children are determined to need those services, the services are furnished by qualified Medicaid providers, and the services meet all of the requirements set forth in the State Medicaid Director Letter 14-006.[6] Typically, however, under section 1915(c) and section 1915(i) of the Act, states must not cover habilitation

[4] Third party liability provisions are found in section 1902(a)(25) of the Act and 42 CFR Part 433, Subpart D.

[5] There are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. As indicated by section 1903(c) of the Act, Parts B and C of the Individuals with Disabilities Education Act (IDEA) is one example of this exception to the payer of last resort rule.

[6] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care), issued December 15, 2014, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

services[7] in the school setting if the services are otherwise available to the individual through a local educational agency.

CMS is clarifying that, in light of the unique circumstances presented by the COVID-19 PHE where students are relying on remote learning in whole or in part, states may cover habilitation services provided to children under section 1915(c) and section 1915(i) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program. For example, schools may be unable to deploy personnel to meet the needs of each individual child participating in remote education. CMS recognizes the significant advances in vaccination rates across the country, including for school-aged children eligible to be vaccinated. As schools return to in-person learning, CMS expects habilitation services will be available through local educational agencies and no longer eligible for coverage under Medicaid.

However, *to the extent necessary given local conditions*, states may choose to avail themselves of this flexibility where services are, in fact, not available through the local educational agency. Local educational agencies must prioritize use of funding available in the ARP, prior to indicating an inability to provide covered habilitation services. This flexibility is available prospectively from the issuance of this guidance. If applicable, states will need to submit an Appendix K application, disaster-related SPA, or 1115 application to implement this flexibility.

CMS notes that states must also continue to provide medically necessary services authorized under section 1905(a), in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) responsibilities.

Conclusion

This guidance describes Medicaid and CHIP coverage and reimbursement of COVID-19 testing under the ARP, and habilitation services during the COVID-19 PHE. As previously stated, CMS will apply the interpretations of statute in this guidance for both COVID-19 testing and habilitation services on a prospective basis beginning with the date of issuance of this letter. Please contact Kirsten Jensen at Kirsten.Jensen@cms.hhs.gov for additional information on COVID-19 testing and Ralph Lollar at Ralph.Lollar@cms.hhs.gov for additional information on habilitation services.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

[7] Defined at section 1915(c)(5) as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."

Mandatory & Optional Medicaid Benefits

This page outlines mandatory Medicaid benefits, which states are required to provide under federal law, and optional benefits that states may cover if they choose.

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

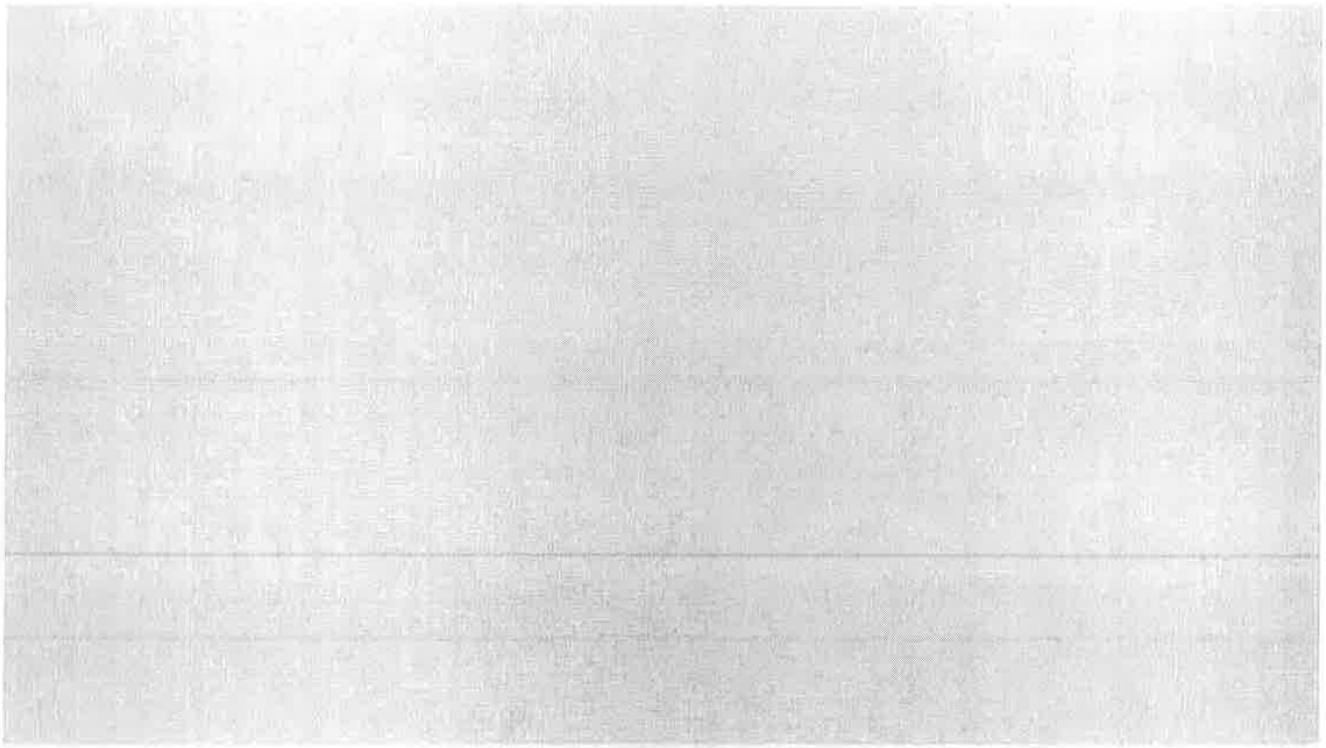
Optional Benefits

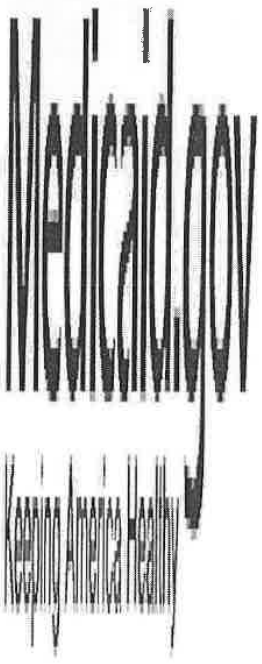
- Prescription Drugs
- Clinic services
- Physical therapy

- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*
- Health Homes for Enrollees with Chronic Conditions – Section 1945

*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

Mandatory & Optional Medicaid Benefits





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7500 Security Boulevard Baltimore, MD 21244

DHHRBMS016222

Centers for Medicare & Medicaid Services

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Exhibit 22

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

1. Documents sufficient to show the total annual number of West Virginia Medicaid participants.

   RESPONSE: Reports have been requested.

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

    a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

    b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

    c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

RESPONSE: Upon entry of an appropriate Protective Order, these Defendants can produce an excel spreadsheet with the pharmacy claims detail for Christopher Fain. Any communications to or from Mr. Fain's Managed Care Organization would not be in the possession of these Defendants.

3. Taking necessary steps to comply with applicable privacy laws and making all necessary redactions to protect any personal health information. Documents in electronic, delimited, and importable format (e.g., excel spreadsheet) sufficient to show number of individuals who have requested coverage for Gender-Confirming Care, the number of claims each

individual has made for Gender-Confirming Care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the Exclusion.

RESPONSE: Any requests made for gender-confirming care to Managed Care Organizations would not be in the possession of these Defendants.

Upon information and belief, counseling is a covered service. However, the data is not kept in a manner which would allow these Defendants to identify which patients have requested counseling for gender confirming care. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason. Therefore, these Defendants are unable to further respond to this Request as stated.

Similarly, with respect to hormone therapy, upon information and belief hormone therapy is not denied on the basis that it is for gender-confirming care. However, the data is not kept in a manner which would allow these Defendants to identify which patients have requested hormone therapy for gender confirming care. These defendants would not necessarily know the reason for hormone therapy and whether it was related to gender-confirming care or some other reason. Therefore, these Defendants are unable to further respond to this Request as stated.

4. All Documents and communications relating to the Exclusion, including but not limited to:

    a. All Documents and communications relating to the decision to maintain the Exclusion in the Health Plans in any plan year.

b. All Documents and communications relating to the decision to permit coverage for hormone therapy for the purpose of treating gender dysphoria.

c. All Document and communications relating to evaluating, examining, analyzing, and/or considering the Exclusion in any way.

RESPONSE: Upon information and belief:

a. These Defendants are conducting a search for any responsive documents;

b. Please see Exhibit 1. (Bates No. DHHRBMS000001-5), relating to the removal of the gender edit for most estrogen and testosterone containing products;

c. These Defendants are conducting a search for any responsive documents.

5. All Documents and communications relating to gender dysphoria, transgender people, and/or Gender-Confirming Care.

RESPONSE: Objection to the scope of the request to the extent that it requests all documents and communications relating to gender dysphoria, transgender people, and/or Gender-Confirming Care throughout the Bureau of Medical Services. Without waiving this objection, these defendants are conducting a search for any responsive documents. A search of communications of Dr. James Becker, Medical Director, Jennifer J. Myers, Director of Professional Services, and Tanya Cyrus, for the terms "gender dysphoria," "transgender people" and "Gender-Confirming Care" is being requested through the Office of Technology.

6. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care considered by the individuals responsible for adopting and/or maintaining the Exclusion in the Health Plans. Please identify the responsive Documents by Bates number. This includes, but is not limited to:

    a. Documents and communications regarding the safety or efficacy of Gender-Confirming Care;

    b. Documents and communications regarding the medical necessity of Gender-Confirming Care; and

    c. Documents and communications regarding the cost of Gender-Confirming Care.

RESPONSE: These defendants are conducting a search for any responsive documents. These Defendants would not be in possession of responsive information related to exclusions contained in Managed Care Organization plans.

7. If Defendants contend that the Exclusion of Gender-Confirming Care is supported by any governmental interest not encompassed in the Requests above, all Documents supporting that contention.

RESPONSE: These Defendants are unaware of any responsive documents.

8. Documents sufficient to identify the circumstances in which counseling and/or therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or

criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 519.22 that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.22_Mental_Health_Counseling_and_Substance_Abuse_Treatment_2018%20update_final.pdf.

9. Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

10. Documents sufficient to identify the circumstances in which orchiectomy, penectomy, vaginoplasty, hysterectomy, phalloplasty, mammoplasty, breast reconstruction surgery, and/or mastectomy are covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

11. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care in relationship to the federal Medicaid Act, 42 U.S.C. Sections 139a(a)(10)(A)-(B) and/or any regulation promulgated thereunder.

    a. With the exception of Documents and communications protected by attorney-client privilege, this Request includes, but is not limited to, all Documents and communications relating to the legal requirements of the federal Medicaid Act, 42 U.S.C. Sections 1396a(a)(10)(A)-(B) and/or any regulation promulgated thereunder with respect to the Exclusion and/or Gender-Confirming Care.

RESPONSE: These Defendants are not aware of any responsive documents.

12. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care in relationship to Section 1557 of the Patient Protection and Affordable Care Act and/or any regulation promulgated thereunder.

    a. With the exception of Documents and communications protected by attorney-client privilege, this request includes, but is not limited to, all Documents and communications relating to the legal requirements if Section 1557 of the Patient Protection and Affordable Care Act and/or any regulation promulgated thereunder with respect to the Exclusion and/or Gender-Confirming Care.

RESPONSE: These Defendants are not aware of any responsive documents.

13. Documents sufficient to show all steps taken by Defendants and/or West Virginia Department of Health and Human Resources, Bureau for Medical Services to comply with any and all requirements of the federal Medicaid Act, 42 U.S.C. Sections 1396a(a)(10)(A)-(B), whether or not related to Gender-Confirming Care.

RESPONSE: This request is vague and does not describe the documents requested with sufficient particularity, and is overly broad and burdensome.

14. Documents sufficient to show all steps taken by Defendants to comply with any and all requirements of Section 1557 of the Patient Protection and Affordable Care Act, whether of not related to Gender-Confirming Care.

RESPONSE: Objection. This request is vague and does not describe the documents requested with sufficient particularity, and is overly broad and burdensome.

15. The Rational Drug Therapy Program's criteria for coverage of hormone therapy for transgender and non-transgender West Virginia Medicaid participants.

RESPONSE: These Defendants are conducting a search for any responsive documents.

16. All statements of witnesses or potential witnesses or persons interviewed in connection with this lawsuit.

RESPONSE: Please see Affidavits of Brian Thompson, Angela Wowczuk and Tadd Haynes, Exhibit 2, (Bates No. DHHRBMS000006-12).

17. Documents obtained from third parties as a result of authorizations, releases and/or subpoenas relating to the subject matter of this lawsuit.

RESPONSE: These Defendants are not aware of any responsive documents.

18. Documents that Defendants intend to use as exhibits at deposition, summary judgment, or trial, or that may be used to refresh the recollection of a witness at depositions or trial.

RESPONSE: Exhibits have not yet been determined. These Defendants reserve the right to use any documents or materials produced in discovery by any party.

19. All Documents relating to audits, advice, and/or communications from any government office relating to the Exclusion.

RESPONSE: These Defendants are not aware of any responsive documents.

20. All communications related to legislation and/or lobbying surrounding the Exclusion and/or coverage for medical care for transgender people and gender dysphoria.

RESPONSE: These Defendants are conducting a search for any responsive documents.

21. All Documents that Defendants may identify in their initial disclosures pursuant to Federal Rule of Civil Procedure 26(a)(1)(A)(ii).

RESPONSE: Please see Exhibit 1 to these responses, and the documents referenced by links to online sources. Please see Unicare Health Plan of West Virginia, Inc., Handbook attached as Exhibit 3, (Bates No. DHHRBMS000013-106). Additionally, upon entry of an appropriate Protective Order, these Defendants can produce an excel spreadsheet with the pharmacy claims detail for Christopher Fain.

22. All documents upon which Defendants considered, relied upon, or intend to rely upon, in support of their admissions and/or denials of any of the allegations contained in the Complaint.

RESPONSE: Please see the Medicaid State Plan available online at: https://dhhr.wv.gov/bms/CMS/SMP/Pages/WV-State-Medicaid-Plan.aspx.

23. All Documents which Defendants considered, relied upon, or intend to rely upon, in answering each interrogatory and each request for admission in this action.

RESPONSE: Please see Exhibits 1 and 2 to these responses.

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

RESPONSE: These Defendants are conducting a search for any additional documents.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Ted Cheatham
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson;
individually and on behalf of all others
similarly situated,
Plaintiffs,
v. Civil Action No. 3:20-cv-00740
WILLIAM CROUCH, in his official capacity as
Cabinet Secretary of the West Virginia
Department of Health and Human Resources;
CYNTHIA BEANE, in her official capacity as
Commissioner for the West Virginia Bureau for
Medical Services; and WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN
RESOURCES, BUREAU FOR MEDICAL
SERVICES;
Defendants.

VIDEOTAPED DEPOSITION OF SHAUNTAE ANDERSON

On the 22nd day of April 2022, beginning at approximately 10:00 a.m., via Zoom Conference, West Virginia before me, Magdalena Szczerba, Court Reporter and Notary Public, appeared SHAUNTAE ANDERSON, Witness, who being by me first duly sworn, gave her oral deposition in the causes pursuant to notice of counsel and for the respective parties as hereinafter set forth. Said deposition is to be used for purposes of discovery and for any and all other purposes permitted by the Federal Rules State of West Virginia Rules of Civil Procedure.

APPEARANCES:

On behalf of the Plaintiffs:

Walt Auvil, Esquire
auvil@theemploymentlawcenter.com
THE EMPLOYMENT LAW CENTER, PLLC
1208 Market Street
Parkersburg, WV 26101
Sasha Buchert, Esquire
sbuchert@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W. 8th Floor
Washington, D.C. 20006-2304
Anna P. Prakash, Esquire
aprakash@nka.com
Nicole J. Schladt, Esquire
nschladt@nka.com
NICHOLS KASTER, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
612 256-3200
Avatara Smith-Carrington, Esquire
asmithcarrington@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, TX 75219-6722
214-219-8585

Tara L. Borelli, Esquire
tborelli@lambdalegal.org
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030

APPEARANCES (Continued)

On behalf of the Defendants:

Lou Ann Cyrus, Esquire
Kimberly M. Bandy, Esquire
lycrus@shumanlaw.com
SHUMAN, MCCUSKEY & SLICER, PLLC
1411 Virginia Street, Suite 200
Charleston, WV 25339
304 345-1400

BY MS. CYRUS:

Q. I'm going to turn your attention to another topic, to the Medicaid plan. Do you know when you became a Medicaid recipient?

A. On or around 2019.

Q. What prompted you to sign up with Medicaid, if you know?

A. When I got to the halfway house, they sent us to a free clinic to get a physical. At that time, they asked us if you had any insurance or you wanted to try to apply for Medicaid, and that's what I did.

Q. Do you know when you first became eligible

you then start getting your hormones through Medicaid or through, you know, a program that was under Medicaid?

A. When I first signed up for Medicaid, I was still under the Bureau of Prisons so they had to pay for it.

Q. Was there a point when you were no longer under the Bureau of Prisons but then you were just strictly under Medicaid?

A. Yes.

Q. At that point, did you seek to have your hormones for gender confirming care paid by Medicaid or a program that would be under Medicaid?

A. Yes, I did.

Q. And was that -- were those approved and covered?

A. The first -- my first time I went to the pharmacy, it was not covered and I had to pay out of pocket.

Q. Do you know why it was not covered the first time you went?

A. From my understanding, it had something to do about when it was filled or something of that nature.

Q. Was a timing issue?
A. I believe so.
Q. As far as you know, has there ever been a denial of your gender confirming hormones by Medicaid based on the fact that you are transgender?
MS. BUCHERT: Objection to form.
THE WITNESS: To my knowledge, no.

Q. You might need to give a spelling of that, but anyway.

So as far as you know, does Medicaid pay for your visits?

Are you looking at something there? Are you Googling?

A. No.

Q. I thought you were trying to help us find the name.

A. No. My screen timed out.

Q. Sorry.

A. You're fine. Can you read the question?

BY MS. CYRUS:

Q. I see.

And you've had other -- you've had medical visits?

Have you had medical visits for gender confirming care since you've been on Medicaid?

MS. BUCHERT: Objection to form.

THE WITNESS: Honestly, I'm -- I can't answer that question, but I can say this, I am a woman. I see an OBGYN just like any other woman.

BY MS. CYRUS:

Q. Is he the one who prescribes your gender confirming hormones?

A. He continued the hormones that I was

already on from the Bureau of Prisons, yes.

Q. As far as you know, does Medicaid pay for your visits to Dr. Patton?

A. To my knowledge, yes.

Q. So to your knowledge, have you had any claims for medical care, whether it's gender confirming or not, not paid by Medicaid for the basis that you're transgender?

MS. BUCHERT: Objection to form.

THE WITNESS: I don't know. I haven't received any bills. If it is, I don't know.

BY MS. CYRUS:

Q. So if there had been a denial, you were not aware of it?

There is no -- in other words -- let me restate that.

There is no denial of any of claim you've made with Medicaid for the basis that you're transgender that you're aware of?

MS. BUCHERT: Objection to form.

BY MS. CYRUS:

Q. Is that right?

A. I can't really answer that question because it's a little -- I don't quite understand

what you're saying. I'm sorry.

Q. That's okay. No. That's fine.

I'm trying to find out, as far as you know, has Medicaid denied one of -- a claim that you've made for some sort of care and said they aren't going to pay it because you're transgender or you have a transgender diagnosis?

MS. BUCHERT: Objection to form.

THE WITNESS: To my knowledge, I don't have -- I've never had any claims denied.

BY MS. CYRUS:

Q. That was my knowledge as well, but I wanted to make sure your information matches what my understanding is.

A. But I will say this though, the reason I had no -- I can't say why, no more than you can.

Q. I think we actually have information in this case. It's probably more than what you have. But at any rate, you've already testified you're not aware of my denial where they've said you can't have some either treatment or a drug because you're transgender; is that right?

MS. BUCHERT: Objection to form.

THE WITNESS: To stop my hormone therapy

can be detrimental to my health, so that's why they haven't stopped it. I don't know the specific reasons why, but I do know that it can cause blood clots which can lead to your death.

BY MS. CYRUS:

Q. Do you know that your hormone therapy is actually covered under Medicaid?

MS. BUCHERT: Objection.

THE WITNESS: I haven't received a bill yet, so I assume that it is covered by my Medicaid.

BY MS. CYRUS:

Q. And you've been getting that -- getting those hormones since you signed up on Medicaid in 2019 up to the present; is that right?

A. I mean, 2019 when I was in prison, I left from prison with hormones on a hormone regimen. They just continued it when I got transitioned into the outside world.

Q. So let me ask you: What is your understanding of what this lawsuit is about?

MS. BUCHERT: Objection to form.

THE WITNESS: My understanding is that I have insurance that doesn't cover anything that's medically necessary for me to continue the quality

of life that I should have, not just me but anyone in my situation.

BY MS. CYRUS:

Q. And when you say it doesn't cover anything that's medically necessary, what are you referring to?

MS. BUCHERT: Objection to form.

THE WITNESS: What I'm referring to is any of the confirmation procedures that are not considered cosmetic but medially necessary for a person like myself.

BY MS. CYRUS:

Q. So you're referring to surgeries; is that right?

A. Not --

MS. BUCHERT: Objection.

THE WITNESS: -- not limited to that.

BY MS. CYRUS:

Q. What else is it that you believe is not covered besides surgeries or gender confirming surgery?

A. I'm sorry. Can you repeat that again?

Q. Yes.

What is it that you believe is not covered

by Medicaid besides gender confirming surgery?

MS. BUCHERT: Objection to form.

THE WITNESS: You mean like a vaginoplasty.

BY MS. CYRUS:

Q. Right. That be would be surgery. Right.

I heard you say that nothing is covered for gender confirming care. So let's back up. We just talked about Medicaid covers your hormones for gender confirming care; is that right?

A. They cover my hormones. I'm not sure -- I can't sit here and say that it's for gender confirming care.

Q. You're getting estrogen female hormones, right?

A. Yes, just like any other woman who has low estrogen would get estrogen hormones to supplement that.

Q. Exactly.

So you agree you get estrogen regardless of the fact that you are transgender, right?

MS. BUCHERT: Objection to form.

THE WITNESS: But you said that it has something to do with gender confirming, that's not

gender confirming.
BY MS. CYRUS:
Q. So you don't consider your female hormones to be gender confirming?
A. Do you -- you were the one that asked the question, but I'm trying to get you to understand that it's -- hormones are for any woman. It doesn't have to be specifically for gender confirming.
Q. Are you taking female hormones for any other reason, to your knowledge, besides the fact that you're transgender?
MS. BUCHERT: Objection to form.
THE WITNESS: I'm taking them because I have low estrogen.
BY MS. CYRUS:
Q. Do you believe you would be taking them if you were not transgender?
MS. BUCHERT: Objection to form.
THE WITNESS: I'm not a doctor. I can't say what they would prescribe to me or not prescribe.
BY MS. CYRUS:
Q. But you did say you're taking them because

you're a woman; is that right?
A. I'm taking them because I have low estrogen.
Q. Do you know whether your estrogen level would be low for a male?
MS. BUCHERT: Objection to form.
THE WITNESS: No. I just know that at this point my estrogen level is where it needs to be the last time I had labs.
BY MS. CYRUS:
Q. Speaking of that, Medicaid also pays for your labs to check your estrogen levels; is that right?
MS. BUCHERT: Objection to form.
THE WITNESS: Just like they do for anyone else.
BY MS. CYRUS:
Q. Sure enough.
Do they -- they also pay for, we talked about, your psychological, psychiatric visits, correct? They pay for that?
MS. BUCHERT: Objection to form.
THE WITNESS: Yes.
BY MS. CYRUS:

MS. BUCHERT: Objection to form.

THE WITNESS: To my understanding, I just know that I receive -- that they continue my hormone therapy from prison. So, you know, no one has ever explained anything else to me about it.

BY MS. CYRUS:

Q. But you have an understanding that Medicaid is paying for your hormone replacement therapy, correct?

MS. BUCHERT: Objection to form.

THE WITNESS: I understand that I have not received a bill, so unless they -- so I haven't received a bill so I assume they are.

BY MS. CYRUS:

Q. I don't know whether -- I don't know that it would include, you were actually receiving counseling. You said you were seeing a psychiatrist. Do you -- have you received counseling that you submitted to Medicaid?

A. My psych counseling is covered by Medicaid.

Q. So you are having both counseling and hormone replacement therapy covered by Medicaid; is that right?

A. Yes.
Q. So it's -- this statement is not accurate to the extent it says, The exclusions all categorically deny transgender people coverage for gender confirming care. Gender confirming care includes, but is not limited to, counseling, hormone replacement therapy and surgical care?
MS. BUCHERT: Objection to form.
THE WITNESS: Actually the statement is correct. Think about --
BY MS. CYRUS:
Q. How is --
A. How is it correct? Just because I'm included because I do get counseling and I do get hormone therapy that may or may not be covered by Medicaid. There are people, other trans people who don't get either one.
Q. What is the basis of that statement that you just made?
A. What is the basis of that statement? The basis of that statement is from seeing on social media people's posts concerning these things saying that they are asking where to go, who to see, what -- because the places that they -- they

haven't been able to find the right person to do anything.

Q. Are you aware of anyone who has been -- who is transgender who has been denied their hormone replacement therapy by Medicaid in West Virginia?

MS. BUCHERT: Objection to form.

THE WITNESS: No one personally.

BY MS. CYRUS:

Q. Are you aware of anyone who is a Medicaid participant who's been denied counseling in West Virginia for being transgender?

A. No. No one personally, no.

Q. And if the testimony in this case is that both counseling and hormone replacement therapy are covered by Medicaid for its participants regardless of being transgender and, in fact, it covers those things for transgender participants, do you have any reason to dispute that?

MS. BUCHERT: Objection to form.

THE WITNESS: You're leaving out the surgical care.

BY MS. CYRUS:

Q. I am. That's right.

My question is about counseling and hormone replacement therapy, that's correct.

A. But if you're going to talk about something you need to discuss it all. That would not make -- that would make that statement still factual, would it not --

Q. Do you have any -- do you have any reason to dispute the testimony that both counseling and hormone replacement therapy are covered by Medicaid for its participants even the transgender ones?

MS. BUCHERT: Objection to form.

THE WITNESS: I can't speak for everybody else. I can only speak for myself.

BY MS. CYRUS:

Q. And based upon your own experience, that is a true statement, both your counseling and hormone replacement therapy are covered by Medicaid; is that right?

MS. BUCHERT: Objection to form.

THE WITNESS: To my knowledge, yes.

BY MS. CYRUS:

Q. Is it your understanding that you have been diagnosed with gender dysphoria?

A. Yes.

Q. What -- and I'm finished with the exhibit for the moment.

What does that condition mean to you?

MS. BUCHERT: Objection to form.

THE WITNESS: I'm not a doctor so I can't put it into technical terms but --

BY MS. CYRUS:

Q. I don't need you to.

A. But as far as myself, it's just what I've always known my whole life that my outward appearance does not reflect my inward appearance, who I am on the inside, who I've always been.

Q. Does that have some impact on you?

A. A great deal of impact.

Q. That's what I'm trying to get at. What is the impact on you? Can you describe for me symptoms that you experience that you believe are gender dysphoria?

MS. BUCHERT: Objection to form.

THE WITNESS: Not being able to be my authentic self, to have to live a lie, to have to be -- to be something that someone else says I'm supposed to be. To let somebody else make the decisions about my life and about my care. It's

hurtful.
BY MS. CYRUS:
Q. Is there somebody who is mocking you now?
MS. BUCHERT: Objection to form.
THE WITNESS: Everywhere I go. I live in a state full of people that are not always receptive of people of being transgender. That's why I try to live as stealth as possible.
BY MS. CYRUS:
Q. Are there certain procedures that you believe you need that will treat your gender dysphoria?
MS. BUCHERT: Objection to form.
THE WITNESS: Just the treatment that is prescribed and that's all the cosmetic that's considered medically necessary treatment.
BY MS. CYRUS:
Q. And what -- I'm sorry.
A. Go ahead.
Q. No. I was going to say what is that? Can you tell me specifically what the treatment is that you're referring to?
MS. BUCHERT: Objection to form.
THE WITNESS: Gender confirmation,

whatever else that I would need, whatever a doctor thinks would give me the best quality of life.

BY MS. CYRUS:

Q. And are you able to be more specific beyond just gender confirmation? Are there specific procedures that you believe you need that are medically necessary to treat your gender dysphoria?

MS. BUCHERT: Objection to form.

THE WITNESS: There are other procedures that -- it's not that -- not just what I believe, it's what a whole list of doctors believe and know to be true. I mean, but me specifically, a breast augmentation is one of them.

BY MS. CYRUS:

Q. And is that the only one?

MS. BUCHERT: Objection to form.

THE WITNESS: No. But it was -- I mean, I could go on for hours about things of that nature but I'm not.

BY MS. CYRUS:

Q. I had an understanding that you were at least initially saying you believed you needed breast augmentation and vaginoplasty?

A. Yes, from my understanding when you asked the line of questioning, vaginoplasty was -- we already knew that that's what I wanted. That was -- I do want -- let me go on the record and say that a vaginoplasty, which is gender confirmation surgery, and a breast augmentation, and not to be limited to just those two things but ...

Q. Believe me. I'm not limiting you -- I'm trying to find out what it is that you're seeking.

What is your -- I don't know if you want to call it a wish list, but if you were to, you know, have what you believe you need to treat your gender dysphoria, what is it you're seeking it and I had understood it would be a breast augmentation and vaginoplasty; is that correct?

MS. BUCHERT: Objection to form.

THE WITNESS: That's correct. And any surgical care that a doctor would recommend for me to have.

BY MS. CYRUS:

Q. Has any doctor recommended you have breast augmentation and vaginoplasty?

A. No doctor has said these things on the record because they know that Medicaid does not

cover it, and they know what kind of distress that would cause me to even talk about it.

Q. How do you know that that's why no doctor has said that on the record?

MS. BUCHERT: Objection to form.

THE WITNESS: Because they've all mirrored the same thing when we've had these conversations. It's not covered by Medicaid.

BY MS. CYRUS:

Q. So you've discussed --

A. So there is no sense in them discussing it any further.

Q. So you have discussed with physicians the fact that breast augmentation and vaginoplasty would not be covered by Medicaid?

MS. BUCHERT: Objection to form.

THE WITNESS: No. The doctors have discussed with me that it's not covered. So there is nothing that they can do about it.

BY MS. CYRUS:

BY MS. CYRUS:

Q. Do you know if any of your medical records say that?

MS. BUCHERT: Objection to form.

THE WITNESS: To my knowledge, no.

BY MS. CYRUS:

Q. So have you ever made a claim with Medicaid requesting that it or one of the MCOs, your MCO, pay for you to have breast augmentation and vaginoplasty?

A. No, I have not.

Q. Have you ever made a claim for any other type of gender confirming surgery through Medicaid?

A. No, I have not.

Q. So assuming you were -- let's just assume that you were to have breast augmentation and vaginoplasty, how do you believe those procedures would affect your gender dysphoria?

MS. BUCHERT: Objection to form.

THE WITNESS: It would make me feel closer to being complete -- to feel a lot better about especially aesthetic wise when I go out into public, how people -- you know, how I'm perceived and that would continue to help me live as stealth as possible and to live happily as a woman.

BY MS. CYRUS:

Q. When you say those would help you be closer to being complete, are you referring to being a complete woman?

A. Yes.

MS. BUCHERT: Objection to form.

BY MS. CYRUS:

Q. If you have breast augmentation and vaginoplasty, do believe your gender dysphoria will be gone completely?

2010 you began to medically transition, and you lacked health -- access to health insurance for gender confirming care but you still had a need to transition that was so urgent you were forced to self treat. So in 2010 we talked about, that was during one of the windows when you were not incarcerated, correct?

A. Yes.

Q. And the self-treating is take estrogen, which we talked about. And then you went to prison, paragraph ten, and continued your process. And in prison you, number 11, you talk about how you updated your status to reflect your transgender identity. You were treated as a woman for purposes of security checks. And evaluated by medical professionals and you got approval to wear typically feminine undergarments as part of your transition. We've talked about all of that in this case; is that right?

A. Yes, we have.

Q. I just don't want to belabor anything or go back over. I just make to want sure we've covered everything that you're saying here.

Page 3 you started -- 12, you began

counseling and were diagnosed with gender dysphoria. And I'm assuming that refers to the time when you were incarcerated, correct?

MS. BUCHERT: Objection to form.

THE WITNESS: Yes.

BY MS. CYRUS:

Q. And then while you were incarcerated you advocated for access to gender confirming care for several years. And then in around 2019 is when you had the recommendation for the hormone replacement therapy and you started that around May of 2019.

You said you were not, however, able to access gender confirming surgery. And your earlier testimony was that was because you hadn't met the criteria; is that correct?

A. Yes. With the passing of the Bureau of Prisons form for caring for transgender people, I would have to meet the criteria. I had not been on hormone therapy long enough.

MS. BUCHERT: And, Shauntae, I'm going to instruct you to take all the time (inaudible) this document. We're going through it pretty quickly and I'm having (inaudible) through. I known we've been doing this for a while but I just think it's

STATE OF WEST VIRGINIA, To-wit:

I, Magdalena Szczerba, a Notary Public and Registered Professional Reporter within and for the State aforesaid, duly commissioned and qualified, do hereby certify that the videotaped deposition of Shauntea Anderson was duly taken by me and before me at the time and place specified in the caption hereof.

I do further certify that said proceedings were correctly taken by me in stenotype notes, that the same were accurately transcribed out in full and true record of the testimony given by said witness.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which these proceedings were had, and further I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

I certify that the attached transcript meets the requirements set forth within article twenty-seven, chapter forty-seven of the West Virginia Code.

My commission expires the 3rd day of July, 2022.

Given under my hand and seal this 1st day of May, 2022.

Magdalena Szczerba

Magdalena Szczerba
Registered Professional Reporter
Notary Public

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5200149
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/22/2022
WITNESS' NAME: Shauntae Anderson

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

05-24-2022 Shauntae Anderson
Date

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 24th day of May, 2022.

Notary Public

03/25/2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Jeremy Ryan Young
The UPS Store
3501 MacCorkle Ave SE
Charleston WV 25304
My Commission Expires March 25, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5200149

PAGE/LINE(S) /	CHANGE	/REASON
Page 11, Line 3:	"port" should be "part"	Typographical error
Page 154, Line 17:	"woman" should be "women"	Typographical error
Page 180, Line 15:	"woman" should be "women"	Typographical error

05-24-2022
Date

Shauntae Anderson

SUBSCRIBED AND SWORN TO BEFORE ME THIS 24th

DAY OF May, 2022.

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Jeremy Ryan Young
The UPS Store
3501 MacCorkle Ave SE
Charleston WV 25304
My Commission Expires March 25, 2026

03/25/2026
Commission Expiration Date

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson;
individually and on behalf of all
others similarly situated,
Plaintiffs,

v. Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

WILLIAM CROUCH, in his
official capacity as
Cabinet Secretary of the
West Virginia Department Of
Health and Human Resources;
CYNTHIA BEANE, in her official
capacity as Commissioner for the
West Virginia Bureau for Medical
Services; and WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN
RESOURCES, BUREAU FOR MEDICAL
SERVICES,
Defendants.

VIDEOTAPED ZOOM DEPOSITION OF CHRISTOPHER FAIN

On the 28th day of April 2022, beginning at approximately 10:00 a.m., via Zoom, before, Melanie Smith, Court Reporter and Notary Public, appeared CHRISTOPHER FAIN, Witness, who being by me first duly sworn, gave his oral deposition in the causes pursuant to notice of counsel and for the respective parties as hereinafter set forth.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:
ANNA P. PRAKASH, VISITING ATTORNEY
NICHOLS KASTER, PLLP
IDS CENTER, 80 SOUTH 8TH STREET
SUITE 4600
MINNEAPOLIS, MN 55402
(612) 256-3200
aprakash@nka.com

ON BEHALF OF THE PLAINTIFFS:
WALT AUVIL, ESQ.
THE EMPLOYMENT LAW CENTER, PLLC
1208 MARKET STREET
PARKERSBURG, WV 26101-4323
(304) 485-3058
auvil@theemploymentlawcenter.com

ON BEHALF OF THE PLAINTIFFS:
AVATARA SMITH CARRINGTON, VISITING ATTORNEY
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
3500 OAK LAWN AVENUE, SUITE 500
DALLAS, TEXAS 75219-6722
(214) 219-8585
asmithcarrington@lambdalegal.org

ON BEHALF OF THE PLAINTIFFS:
TARA L. BORELLI, VISITING ATTORNEY
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
158 WEST PONCE DE LEON AVE., SUITE 105
DECATUR, GA 30030
tborelli@lambdalegal.org

APPEARANCES (cont'd)

ON BEHALF OF THE DEFENDANTS:
LOU ANN S. CYRUS, ESQ.
KIMBERLY M. BANDY, ESQ.
SHUMAN MCCUSKEY SLICER PLLC
P.O. BOX 3953
CHARLESTON, WV 25339
(304) 345-1400
lcyrus@shumanlaw.com
kbandy@shumanlaw.com

ALSO PRESENT:
ANDREW BAKER
(VIDEOGRAPHER)

MS. PRAKASH: Objection. Foundation.

THE WITNESS: She started the process of referring me to an endocrinologist.

BY MS. CYRUS:

Q. Then did you go to an endocrinologist?

A. Yes.

Q. Was your understanding that the purpose of the male hormones was for some -- a type of gender-confirming care?

MS. PRAKASH: Objection to form.

THE WITNESS: Yes. That's what sex hormones are for. Mine are for masculinization, yes.

BY MS. CYRUS:

Q. And you started taking those in March of 2019?

A. Yes.

Q. Are you familiar with the term "gender-confirming surgical procedures"?

boss?

A. No.

Q. Okay. Did you then suffer nightmares and disturbed sleep because of these work confrontations?

A. Yes.

Q. Okay. Are those types of things still going on where you work, either at the liquor store or at the university or at the school?

MS. PRAKASH: Objection. Form.

THE WITNESS: They happen about 25 to 35 percent of the time at the store. For the most part, my regulars don't slip. My voice sometimes will slip. When I was wearing a mask, I was misgendered nine times out of ten. It became very stressful and anxiety-producing to hear that all day. So I made a conscious decision to take my mask off and work without it in order to be properly gendered.

So that dropped down to only about 20 to 35 percent of the people still having issues with it, but it's not rudeness, it's just perception.

BY MS. CYRUS:

Q. Okay. Did you have a hysterectomy?

A. Yes.

Q. Okay. When was that?

A. Fall of 2018.

Q. And so it was -- the surgery was not related to you being transgender?

A. No.

Q. Okay. And did insurance -- did you have insurance that paid for your hysterectomy?

A. Yes.

Q. And what insurance was that?

A. That was Medicaid.

Q. So Medicaid paid for your hysterectomy in 2018?

A. Yes.

Q. Now, have you -- did you also have surgery on your back as well?

A. Yes. I had surgery on my -- on my upper back and neck.

Q. And when was that?

A. June the 1st of this year.

Q. So 2021?

A. Yeah, 2021.

Q. Okay. And did Medicaid pay for that?

A. No.

Q. Okay. Did you have any insurance coverage for that?

A. No. Medicaid denied everything to do with it.

Q. Do you know why it was denied?

A. They were recommending a procedure that would have left me with a lot less mobility and my surgeon absolutely would not work with that. She insisted that it had to be a disc replacement instead of a fusion. However, Medicaid was not going to pay for a disc replacement, so they didn't.

Q. So I see, there was an -- there was an offer to pay for some type of surgery for your back, just not the one that you preferred; is that right?

A. I wouldn't call it a preference. I would call it the one that left me with the most amount of mobility at 46 years old.

Q. When you say Medicaid denied it, do you have any indication that Medicaid denied that surgery because of your being transgender?

A. No.

Q. Okay. After -- now, there's a reference to your records that after you had a surgery nurses referred to you as female. Do you -- let me ask you: Did that happen after your back surgery or your hysterectomy or something else?

MS. PRAKASH: Objection. Form. And I'll just note again none of these purported records are being shown to Mr. Fain. Go ahead.

THE WITNESS: I do however know exactly what's being discussed. After spine surgery, yes, while in horrendous pain and unable to handle it, and disoriented from drugs, I was subjected to a number of nurses in the entryway of my room consistently referring to me as "she" and "her." And, when I called out about it and said, "Look, I can hear you," one of them laughed and said, "Yes, we know."

BY MS. CYRUS:

Q. Did they change their behavior then after you called them out?

A. No.

Q. Okay. Did you report that to anybody at the hospital or complain?

A. My anxiety levels soared through the roof to the point where I went into the start of cardiac arrest.

Q. And, after you obviously made it through your cardiac arrest, did you ever report that incident to the hospital or to any administration?

A. Oh, yes, yes, everybody on that floor got to hear about it because I was very loud and angry.

Q. Did you file a formal complaint, if you know?

A. I chose not to file a formal complaint. Instead, I wrote on the form that I was given they ought to consider, you know, some cultural sensitivity training.

Q. Did you have a transphobic experience with your primary care physician?

MS. PRAKASH: Objection. Form.

THE WITNESS: At one time, yes, and it was the reason why I switched to Kim Neely.

BY MS. CYRUS:

Q. Okay. And what was the transphobic experience?

A. I had an incident with the receptionist at a Valley Health office.

Q. Okay.

A. Oh, would you like me to tell you about that?

Q. Sure.

A. She looked and acted like she could crawl up a wall backwards to get away from me when I told her I needed to change my name and gender markers on my files. She looked absolutely horrified, and this is a woman I've known for at least a decade.

Q. Did you -- did you make any type of formal complaint against the doctor's office as a result of that?

A. I called the number on the back of my insurance card that was listed as the actual like Valley Health office for filing complaints, but at that point the numbers apparently had changed, the telephone numbers had changed because instead of getting ahold of like anybody to formally lodge a complaint with, I ended up getting ahold of Kim Neely's nurse.

I had called Kim's office, and after explaining everything to this nurse, she pulled up -- she had pulled up my records while we were talking and she was like, "So can I set you an appointment?" I switched doctors while trying to, you know, formally complain.

MS. PRAKASH: Lou Ann, we've been going for

about an hour. Can we take a break?

MS. CYRUS: Yeah, I was exactly going to say that, so absolutely. Let's go ahead and do that. We'll come back in ten minutes?

MS. PRAKASH: That sounds good.

MS. CYRUS: okay. Thank you.

MS. PRAKASH: Uh-huh.

VIDEOGRAPHER: This is the end of Media Unit No. 1. We are off the record at 11:05 a.m.

(Short recess.)

VIDEOGRAPHER: This is the beginning of Media Unit No. 2. We are on the record at 11:15 a.m.

BY MS. CYRUS:

Q. Okay. Mr. Fain, earlier I made a note that you said you think you've been on Medicaid off and on for a number of years. Is that right?

A. Yes, that is correct.

Q. Okay. And I made a note about 2016. Was that when you most recently became a Medicaid participant?

A. That's the one I can remember the best because when I injured my back I needed to go apply for insurance, make sure I had insurance.

Q. So your injury to your back is what prompted you to sign up on Medicaid at that time?

A. Yes. I had been without insurance for a while.
Q. Okay. And how did you know you were eligible for Medicaid?
A. Because I was working a minimum-wage job at 20 hours a week.
Q. Okay. And I take it when you signed up for Medicaid you had no health insurance coverage?
A. That's absolutely true, yes.
Q. Okay. Do you know what MCO stands for?
A. No.
Q. Okay. Do you know what a managed care organization is?
A. Sort of.
Q. Okay. When you signed up for Medicaid, were you required to pick, and it's called a managed care organization? Do you know -- do you know if that's accurate, that you were required to do that?
MS. PRAKASH: Objection. Foundation.
THE WITNESS: I don't know and I -- or don't remember. I just know that I applied and they sent cards, they sent my insurance cards to me in the mail. That's I think the first time I'd saw UniCare written on anything.
BY MS. CYRUS:

Q. That's what I was going to ask you, about UniCare. Do you know what UniCare's role is with regard to Medicaid?

A. No.

Q. Okay. Do you know what UniCare's role is with regard to you and your Medicaid coverage?

A. No.

Q. So it sounds like you did not pick UniCare?

A. I don't remember picking one.

Q. Okay. Do you remember whether you reviewed the Medicaid manual in connection with signing up on Medicaid?

A. I remember being sent a manual that I read, well, that I looked through after receiving Medicaid.

Q. So after you were already enrolled you took a look at the manual you received?

A. Yes.

Q. Okay. So did you look into whether Medicaid covered gender-confirming care before signing up?

A. No.

Q. Okay. Did you talk with anyone with Medicaid about what gender-confirming care was covered by Medicaid in connection with signing up?

A. No.

Q. Okay. So, when you signed up for Medicaid, did you have any understanding of what -- of whether Medicaid covered any gender-confirming care or not?

A. No.

Q. So, when you signed up for Medicaid, I take it you didn't have any understanding that it covered hormones for gender-confirming care?

A. No.

Q. Okay. Do you have an understanding now that Medicaid does cover hormones for gender-confirming care?

A. Yes.

Q. Okay. When did you learn that?

A. After realizing that my endocrinologist wasn't billing Medicaid and that was the reason why I was still paying for my hormones, and that was when I was informed that that was something that Medicaid was supposed to be paying for.

Q. Okay. So, when you first started getting the hormones, were they paid by Medicaid, or no?

A. The first prescription, when it went through, yes, it was paid by Medicaid. In the immediate after that something went down in my doctor's office, they stopped communicating with Medicaid, and suddenly I am paying full price for hormones, even though my labs and

doctors' visits were still covered.

Q. Okay. I was going to ask you that. So you had to have lab work done as part of taking your gender-confirming hormones and those were covered by Medicaid?

A. Yes.

Q. And your visits to your doctor, your endocrinologist who was prescribing the hormones, those were covered; correct?

A. Yes.

Q. Okay. And how did that ultimately -- if it ultimately got straightened out, how did it get straightened out, if you know?

A. It got straightened out through I communicated with the supervisor at the clinic and I switched doctors, but it was actually the pharmacist who reminded -- who pointed out that if I'd been covered once I should definitely be covered. So I switched doctors and got that straightened out and never had a problem with it again.

Q. Okay. So, when you discussed it with the pharmacist, the fact that the it was not being -- the hormones were not being paid, the pharmacist said if you were covered previously it should still be covered?

A. Yes.

Q. Okay. So no pharmacist told you that the hormones were not covered by Medicaid; is that right?

A. That's true.

Q. Okay. So what is your understanding of what this lawsuit is about?

A. This lawsuit is to -- let me find words to describe this. This lawsuit is to gain gender-confirming surgical insurance through Medicaid --

Q. Okay. So do you -- I'm sorry. Go ahead.

A. -- and to have that exemption lifted so that other procedures are possible beyond hormones.

Q. Okay. So do you have an understanding that there is an exclusion in the Medicaid plan that's at issue, specifically for what's called transexual surgery?

MS. PRAKASH: Objection. Form. You can answer.

THE WITNESS: Yes.

BY MS. CYRUS:

Q. Okay. And do you understand that the exclusion does not categorically deny transgender people all coverage for gender-confirming care?

MS. PRAKASH: Objection. Form. You can

answer.

THE WITNESS: I don't think I've read that deep into it.

BY MS. CYRUS:

Q. Okay. Well, gender-confirming care includes counseling or therapy; is that right?

A. Yes.

Q. And yours, for transgender purposes, has been covered --

A. Yes.

Q. -- by Medicaid; is that right?

A. Yes.

Q. Okay. And do you agree that hormone therapy, hormone replacement therapy, is also part of gender-confirming care?

A. Yes.

Q. Okay. And that -- your hormone replacement therapy has been, and is being, covered by Medicaid?

A. Yes.

Q. Okay. And are you aware that the lawsuit that was filed on your behalf alleges that Medicaid excludes -- it's a categorical denial for all transgender coverage for gender-confirming care?

MS. PRAKASH: Objection. Misstates the

record in this case. Foundation. You can answer.

THE WITNESS: I'm pretty sure that it's not saying anything about all gender-confirming care. As far as I know, the lawsuit's specific to gender-confirming surgical care.

BY MS. CYRUS:

Q. Okay. Have you -- so you've actually looked at the lawsuit that was filed on your behalf in this matter?

MS. PRAKASH: Objection. Asked and answered.

THE WITNESS: Yes.

BY MS. CYRUS:

Q. Okay. Now, were you aware there was an amendment to the original lawsuit?

A. Yes.

Q. Okay. All right. And do you remember whether you -- so you looked at the -- well, you looked at the lawsuit before it was filed on your behalf?

A. I'm sorry, I don't understand the question.

Q. Yes. I'm just asking -- and I asked you if you looked at the lawsuit that was filed in this matter on your behalf, and I understood you to say yes, you did, and I'm asking did you look at it before it was filed.

A. Yes.

Q. Okay. We're going to go ahead and mark our first exhibit. Do you have double monitors there in front of you?

A. Yes.

Q. Okay. And I will let you know when that is loaded. Okay, so if you click on the marked exhibits, we've marked as Exhibit No. 1 --

A. Okay.

Q. -- a pleading that was -- it's the First Amended Class Action Complaint, filed on 10/28/21.

(Exhibit No. 1 identified for the record.)

BY MS. CYRUS:

Q. Do you see that?

A. Yes.

Q. Okay. All right. Is this -- do you know whether this is the lawsuit that you've looked at?

A. I'm looking at this document. Yes.

Q. Okay. All right. So, just looking at paragraph No. 1, it starts out, "This case is about discrimination in health care and employment." Plaintiffs bring this suit to challenge discrimination under West Virginia state health insurance plans that deprive transgender people of essential, and sometimes

life-saving, health care." Is that right?

A. True, yes.

Q. Okay. And then it says, "These state health plans facially, and categorically, exclude coverage for health care that transgender people require." Is that right?

A. Yes.

MS. PRAKASH: Objection. Lou Ann, are you asking if you are reading this correctly or are you asking whether the sentence is accurate? I'm not sure what your question is.

MS. CYRUS: Okay. Thank you. I'm just asking if I'm reading it accurately.

MS. PRAKASH: Okay. So then I will just object as duplicative, redundant, kind of a waste of time because the document is in the record and states what it states. But go ahead.

BY MS. CYRUS:

Q. And then it goes on to say, "The exclusions in the state health plans described in paragraphs 63 and 66 use antiquated and improper language, but their targeting of transgender people on explicitly sex-based terms is unmistakable." Is that what it says?

A. Yes.

Q. Okay. Then it says, "The exclusions all categorically deny transgender people coverage for gender-confirming care." Is that correct? It does say that; correct?

A. Yes.

Q. Okay. And then it defines, "Gender-confirming care includes, but is not limited to, counseling, hormone replacement therapy, and surgical care." Is that correct? It says that?

A. Yes.

Q. Okay. And, in this instance, the exclusion that is at issue for West Virginia Medicaid does not categorically deny transgender people coverage for gender-confirming care as far as you understand; correct?

MS. PRAKASH: Objection. The question mischaracterizes the purpose of the complaint, also calls for a legal conclusion. Go ahead.

THE WITNESS: It says a lot about different types of gender-confirming care, but gender-confirming care involves surgery as well. And, as far as I know, this lawsuit is about the surgery, you know, lifting those exclusions totally. There's no point in giving someone only half of what they need.

BY MS. CYRUS:

Q. Well, the allegation in the lawsuit is that there's an exclusion that categorically denies transgender people coverage for gender-confirming care, including, but not limited, to counseling, hormone replacement therapy and surgical care; correct?

MS. PRAKASH: Objection. Misstates document. Go ahead.

THE WITNESS: That is -- that does very much misstate what this says.

BY MS. CYRUS:

Q. Okay. You tell me then what you believe this says.

MS. PRAKASH: Objection. Calls for a legal conclusion. Go ahead.

THE WITNESS: Well, it lists what gender-confirming care is and then it confirms it, and then it says, "Accordingly, as used herein, gender-confirming care includes the care denied pursuant to each of these -- of those exclusions."

The exclusions that we are asking to have lifted have nothing to do with the ones that are already allowed. It has to do with the ones that are not allowed.

BY MS. CYRUS:

Q. There is no exclusion for coverage for your gender-confirming counseling; is that right?

MS. PRAKASH: Objection. Asked and answered.

THE WITNESS: Counseling is not surgery.

BY MS. CYRUS:

Q. My question is: There is no exclusion for gender-confirming care in the form of counseling; is that right?

MS. PRAKASH: Objection. Asked and answered. You can answer again.

THE WITNESS: That is correct, my therapy is covered.

BY MS. CYRUS:

Q. Okay. And there is no exclusion for your hormone replacement therapy that is gender-confirming care; correct?

A. That is correct.

MS. PRAKASH: Object. Asked and answered.

THE WITNESS: That is -- that is correct.

BY MS. CYRUS:

Q. And, to the extent this document suggests that there is an exclusion for counseling and hormone

replacement therapy as part of gender-confirming care, that is not accurate; correct?

MS. PRAKASH: Objection to form, also hypothetical. But go ahead, Christopher.

THE WITNESS: Could you point out to me where it specifically says denial about -- I mean point out exactly what you are trying to say to me.

BY MS. CYRUS:

Q. I'm asking you about the last sentence on page 1, where it says, "The exclusions all categorically deny transgender people coverage for gender-confirming care. Gender-confirming care includes, but is not limited to, counseling, hormone replacement therapy, and surgical care."

The question is: Doesn't this document indicate there's an exclusion that categorically denies transgender folks coverage for counseling, hormone replacement therapy and surgical care, among others?

MS. PRAKASH: So same objection to form, to misstating the document, to calling for a legal conclusion. But you can answer, Christopher.

THE WITNESS: I refer to my lawyers. I can't follow what's being asked.

BY MS. CYRUS:

Q. Well, I'm asking -- so you're not able to follow what's being asked?

A. No?

Q. Is that your answer?

A. No, I can't follow what you're actually trying to point out here.

Q. But you certainly don't dispute that there is not an exclusion in Medicaid for counseling or hormone replacement therapy; is that right?

MS. PRAKASH: Objection. Asked and answered numerous times. You can answer again.

THE WITNESS: There's no exclusion for those types of care, no.

BY MS. CYRUS:

Q. And, to your knowledge, has Medicaid or one of -- or UniCare ever denied payment for your therapy, for seeing a psychiatrist or psychologist as part of your gender-confirming care?

A. As far as I know, no.

Q. To your knowledge, has Medicaid or UniCare ever denied a claim for hormone therapy on the basis that you were transgender?

A. No, not that I know of.

Q. Are you aware of any denial of a claim you made

that was a denial by Medicaid or UniCare on the basis that you are transgender?

MS. PRAKASH: Objection. Form.

THE WITNESS: No, there's been no direct denial, yeah, no.

BY MS. CYRUS:

Q. Would it be fair to say there is not a blanket refusal for all transgender health care by Medicaid?

MS. PRAKASH: Objection. Form.

THE WITNESS: According to the book itself, it says all transgender care.

BY MS. CYRUS:

Q. Okay. What book says all transgender care?

A. The actual medical insurance book that I was sent --

Q. Is that --

A. -- by Medicaid.

Q. By Medicaid?

A. Yeah, actually the UniCare, the UniCare book actually has it in there, "all transgender care."

Q. But, in your experience, you are aware that you have coverage for everything you've submitted; is that right?

MS. PRAKASH: Objection. Vague.

THE WITNESS: Yeah, for everything that's been submitted.

BY MS. CYRUS:

Q. Okay. So it would not be accurate to say Medicaid has a blanket refusal for all transgender health care; is that correct?

MS. PRAKASH: Objection. Asked and answered. Christopher, you can answer this question, but, Lou Ann, I think you are debating semantics at this point, and I think the witness has answered thoroughly. Christopher, go ahead.

THE WITNESS: Regardless of what is de facto being practiced, the allowance for hormones and therapy and things like that, which by the way I'm pretty sure it doesn't cover voice therapy, but that would be interesting to see if it does, it does however state in the manual all transexual surgeries and procedures.

BY MS. CYRUS:

Q. Well, I'm not --

A. And that has nothing to do with hormones and therapy. That is surgery.

Q. When you say, "That has nothing to do with hormones and therapy, that is surgery," what is that

that you're referring to?

A. The refusal in the manual refers specifically to transexual surgeries.

Q. Correct. And, therefore, isn't it true it would not be accurate to say Medicaid has a blanket refusal for all transgender health care?

MS. PRAKASH: Objection. Asked and answered numerous times. And, Counsel, I will -- I will state for the record that we have made representations to the Court, you have made representations to the Court, and the Court has in fact issued orders that talk about the scope of this case, and so I am unclear why you are hammering on this point when the witness has thoroughly answered your question, and any argument you have can be made based on the record in this case that exists or on the papers. But, Christopher, you can answer again.

THE WITNESS: No, I'm done answering this question.

MS. PRAKASH: Well, I mean you have to answer her again, but you can give her the same answer, unless your answer has changed.

MS. CYRUS: Well, I didn't get the answer. You objected the last time I asked the question and then

I did not hear him answer the question. I think he gave a non-responsive response. So that's why I asked it again.

BY MS. CYRUS:

Q. My question is: Isn't it true it is not accurate to say Medicaid has a blanket refusal for all transgender health care?

MS. PRAKASH: Same objections. Go ahead.

THE WITNESS: Repeat the question again.

BY MS. CYRUS:

Q. Isn't it true that it is not accurate to say Medicaid has a blanket refusal for all transgender health care?

MS. PRAKASH: Same objections. Go ahead.

THE WITNESS: That's a really twisty way of asking that question. Could you ask that more simply, please?

BY MS. CYRUS:

Q. Medicaid does not have a blanket refusal for all transgender health care; is that correct?

MS. PRAKASH: Same objection.

THE WITNESS: According to its manual, it does.

BY MS. CYRUS:

Q. According to your experience, is that accurate?

MS. PRAKASH: Same objection.

THE WITNESS: I'm pretty sure I answered this before. I get therapy, I get hormones, but I'm denied surgery.

BY MS. CYRUS:

Q. And, in fact, the manual, the Medicaid manual, excludes transexual surgery only; correct?

A. Yes, and that's why this lawsuit exists.

Q. So the Medicaid manual does not exclude these other items aside from transexual surgery; correct?

MS. PRAKASH: Objection to form.

THE WITNESS: To be absolutely certain, I would have to read -- to look at the manual again. But, like I said, I get therapy and hormones, but I'm denied surgery.

BY MS. CYRUS:

Q. Have you ever told anyone that Medicaid has a blanket refusal for all transgender health care?

MS. PRAKASH: Objection. Vague.

BY MS. CYRUS:

Q. If you did say that, that would not be accurate, certainly not based on your experience; correct?

MS. PRAKASH: Objection. Hypothetical. Go ahead.

THE WITNESS: I don't understand why you keep using "blanket refusal" because obviously, you know, there's not a blanket exclusion, obviously, even though it says directly in the manual that they don't. Obviously I'm getting hormones and therapy, so obviously Medicaid and UniCare are paying for this. However, we are arguing against exclusion against surgery.

BY MS. CYRUS:

Q. So obviously there's no blanket refusal for all transgender health care; correct?

MS. PRAKASH: Objection. Form.

THE WITNESS: I've already answered you on this.

BY MS. CYRUS:

Q. I'm sorry, did you say correct?

A. I have already answered you.

Q. Okay. Well, I want to make sure I heard your answer. I didn't hear --

A. I think I said yes a few times too, but yes.

Q. Okay. I think we're going to go ahead and mark our next exhibit.

Okay, it should be there for you. We've

marked as Exhibit 2 to your deposition a document that was produced by -- on your behalf in this case that is Bates stamped CFAIN0004767.

(Exhibit No. 2 identified for the record.)

BY MS. CYRUS:

Q. Do you recognize what this document is?

A. It's a chat transcript.

Q. Okay. And this -- according to this, if the timing is accurate, this chat took place on June 10, 2021. Is that right?

A. Yes.

Q. Okay. And, if you go down to the bottom, the next-to-the-last comment by you, 6/10/2021 at 2:02 p.m., you said, "Well, the top surgery is what I'm suing the state of West Virginia for. They won't cover it because they have a blanket refusal for all transgender health care." Did I read that right?

A. Yes.

Q. Did you say there was a blanket refusal for all

transgender health care?

MS. PRAKASH: Objection. Document speaks for itself. Vague as to "Did you say." Go ahead.

THE WITNESS: This was how I worded it to Brigitte, yes.

BY MS. CYRUS:

Q. And that was not a correct statement; is that right?

MS. PRAKASH: Objection. Form. Argumentative. Go ahead.

THE WITNESS: It's very obvious that this was what was being written at the moment; however, I think you're again playing with semantics.

BY MS. CYRUS:

Q. But it is not accurate to say there is a blanket refusal for all transgender health care; is it?

MS. PRAKASH: Objection. Form.

THE WITNESS: No, it would not be entirely accurate because again, as I've pointed out over and over again, I get therapy and I get hormones. However, I want top surgery, and therefore I need, just like everybody else in the state of West Virginia like me, needs to have the exclusion struck down.

BY MS. CYRUS:

BY MS. CYRUS:

Q. Regarding your diagnosis of gender dysphoria, what does that condition mean to you?

MS. PRAKASH: Objection. Form. Go ahead.

THE WITNESS: It's difficult to describe what it means to you to have something riding around inside of you that -- it's like living in a machine because you learn not to pay attention to your body. But gender dysphoria is -- is horrific and it's painful and it's disorienting and it makes you want to hide. That's what gender dysphoria is like, and often that's what it means.

BY MS. CYRUS:

Q. If I were to --

A. It --

Q. I'm sorry. Go ahead.

A. It cuts -- it cuts your life in half.

Q. If I were to ask you what -- to describe for me

the symptoms you experience that you believe are gender dysphoria, would your answer be the same as what you just said or would you have other things you would add?

A. I would --

MS. PRAKASH: Object to form.

THE WITNESS: I would go in and describe the symptoms. Is that something that you actually need?

BY MS. CYRUS:

Q. Yes. I just didn't want to ask you to repeat yourself. What -- can you describe for me what symptoms you experience that you believe are gender dysphoria?

A. I experience severe pain in my breasts. I experience stomach and heart anxiety, palpitations and tightenings. I experience trembling. I experience hostility and fear.

Q. Okay. Are there certain procedures you believe you need to treat your gender dysphoria?

A. Yes.

Q. Okay. And what do you believe you need to treat it?

A. I believe top surgery is necessary.

Q. Okay. And, when you refer to top surgery, what is it that you would anticipate would happen?

A. The complete removal of my breast tissue and

remodeling of my nipples so that they would be placed in a better place, a better position on any chest.

Q. Okay. So would that be a mastectomy and some sort of reconstruction?

MS. PRAKASH: Objection to form. Go ahead.

THE WITNESS: Yeah. Yes.

BY MS. CYRUS:

Q. Okay. And you -- have you obtained a letter from a doctor recommending you have a mastectomy?

A. Yes, two letters.

Q. Okay. When did you obtain the first letter?

A. In November of 2018.

Q. Now, is that the one where you were referred -- recommended to have the hormones?

A. And further on the surgery.

Q. Okay. Did you ever provide a copy of the November letter to anyone with Medicaid or UniCare?

A. Yes. My doctor, my primary care physician, was given a copy when she made -- before she made the referral for hormones.

Q. Okay. But my question was: Did you ever give a copy of the November 2018 letter to either Medicaid or UniCare?

A. I'm pretty sure that the letter has to be

submitted by the doctor with the referral.

Q. Okay. Do you know if you had a doctor who submitted that letter, the 11/18 letter, to Medicaid?

A. I have no idea whether or not it was submitted.

Q. Okay. And do you have a more recent letter that has recommended mastectomy?

A. Yes.

Q. Okay. We're going to mark -- we've marked your next exhibit and you can open it. You can go ahead and open the next one.

A. All right.

MS. PRAKASH: Hey, Lou Ann, just for planning purposes, I'd like to take a break after you're done with this exhibit.

MS. CYRUS: okay. Sure.

THE WITNESS: Okay, I've got the letter open.

(Exhibit No. 3 identified for the record.)

Q. Okay. And, if you go back to the first page, it has, "Visited on: 2021 June 10th." So this was -- is it your understanding this was -- and at the very -- right below that it says, "CC Surgical Candidacy Letter, June 10, 2021." Correct?

A. Yes.

Q. So it's your understanding this letter was issued on June 10th of 2021?

A. Yes.

Q. Do you know, has this letter, to your knowledge, been provided to either Medicaid or UniCare?

A. No.

Q. Okay. And do you know why not?

A. Because I have not approached my primary care physician yet for a referral for top surgery.

Q. Okay. So you gave her a copy of the letter, but you haven't asked her to I guess take whatever next steps there might be so that this gets requested to Medicaid or UniCare?

A. Yes.

Q. Okay. And why have you not done that?

A. I have had medical issues that we've been handling with my back that I wanted to take care of that and make sure everything was okay there before I said let's talk to a surgeon for referral to get top surgery.

Q. So, from your perspective, would it be fair to say even if the surgery were covered by Medicaid, as of today you're not prepared to go forward and have it?

MS. PRAKASH: Objection. Mischaracterizes testimony. Go ahead.

THE WITNESS: Oh, I'm more than ready. They've already fixed what was wrong with my back, so yeah, I'm actually ready. I just haven't gone to the doctor about this yet.

BY MS. CYRUS:

Q. And so, if you are ready, why haven't you gone to the doctor about it?

A. Because I'm in the process of quitting smoking so that I will better my chances of healing correctly.

Q. Has any doctor told you that prior to having the top surgery you need to quit smoking?

A. Oh, yes. I had quit smoking for a long time and I picked them up again out of anxiety. So, until I have completely kicked the habit, I am not willing to risk it. However, I'm seeing a doctor that is preparing to take that next step with medication.

Q. Medication to stop -- help you stop smoking?

A. Yes.

Q. Okay. So you're not willing to have the surgery until you've stopped smoking; is that right?

MS. PRAKASH: Object to form.

THE WITNESS: Not until I know for certain that I'll be okay, but yeah, I can quit smoking any time, it's whether or not I can handle the cravings afterwards. But, yes, I could actually lay them down today and go have surgery tomorrow if I needed to.

BY MS. CYRUS:

Q. Is it -- is it fair to say then you have not

been -- as of today you've never been denied a claim with Medicaid or UniCare requesting that they pay for you to have a mastectomy?

A. No.

Q. Okay. No, that's not true, or, no, you haven't been denied?

A. I have not been denied. However, I was under the impression that that wouldn't be necessary.

Q. What wouldn't be necessary?

A. I already know that I'll be denied.

Q. You haven't actually gone through the process and submitted a claim that has been denied; is that correct?

A. No, but --

MS. PRAKASH: Objection. Asked and answered. Go ahead.

THE WITNESS: -- it seems pointless to go and ask my doctor to do something when we both know the result will be a denial.

BY MS. CYRUS:

Q. Okay. Have you -- have you considered moving to another state that its Medicaid might cover this surgery?

A. No.

was a question about your dosage that had caused your prescriptions not to be filled?

A. Yeah.

Q. Okay. And then did you -- when that situation was happening, were you under the impression that your hormones were not covered?

A. That was sort of the impression I had gotten from just the way my doctor was behaving about it. She said that Medicaid wouldn't approve, so I just took it as said, and that, from what I understand, was not what was going on there. That was entirely on her part and the part of her staff. Yeah, I believed that it was not approved.

Q. In other words, that it was not covered?

A. Yeah, that it was not covered.

Q. Okay. But, after that was brought to your attention, I take it you were able to work with the doctor's office, or some doctor, and get the question answered and get your medication going again?

A. Exactly. They were able to call in and handle the question that was being asked about the dosage because all of it kicked on a dosage.

Q. Correct.

A. And, for some reason, she and her nurses would

not communicate with Medicaid and explain why that dosage was necessary.

Q. Okay. If you go to box 17 -- no, I'm sorry, 18, the next one down --

A. Okay.

Q. -- you noted, "Well, just unfriended a family member after some horrific anti-transgender BS." And that looks like -- is that 4/11/19?

A. Yeah, yeah, 4/11/19.

Q. Yeah. What was that about?

A. That is my cousin's wife, and she was part of a conversation on Facebook that I was reading and it turned pretty anti-transgender and I started to withdraw, and then she got involved in the conversation and it upset me, it upset me that her attitude was is that: So what if I -- you know, if someone transgender needed therapy or hormones when she couldn't even get her teeth fixed. And my attitude was apples are not oranges.

Q. Okay. And then you have, "I deserve affordable health care just like you, and if your insurance doesn't cover your teeth, that has nothing to do with me getting hormones." What -- what was that about?

A. That's what that was about.

But, once I reached the point where I could put things on overtop of my head again, I started wearing an official binder, the ones on the market now, and that was in 2017. And I have not worn anything even resembling a bra since mid 2017.

Q. Okay. And, if you'll go to paragraph 19, you say you require a bilateral mastectomy as medically necessary to care and treat your gender dysphoria, and it's my understanding and you go on to talk about, that would eliminate your need for the binder; is that right?

A. That's absolutely true, yes.

Q. Okay. And, again, that's the only procedure that you're seeking at this time?

A. Yes.

Q. Okay. In No. 20 you say your Medicaid -- as a Medicaid participant you receive coverage through the managed care organization UniCare, which we've talked about, and you say you are aware there is an exclusion in the state Medicaid plan that bans the gender-confirming surgery care you need; is that right?

A. That's true.

Q. Okay. Have you had some instance where you felt like you needed to drop this lawsuit for some reason?

CERTIFICATION OF COURT REPORTER AND NOTARY PUBLIC

I, Melanie Smith, Court Reporter and Notary Public, duly Commissioned and qualified, do hereby certify that the foregoing deposition was duly taken by me and before me at the time and place and for the purpose specified in the caption hereof, the said witness having been by me first duly sworn.

I do further specify that the said deposition was correctly taken by me in Stenotype and that the same was reduced to computer print by me or under my direct supervision.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in the action.

I certify that the attached transcript meets the requirements set forth within article twenty-

seven, chapter forty-seven of the West Virginia Code.

Before completion of the deposition, review of the transcript { X } was { } was not requested. If requested, any changes made by the deponent (and provided to the reporter) during the period allowed are appended hereto.

Given under my hand this 11th day of May, 2022.

My Commission expires February 13, 2026.

Melanie E. Smith

Melanie E. Smith

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5200225
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/28/2022
WITNESS' NAME: Christopher Fain

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

5-23-2022 Christopher Fain
Date Christopher Fain

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 23rd day of May, 2022.

Elizabeth A. Cross
Notary Public

5/3/27
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Elizabeth Ann Cross
The UPS Store
729 9th Ave.
Huntington WV 25701
My Commission Expires May 3, 2027

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, and
SHAWN ANDERSON,
a/k/a Shauntae Anderson;
individually and on behalf of all others
similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Defendants.

AFFIDAVIT OF JENNIFER MYERS

STATE OF WEST VIRGINIA,

COUNTY OF Kanawha

I, Jennifer Myers, duly sworn, make oath upon my knowledge as follows:

1. I currently serve as the Director of Professional Services for the West Virginia Bureau for Medical Services (WVBMS).

2. I have reviewed the claim information available to WVBMS as of January 28, 2022, contained in the Medicaid Management Information System ("MMIS") for Plaintiff Christopher Fain which has been produced in discovery in this matter. I have identified several medical claims with the documented primary diagnosis of F64.0, "Transsexualism," F64.8, "Other gender identity

EXHIBIT
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DHHRBMS021712

disorders," Z79.890, "Hormone replacement therapy," or Z87.890, "Personal history of sex reassignment."

3. Each of these claims has been paid, as set forth below.

4. I have reviewed the claim information available to WVBMS as of January 27, 2022, contained in the Medicaid Management Information System ("MMIS") for Plaintiff Shauntae Anderson which has been produced in discovery in this matter. I have identified several medical claims with the documented primary diagnosis of F64.0, "Transsexualism," F64.1, "Dual role transvestism," F64.9, "Gender identity disorder, unspecified," or Z87.890, "Personal history of sex reassignment."

5. Each of these claims has been paid, as set forth below.

AND FURTHER AFFIANT SAYETH NOT.

Jennifer Myers
Director of Professional Services
West Virginia Bureau for Medical Services

Sworn and subscribed to before me this 29th day of April, 2022.

My commission expires: April 7, 2024

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
ROBIN MARTIN
1411 VIRGINIA ST. E., STE 200
CHARLESTON, WV 25301
My Commission Expires April 07, 2024

[SEAL]

NOTARY PUBLIC

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF BRIAN THOMPSON

DATE: April 13, 2022
TIME: 8:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5128144

APPEARANCES

On Behalf of the Plaintiffs (Via Videoconference):

TARA L. BORELLI, ESQ.
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Ave., Suite 105
Decatur, Georgia 30030
470.225.5341
tborelli@lambdalegal.org

AVATARA SMITH-CARRINGTON, ESQ.
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

ANNA PRAKASH, ESQ.
Nichols Kaster PLLP
80 South 8th Street, Suite 4700
Minneapolis, Minnesota 55402-2224
612.256.3291
aprakash@nka.com

WALT AUVIL, ESQ.
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
304.485.3058
auvil@theemploymentlawcenter.com

On Behalf of Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services (Via Videoconference):

KIMBERLY M. BANDY, ESQ.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street East, Suite 200
Charleston, West Virginia 25301
304.345.1400
kbandy@shumanlaw.com

NOTE: The original deposition transcript will be delivered to Attorney Smith, Esq., as the taking attorney.

and some of them we can create and customize according to our needs.

Q. Okay. And, let's see. I'm going to read the response that was provided to this interrogatory. So if you start at the top of Page 3, I will read a section of that response, okay?

A. Okay.

Q. Okay. So, "Further without waiving the objection with regard to hormone therapy, these defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender confirming care." Did I read that correctly?

A. You did.

Q. Okay. And then, let's see. So just to confirm, BMS covers hormone replacement therapy for treatment of gender dysphoria, correct?

A. Yes. I think it would be more accurate to say that we don't restrict it. We would never, for instance, if testosterone is run through, we would never know what it was being used for unless a human being told us what it was being used for. There's not a diagnosis requirement when you enter a claim at a retail pharmacy that would stop it. It might get stopped for some other reason at which case then you would have a conversation and find out what it's being used for.

Q. Okay. So just to make sure that I understand what you're describing, so essentially, and correct me if I'm wrong, the diagnosis would not stop the claim, but there are other data points that could?

A. Yeah, like those edits that I was talking about, if you try to fill it too early. A lot of injectables are only stopped because they are an injectable because of the nature, it's just a little bit more of a concern for safety when you're injecting something as opposed to giving somebody pills that you can discontinue the pills mid therapy. If you inject it, you know, there's nothing you can do until they metabolize the drug, so. So in the conversation of, if you do have a conversation about say testosterone or whatever, we do not restrict according to gender dysphoria, if we are made aware that's why it's being used, there is no restriction for

that, no policy for that.

Q. Okay. And does that apply, or does that include both estrogen and testosterone, so talking about hormone replacement therapy broadly, does that when you narrow it down include estrogen and testosterone?

A. It does, yes.

Q. And does that include any other hormones?

A. Yeah, if it's -- so all of these, so the use of testosterone and estrogen in various other drugs that are typically used in gender confirming care, they are all off label use right now, the FDA hasn't approved those. So there's not, there's not a policy around, so I guess what I'm saying is that with off label use they often require discussion about why it's being used, about the proper dosing and the proper frequency of use. So there is no, like there are no edits that would stop those from going through for various diagnoses.

The only time that we would even become aware of why it would be used would be if there's some other reason that the drug stops. Estrogens don't get stopped a lot because of birth control, things like that, they're oral. Testosterones get stopped a little bit more because they are very common used injectables, so they are stopped just simply because they're an injectable.

that you might have to go to the doctor's office to get them to inject or to administer, so for their own members they're responsible for making those coverage decisions. But if we cover it, they're supposed to provide some way of covering it as well. They might have different policies around it, but they have to provide some way of getting something that we cover by contract, is my understanding.

Q. Understood. And are there any reasons why coverage for hormone replacement therapy for treatment of gender dysphoria would be denied?

A. Other than safety, no, I can't, for that specific diagnosis, I can't imagine, you know, from a pharmacy standpoint why we would.

Q. And has BMS ever denied coverage for Mr. Fain's hormone replacement therapy?

A. There was one, when I looked at the profile there was one denial. There was several edits that prevented it from paying because it required, I think there was, it might have been a pregnancy, I can't remember all the edits that have fired, but in general every time, they called Rational Drug three times, got two approvals, there was one denial, and that was simply because they were trying to use it every five days and it was supposed to be used every seven days, so as soon

as they clarified that, it got paid. So I would say no, we did not deny it for gender dysphoria.

Q. Okay. And has BMS ever denied coverage for Ms. Anderson's hormone replacement therapy?

A. No. There were some edits that prevented the claim from going through initially, I think most of those were like early refills, things like that, and I think there was maybe an injectable at one point, but no. And I would also add that on both of these patients none of their claims for estrogen or testosterone ever made it up to us for review, they were always approved eventually at Rational Drug level.

Q. Understood. And you have already gone through the breakdown of the review process, so.

(Exhibit 12 marked for identification.)

Q. I've just introduced another exhibit, but before I turn to this, Mr. Thompson, just to make sure, are you looking at anything else on your screen other than Exhibit Share?

A. No, I'm just looking at the exhibits that you have pulled up.

Q. Okay. So do you see what has been marked as BT0012?

A. Sixth supplement to plaintiffs?

Q. Yes.

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

I hereby certify that I reported the Zoom deposition of Brian Thompson on the 13th day of April 2022, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was reserved.

WITNESS MY HAND AND SEAL THIS 13th day of April 2022.

Kelley E. Zilles, RPR
Notary Public, Washington County, Minnesota
My commission expires 1-31-2025

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5128144
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/13/2022
WITNESS' NAME: Brian Thompson

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

5-18-2022 Brian Thompson
Date Brian Thompson

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 18th day of May, 2022.

Kimberly M O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5128144

PAGE/LINE(S) / CHANGE /REASON

p.14 / 14-15 "looks for outstanding & unusual claims to help us manage fraud & waste." By unusual I mean excessive quantities or claims billed to Medicaid 1st when the member ~~already~~ had ~~primary~~ unreported primary insurance. / Clarification

p.15 / 17 "... ~~at the~~ in the inpatient pharmacy" / Clarification

p.15 / 25 "considered the Heart Hospital" / Clarification

p.35 / 12-13 EPSDT is not required for children. - It is / & 23 a benefit that provides comprehensive & preventative health care services for children under age 21 who are enrolled in Medicaid. The EPSDT benefit ~~services~~ can cover medically necessary services not normally covered under Medicaid. / Clarification & Correction

p.67 / 13 Hepatic "B" → Should be Hepatitic C / Correction

p.73 / 10 ~~PO~~ "POs" folder → Should be "PA folder" / Correction

5-18-2022 Brian Thompson

Date Brian Thompson

SUBSCRIBED AND SWORN TO BEFORE ME THIS 18th

DAY OF May, 2022.

Kimberly M O'Brien

Notary Public

July 28, 2026

Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5128144

PAGE/LINE(S) /	CHANGE	/REASON
p.76 / 3-5	"And so the data that he would have been accessing was probably at least 2 months old or so ..."	/ Correction.
p.78	pharmacogenticallly → "Pharmacokinetically"	/ Spelling Correctio

5-18-2022 Brian Thompson

Date Brian Thompson

SUBSCRIBED AND SWORN TO BEFORE ME THIS 18th

DAY OF May, 2022.

Kimberly M O'Brien

Notary Public

July 28, 2026

Commission Expiration Date

OFFICIAL SEAL
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WV DHHR Bureau for Medical Services
350 Capitol St. Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' FIRST SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

8. Documents sufficient to identify the circumstances in which counseling and/or therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 519.22, attached as Exhibit 4, beginning with Bates Number DHHRBMS000107.

9. Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 518 Pharmacy Services, attached as Exhibit 5, beginning with Bates Number DHHRBMS000109, and the most recently updated Preferred Drug List with Prior Authorization Criteria, attached as Exhibit 6, beginning with Bates Number DHHRBMS000145.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

10. Documents sufficient to identify the circumstances in which orchiectomy, penectomy, vaginoplasty, hysterectomy, phalloplasty, mammoplasty, breast reconstruction surgery, and/or mastectomy are covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see BMS Provider Manual Chapter 519.16 Surgical Services, attached as Exhibit 7, beginning with Bates Number DHHRBMS000199.

22. All documents upon which Defendants considered, relied upon, or intend to rely upon, in support of their admissions and/or denials of any of the allegations contained in the Complaint.

SUPPLEMENTAL RESPONSE: Please see the Medicaid State Plan, attached as Exhibit 8, beginning with Bates Number DHHRBMS000203, and the online table of contents, attached as Exhibit 9, beginning with Bates Number DHHRBMS001003.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 13th day of October, 2021, a true and exact copy of **DEFENDANTS' FIRST SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Ted Cheatham
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

Exhibit
BT 0011

	Males on estrogen	Females on Testosterone (Including Oxandrolone)	Females on testosterone (Excluding Oxandrolone)
2012	1	4	0
2013	2	5	0
2014	2	2	0
2015	2	6	0
2016	0	4	1
2017	19	20	14
2018	39	48	41
2019	44	65	56
2020	61	79	71
2021	114	139	121

EXHIBIT
173

DHHRBMS021563

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Exhibit
BT 0012

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

DEFENDANTS' SIXTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

2. All documents relating to Plaintiff' s communications, injuries, requests for coverage, requests for prior authorization, requests for reimbursement and/or complaints regarding coverage for Gender-Confirming Care through the West Virginia Medicaid Program. This Request includes but is not limited to:

a. All communications to and from Plaintiff relating to coverage for Gender-Confirming Care;

b. All Documents and communications regarding Plaintiff's requests for Gender-Confirming Care, including but not limited to communications among Defendants, and/or the employees, entities, agents, representatives, contractors, vendors, and/or consultants of Defendants and/or West Virginia Department of Health and Human Resources, Bureau of Medical Services;

c. All Documents and communications relating to consideration or processing by third-party administrators, contractors, and/or vendors of requests for Gender-Confirming Care by Plaintiff.

SUPPLEMENTAL RESPONSE: See attached excel spreadsheet with claim information for hormones for Plaintiffs Fain and Anderson, attached as Exhibit 97, Bates No. DHHRBMS016224. With regard to Plaintiff Fain, see the attached audio recording regarding request for approval for medication, attached as Exhibit 98, Bates No. DHHRBMS016225; West Virginia Controlled Substance Report from Board of Pharmacy records, attached as Exhibit 99, Bates No. DHHRBMS016226-16228; and Member Notes attached as Exhibit 100, Bates No. DHHRBMS016229-16230. All materials are CONFIDENTIAL.

4. All Documents and communications relating to the Exclusion, including but not limited to:

a. All Documents and communications relating to the decision to maintain the Exclusion in the Health Plans in any plan year.

b. All Documents and communications relating to the decision to permit coverage for hormone therapy for the purpose of treating gender dysphoria.

c. All Document and communications relating to evaluating, examining, analyzing, and/or considering the Exclusion in any way.

SUPPLEMENTAL RESPONSE: See attached West Virginia Model Member Handbook, attached as Exhibit 105, Bates No. DHHRBMS016291-16320.

24. To the extent not requested above, all Documents that Defendants may rely upon to support their defenses against Plaintiff's claims in this action.

SUPPLEMENTAL RESPONSE: See the attached 2019-2020 Aetna Member Handbook attached as Exhibit 101, DHHRBMS016231-16278; See email with subject: Enrollment Data – Health Equity/ SDOH Accreditation, attached as Exhibit 102, Bates No. DHHRBMS016279-16283 ; email with subject: Enrollment Data - Health Equity / SDOH Accreditation, attached as Exhibit 103, Bates No. DHHRMBS016284-16287; and email with subject: Health Equity Follow Up, attached as Exhibit 104, Bates No. DHHRBMS016288-16290; Please note, confidential attorney/client privileged communication redacted.

WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,
By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esq. (WVSB #6558)
Roberta F. Green, Esq. (WVSB #6598)
Caleb B. David, Esq. (WVSB #12732)
Kimberly M. Bandy, Esq. (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; and **BRIAN MCNEMAR,** Individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department Of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 24th day of February, 2022, a true and exact copy of **DEFENDANTS' SIXTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058; (304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200; (612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245; (202) 429-9574 (fax)
sbuchert@lambdalegal.org

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3500 Oak Lawn Avenue, Suite 500
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(214) 219-8585; (214) 219-4455 (fax)
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Los Angeles, CA 90010
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Counsel for Plaintiffs
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730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
(470) 225-5341
(404) 897-1884 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
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Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esq. (WVSB #6558)
Roberta F. Green, Esq. (WVSB #6598)
Caleb B. David, Esq. (WVSB #12732)
Kimberly M. Bandy, Esq. (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL;BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' SECOND SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

DOCUMENT REQUESTS

25. To the extent not already produced, all Documents related to Plaintiff Christopher Fain, and proposed Plaintiff Shauntae Anderson.

SUPPLEMENTAL RESPONSE: Please see three excel spreadsheets regarding Plaintiff Fain's medical information attached as Exhibit 87, 88, and 89, Bates Nos. DHHRBMS016069; DHHRBMS016070 and DHHRBMS016071, respectively. Additionally,

please see other patient information regarding Plaintiff Fain, attached as Exhibit 90, Bates No. DHHRBMS016072-16077.

With regard to Plaintiff Anderson, please see two excel spreadsheets with medical information, attached as Exhibits 91 and 92, Bates No. DHHRBMS016078 and DHHRBMS016079.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/ Caleb B. David
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

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Hon. Robert C. Chambers, Judge

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Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 1st day of February, 2022, a true and exact copy of **DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' SECOND SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
(404) 897-1880
(404) 506-9320 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/ Caleb B. David
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

In the Matter of:

CHRISTOPHER FAIN

vs

WILLIAM CROUCH, et al.

DR. DAN KARASIC

April 15, 2022

5010 Dempsey Drive
Cross Lanes WV 25313
304-415-1122

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN McNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

vs. Civil Action No. 3:20-cv-00740

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; CYNTHIA BEANE, in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT, in his official capacity as Director of the West Virginia Public Employees Insurance Agency; and THE HEALTH PLAN OF WEST VIRGINIA, INC.,

Defendants.

"CONFIDENTIAL"
VIDEOTAPED DEPOSITION OF DR. DAN KARASIC
BY VIDEO CONFERENCE

The videotaped deposition of Dr. Dan Karasic was taken on April 15, 2022, at 12:02 p.m., at 5010 Dempsey Drive, Cross Lanes, West Virginia.

ELITE COURT REPORTING, LLC
5010 Dempsey Drive
Cross Lanes, West Virginia 25313
(304) 415-1122

Martha Fourney, CSR

A P P E A R A N C E S

Caleb B. David
Attorney at Law
Shuman McCuskey Slicer, PLLC
1141 Virginia Street, East, Suite 200
Charleston, West Virginia 25301
(By video conference)

Walt Auvil
Attorney at Law
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
(By video conference)

Avatara Smith-Carrington
Attorney at Law
Lambda Legal Defense and Education Fund
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219-6722
(By video conference)

Tara L. Borelli
Attorney at Law
Lambda Legal Defense and Educational Fund
1 West Court Square, Suite 105
Decatur, Georgia 30030
(By video conference)

gender-related conditions?

ATTORNEY SMITH: Object to form.

A. So I just was -- I thought about that and looked at patients that I saw over a couple of days, and about two-thirds of my private practice patients are transgender.

Q. Do all of those patients who are transgender treat with you for gender dysphoria or gender incongruence?

ATTORNEY SMITH: Object to form.

A. No. Many of them are transgender but are seeing me for -- for example, mood and anxiety disorders or other psychiatric conditions.

Q. And I think that from reading your report there is a difference between someone having a transgender identity and someone having gender dysphoria; is that correct?

ATTORNEY SMITH: Object to form.

A. Yes.

Q. Can you explain what that difference is?

A. Sure. So being transgender is an identity. It's how someone identifies. And

gender dysphoria is used both to describe a symptom, but also to describe a DSM-5 disorder of gender dysphoria.

Q. Is there a difference between gender dysphoria as a symptom and gender dysphoria as a diagnosis?

ATTORNEY SMITH: Object to form.

A. Yes. The DSM diagnosis requires that the person be -- the distress that somebody is experiencing from gender dysphoria be clinically significant or affecting social or occupational -- causing social or occupational impairment.

Q. Does clinical significance mean that it's causing those social or occupational impairments?

A. So it can be social or occupational impairment, or it can be so much distress that you go to the doctor. So that's what's clinically significant.

Q. So there are patients who experience gender dysphoria as a symptom, but do not have the clinical significance that rises to the level of a DSM-5 diagnosis; is that correct?

ATTORNEY SMITH: Object to form.

A. Yes. In that -- we assume so, in that there's a fairly decent percentage of people, maybe one in 200 in large health surveys, who identify as transgender. So maybe one in 200.

Perhaps one in a thousand, according to a paper I reference Zhang, are in clinical care for gender dysphoria. So we assume that there are people who experience gender dysphoria but don't go to the doctor for it.

Q. Okay. So there are - based on the numbers that you just quoted to me - one in 200 identify as transgender, one in a thousand are treating for gender dysphoria. So that's -- if I'm doing quick math correctly -- approximately one-fifth of transgender individuals are seeking treatment for gender dysphoria?

ATTORNEY SMITH: Object to form.

A. It's never been exactly teased out that way.

Q. Okay.

A. But we assume that that's so because there are fewer people who are actually going to the doctor. And to get a diagnosis of

gender dysphoria, you would need to go to the doctor.

Q. Now, your patient population -- the two-thirds of your patients who are transgender -- of those two-thirds, are you able to break it down between children, adolescents and adults?

ATTORNEY SMITH: Object to form.

A. Yes. I actually -- at the same time, I looked at a few days of patients. It broke down to -- about a third of my patients were patients that I had started seeing in adolescence in my private practice. So some of them may have turned 18 -- might have been -- may be legal adults by now.

About a third were adults when they came into my private practice. And then the other third were cisgender. So just an approximate breakdown of a few days of patients that I looked at.

Q. I'll ask you a few more questions about your background. I noticed in your report, in -- in your initial report -- the first report that you did, in paragraph six, you say

getting gender-affirming care?

Q. No. No, not that.

I'm asking if there is a methodology or a treatment plan that can assist individuals with managing the symptoms of gender dysphoria separate from receiving hormone therapy or surgical therapy?

ATTORNEY SMITH: Object to form.

A. So there's not a specific psychiatric treatment to cause relief from gender dysphoria.

Q. So when you are seeing patients with gender dysphoria, you are generally assisting them -- or providing therapy for other conditions, like depression and anxiety. What else are you doing for those patients with gender dysphoria?

ATTORNEY SMITH: Object to form.

A. Sure. So I do work with them in terms of exploring their identity and their symptoms of gender dysphoria. I try to leave it to the patient to steer the ship in terms of whether or not -- or when they might get gender-affirming care.

Sometimes people know they want gender-affirming care, but they can't get it at that time for example. Somebody living at home with parents or otherwise dependent on another person might be an example where they might need to postpone that.

So I'm certainly working with the symptoms of gender dysphoria as -- among the symptoms that the person is experiencing without there being a specific psychiatric treatment for gender dysphoria.

Q. So on the -- you just mentioned gender-affirming care and -- how is it determined whether a patient needs or -- I'll just use the word "needs." Whether a patient needs gender-affirming care, hormone therapy or surgical therapy?

ATTORNEY SMITH: Object to form.

A. Sure. So in practice -- first of all, there are some differences. There are differences between adolescents seeking gender-affirming care and adults. And practices also -- I think a difference between when someone is exploring their gender identity

or unsure of the kind of gender-affirming care they might want or if or when they might want it.

And then there are other people who for example have lived in the gender in which they identify for extended periods of time, where gender identity and what they want to do about it is not really in question. I think there's a whole range of approaches depending on the patient.

Q. Let's start with adults. The two plaintiffs in this case are adults.

A. Uh-huh.

Q. How do you determine whether -- well, let me just start over here.

So if you were going to recommend a course of treatment for a patient -- I assume that there has to be indications for that course of treatment, correct?

ATTORNEY SMITH: Object to form.

A. Yes. So I think that certainly the presence of a diagnosis of gender dysphoria where somebody has had persistent and prominent in some ways distress related to their gender

dysphoria. And of course having the capacity to consent for care. I think those are essential factors for an adult seeking hormones.

Q. So not all adults who are diagnosed with gender dysphoria undergo hormonal or surgical treatment, correct?

ATTORNEY SMITH: Object to form.

A. Yes. As I said, we presume that because of differences in statistics between how many people are in clinical care and how many people identify as transgender -- presumably many of the people who identify as transgender, you know, aren't coming to me. And so they may -- they may have some level of distress that is not severe enough that they need relief from transitioning.

Q. So how is there a determination whether someone's level of distress is severe enough to require those medical or surgical treatments?

ATTORNEY SMITH: Object to form.

A. So I think that a good guide is the DSM-5 diagnosis. Clinically significant distress, social and occupational impairment so

that the distress of gender dysphoria is significantly affecting their life.

ATTORNEY SMITH: Caleb, not to interrupt you -- we've been going for a little bit -- for an hour now. Can we go ahead and take a break for a minute?

MR. DAVID: Absolutely. You want to take five minutes?

ATTORNEY SMITH: Yes. That works.

VIDEOGRAPHER: We are going off the record at 1300.

(Break in proceedings.)

VIDEOGRAPHER: We are back on the record at 1306.

BY MR. DAVID:

Q. Doctor, before we took a break, I was asking some questions about how the determination is made that someone's distress from gender dysphoria rises to the level of needing medical or surgical treatment. You referred me to the DSM-5 and the discussion on clinical -- clinically significant distress. Is that where we were?

ATTORNEY SMITH: Object to form.

A. Yes.

Q. Okay. Is there a diagnostic test to determine whether someone's stress (sic) is clinically significant?

ATTORNEY SMITH: Object to form.

A. Whether someone's distress is clinically significant?

Q. Yes.

A. So that is determined in the course of psychiatric evaluation; not by a specific distress test, but using the clinical judgment of the clinician.

Q. So we had broken this down -- because I had asked you a very broad question. And you said that it would be different for adults, adolescents and children. So let me ask you -- adolescents, how do you determine whether that individual requires or needs medical or surgical therapy for gender dysphoria?

ATTORNEY SMITH: Object to form.

A. Sure. So we -- if I am going by my clinical practice and that of a child in the Adolescent Gender Center at UCSF, we -- as well as I think guidance from WPATH, we agree that

adolescents require more evaluation -- a longer-term evaluation, especially if just presenting with gender dysphoria in adolescence. So it's typically not the work that I do, although there have been times when I have. But it's typically not the work that I do because it's -- I will typically refer them to some of my psychotherapist colleagues to meet with the adolescent over time and to make a determination in terms of whether -- along with the patient, along with the patient's parents. There is a -- they can come to an agreement in terms of what is or isn't to be done next.

Q. Why do you refer those patients to psychotherapist colleagues rather than make that determination yourself?

ATTORNEY SMITH: Object to form.

A. So I have limited time. I had limited time when I was at a UCFS faculty member. And I have limited time now, and so -- and this is often a time-intensive process.

So I have had -- at times there have been, you know, adolescents where I have done

that work. But typically I will refer them to psychotherapists who do that work as a regular thing in their practice and have the time to devote to that individual for psychotherapy, to do that work.

Q. And if you know, what is the purpose of the psychotherapy that is provided to those adolescents?

ATTORNEY SMITH: Object to form.

A. Sure. So it depends on the adolescent. But it can be to help them explore -- not only their identity, but whether or not they want to take steps -- if we're talking specifically in the context of gender-affirming care -- whether or not that is a next step for them.

And so that's work done with a therapist getting to know their client and getting to know the client's parents and assessing the degree of distress and the persistence of that distress that might be relieved by gender-affirming care.

Q. Okay. So do you treat children? And when I say children, I mean people younger than adolescents. Do you provide psychiatric

treatment for gender dysphoria to children?

ATTORNEY SMITH: Object to form.

A. No.

Q. So in your practice, have you recommended to adolescents that they undergo medical therapy, so hormonal therapy?

ATTORNEY SMITH: Object to form.

A. So I would say that it is -- I would say that we let the adolescent bring that up first, and then explore it as opposed to, for example, my pushing forward with any particular direction for that adolescent.

So the adolescent might bring up that -- you know, having distress where they want a particular intervention. As I said, typically, I'll refer them to a therapist to work with them more intensively before making a recommendation to -- for example, call the Child and Adolescent Center at UCSF.

Q. So if a patient brings up a potentially medical or surgical transition, do you always refer that patient out to a separate gender clinic?

ATTORNEY SMITH: Object to form.

you know, it seems clear from a clinical exam.

Q. Are you aware of any other DSM-5 diagnosis that is treated surgically?

ATTORNEY SMITH: Object to form.

A. I cannot think of another DSM-5 diagnosis that is treated surgically.

Q. Okay. If you can, flip to your expert rebuttal report which has been marked as Exhibit 2 to your deposition. There are a few things -- and I promise we're not going to go through this paragraph by paragraph. But there are a few things that I wanted to ask you about. And the first is in paragraph 15 of Exhibit 2. Are you there?

A. Yes. I'm there.

Q. And I'll go ahead and read it. In an American prospective study of 104 transgender and nonbinary youth, treatment with puberty blockers or hormones was associated with 60 percent less moderate to severe depression, and 73 percent less suicidal ideation over 12 months compared to youth not treated. And you say Tordoff, et al., 2022.

Did I read that correctly?

I, Martha Fourney, Certified Court Reporter and Notary Public, do hereby certify that the foregoing deposition of the above-named witness, was duly taken by me in machine shorthand, was recorded via Zoom, and that the same were accurately written out in full and reduced to computer transcription.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, nor do I have a financial interest in the action.

My commission expires May 27, 2022

Martha Fourney
Certified Court Reporter/Notary Public

SIGNATURE/ERRATA SHEET

I, DAN KARASIC, hereby certify I have read the foregoing transcript and that the same is a true and accurate transcription of my testimony, except as noted below:

PAGE: LINE: CHANGE: REASON FOR CHANGE:

See Attachment A.

DAN KARASIC

STATE OF VIRGINIA

COUNTY OF NORFOLK

Subscribed and sworn to before me this

6 day of May, 2022.

Notary Public

KETSIA MCCLEASE
Electronic Notary Public
Commonwealth of Virginia
Registration No. 327724
My Commission Expires Apr 30, 2023

My Commission Expires: 04/30/2023

This notarial act was performed online by way of two-way audio/video communication technology.

ATTACHMENT A

Errata Sheet

Fain, et al. v. Crouch, et al.
Dan Karasic, MD

Page	Line	Correction
19	23	"gender identity" not "a gender identity"
21	2-3	"develops" not "develops as"
30	1	"across" not "cross"
33	16	"they're coming" not "coming"
41	22-23	"that of the Child and Adolescent Gender Center," not "that of a child in the Adolescent Gender Center"
75	21	"as a term" not "as to term"
87	1	"the study" not "my study"
126	10	"orchiectomy" not "oophorectomy"
126	13	"orchiectomy" not "oophorectomy"
126	17	"orchiectomy" not "oophorectomy"
158-9	24-1	"Child and Adolescent Gender Center" not "Child and Adolescents Gender Clinic"
167	8-9, 14	"inter-rater" not "interrater"
168	5, 9, 16, 24	"inter-rater" not "interrater"
179	21	"is" not "he did"

Dan Karasic

State of Virginia

County of Norfolk

Subscribed and sworn to before me this 6 day of May 2022.

Notary Public

KETSIA MCCLEASE
Electronic Notary Public
Commonwealth of Virginia
Registration No. 327724
My Commission Expires Apr 30, 2023

My Commission Expires: 04/30/2023

This notarial act was performed online by way of two-way audio/video communication technology.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, *et al.*, individually and on behalf of all others similarly situated, *Plaintiffs,* v. WILLIAM CROUCH, *et al.*, *Defendants.*	CIVIL ACTION NO. 3:20-cv-00740 HON. ROBERT C. CHAMBERS

CERTIFICATE OF SERVICE

I hereby certify that the EXPERT DISCLOSURE REPORT OF DAN H. KARASIC, M.D. was served electronically on the 18th day of March, 2022 on the following counsel for Defendants in the above-captioned case:

Lou Ann S. Cyrus (WVSB # 6558)
Roberta F. Green (WVSB #6598)
Caleb B. David (WVSB #12732)
Kimberly M. Bandy (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953, Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

Attorneys for Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services

Eric D. Salyers (WVSB #13042)
Perry W. Oxley (WVSB # 7211)
David E. Rich (WVSB #9141)
Christopher K. Weed (WVSB #13868)
OXLEY RICH SAMMONS, PLLC
P.O. Box 1704
517 9th Street, Suite 1000
Huntington, West Virginia 25718
Phone: (304) 522-1138
Fax: (304) 522-9528
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

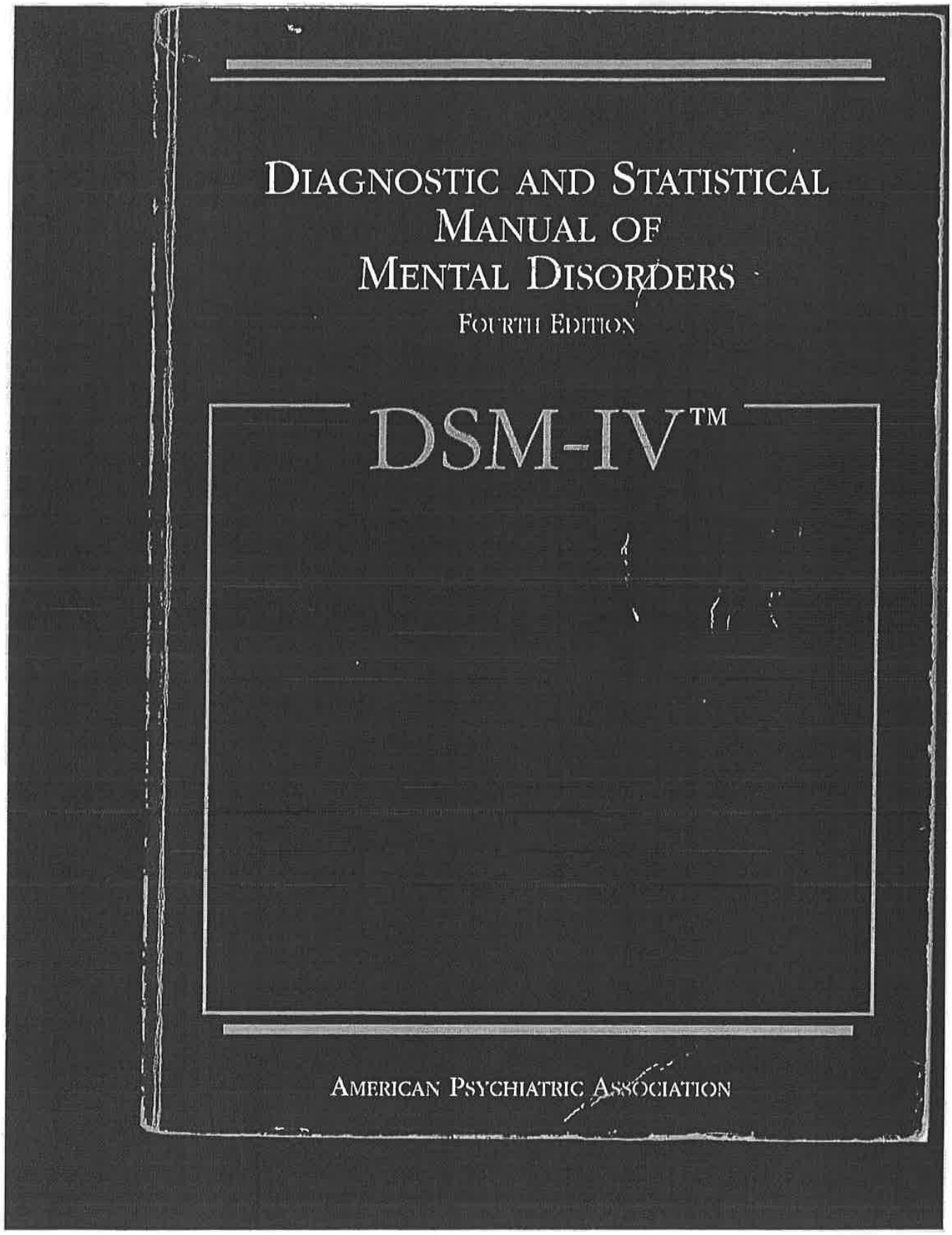
Attorneys for Defendant Jason Haught

Dated: March 18, 2022

Respectfully submitted,

s/ Walt Auvil

Walt Auvil, WV Bar No. 190
THE EMPLOYMENT LAW CENTER, PLLC
1208 Market Street
Parkersburg, WV 26101
Phone: 304-485-3058
Facsimile: 304-485-3058
auvil@theemploymentlawcenter.com


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FOURTH EDITION
DSM-IV™
AMERICAN PSYCHIATRIC ASSOCIATION

302.82 Voyeurism

The paraphiliac focus of Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity or later in response to the memory of what the person has witnessed. Often these individuals have the fantasy of having a sexual experience with the observed person, but in reality this rarely occurs. In its severe form, peeping constitutes the exclusive form of sexual activity. The onset of voyeuristic behavior is usually before age 15 years. The course tends to be chronic.

Diagnostic criteria for 302.82 Voyeurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex

(Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boy's toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes may be required. They prefer boy's clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-play, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex. The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who

present later in life, (often following marriage), sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common and functioning at school or at work may be impaired.

Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both,** and **Sexually Attracted to Neither.** Males with Gender Identity Disorder include substantial proportions with all four specifiers. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

Associated Features and Disorders

Associated descriptive features and mental disorders. Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. Relationships with one or both parents also may be seriously impaired. Some males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy. Especially in urban centers, some males with the disorder may engage in prostitution, which places them at high risk for human immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Disorders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present. Some adult males have a history of Transvestic Fetishism as well as other Paraphilias. Associated Personality Disorders are more common among males than among females being evaluated at adult gender clinics.

Associated laboratory findings. There is no diagnostic test specific for Gender Identity Disorder. In the presence of a normal physical examination, karyotyping for sex chromosomes and sex hormone assays are usually not indicated. Psychological testing may reveal cross-gender identification or behavior patterns.

Associated physical examination findings and general medical conditions. Individuals with Gender Identity Disorder have normal genitalia (in contrast to the ambiguous genitalia or hypogonadism found in physical intersex conditions). Adolescent and adult males with Gender Identity Disorder may show breast enlargement resulting from hormone ingestion, hair denuding from temporary or permanent epilation, and other physical changes as a result of procedures such as rhinoplasty or thyroid cartilage shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes may be seen in females who wear breast binders. Postsurgical complications in genetic females include prominent chest wall scars, and in genetic males, vaginal strictures, rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult females with Gender Identity Disorder may have a higher than expected likelihood of polycystic ovarian disease.

Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism because of cross-gender interests and may suffer less from peer rejection, at least until adolescence. In child clinic samples, there are approximately five boys for each girl referred with this disorder. In adult clinic samples, men outnumber women by about two or three times. In children, the referral bias toward males may partly reflect the greater stigma that cross gender behavior carries for boys than for girls.

Prevalence

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in later adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood or early adolescence. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

Transvestic Fetishism occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria

for Gender Identity Disorder are not met, the specifier With Gender Dysphoria can be used.

The category **Gender Identity Disorder Not Otherwise Specified** can be used for individuals who have a gender identity problem with a **concurrent congenital intersex condition** (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia).

In **Schizophrenia,** there may rarely be delusions of belonging to the other sex. Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.

Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

(continued)

☐ **Diagnostic criteria for Gender Identity Disorder** (*continued*)

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:
302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):
Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include

1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation

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Reliability and Clinical Utility of Gender Identity-Related Diagnoses: Comparisons Between the ICD-11, ICD-10, DSM-IV, and DSM-5

Annelou L.C. de Vries, MD, PhD,[1] Titia F. Beek, MA,[2] Karlien Dhondt, MD, PhD,[3]
Henrica C.W. de Vet, PhD,[4] Peggy T. Cohen-Kettenis, PhD,[2]
Thomas D. Steensma, PhD,[2] and Baudewijntje P.C. Kreukels, PhD[2]

Abstract

Purpose: The World Health Organization general assembly approved the 11th revision of the International Classification of Diseases (ICD) in 2019 which will be implemented in 2022. Gender identity-related diagnoses were substantially reconceptualized and removed from the mental health chapter so that the distress criterion is no longer a prerequisite. The present study examined reliability and clinical utility of gender identity-related diagnoses of the ICD-11 in comparison with the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, ICD-10, and DSM-IV.
Methods: Sixty-four health care providers assessed six videos of two children, two adolescents, and two adults referred for gender incongruence. Each provider rated one pair of videos with three of the four classification systems (ICD-11, DSM-5, ICD-10, and DSM-IV-TR). This resulted in 72 ratings for the adolescent and adult diagnoses and 59 ratings for the children's diagnoses.
Results: Interrater agreement rates for each instrument ranged from 65% to 79% for the adolescence/adulthood diagnoses and from 67% to 94% for the childhood diagnoses and were comparable regardless of the system used. Only agreement rates for ICD-11 were significantly better than those for DSM-5 for both age categories. Clinicians evaluated all four systems as convenient and easy to use.
Conclusion: In conclusion, both classification systems (DSM and ICD) and both editions (DSM-IV and DSM-5 and ICD-10 and ICD-11) of gender identity-related diagnoses seem reliable and convenient for clinical use.

Keywords: classification, DSM, gender dysphoria, gender incongruence, ICD, reliability, utility

Introduction

On May 25th 2019, the World Health Organization's general assembly approved the 11th revision of the International Classification of Diseases (ICD), including a reconceptualization of the gender identity-related diagnoses.[1] Fifty years ago, a diagnostic category describing the incongruence between one's experienced and assigned gender was introduced in the two most broadly used (mental) health classification systems, the ICD of the World Health Organization (WHO) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA).[2,3] In the ICD-9 and the ICD-10 at the time, the term Transsexualism was used for the gender identity-related diagnosis.[4] The DSM-III diagnostic term for adults was also Transsexualism (DSM-III).[5] This term was first changed to Gender Identity Disorder (GID, DSM-IV) and subsequently to Gender Dysphoria (GD) in the most recent version of the DSM, the DSM-5.[6,7] The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health proposed the term Gender Incongruence (GI), a universal term with no reference to emotional stress.[8–10]

Departments of [1]Child and Adolescent Psychiatry and [2]Medical Psychology, Center of Expertise on Gender Dysphoria, Amsterdam University Medical Centers, Location VUmc, Amsterdam, The Netherlands.
[3]Center for Sexology and Gender, Pediatric Gender Clinic, Ghent University Hospital, Ghent, Belgium.
[4]Department of Epidemiology and Biostatistics, Amsterdam Public Health Research Institute, Amsterdam University Medical Centers, Location VUmc, Amsterdam, The Netherlands.

Since its introduction into the classification systems, there have always been controversies around the gender identity-related diagnoses.[11] Because medical gender affirmative interventions are not (yet) needed in prepubertal children, in particular the childhood diagnosis is considered unnecessary by some to allow for access to health care.[12–14] Yet, clinicians working in other contexts claim that a childhood diagnosis for gender incongruence is still necessary to provide appropriate care.[15,16] The diagnosis for adolescents and adults has also been criticized.[13] Most importantly, gender incongruence by itself is considered not a mental disorder, but one of many possible expressions of gender diversity.[10,17,18] To assure access to care, while revising the DSM-IV, the diagnosis was retained in the DSM-5, but in a separate chapter away from conditions such as sexual dysfunctions and paraphilia. In the ICD-11, the diagnosis is entirely removed from the mental health disorders chapter and placed in a separate chapter named "Conditions related to Sexual Health." This shift is to improve transgender persons' human rights and health status by avoiding the combined stigmatization that is still associated with being transgender as well as with having a psychiatric disorder.[8,9,18]

Classification systems in general have proven to be of great value in that a criteria-based approach to diagnosis has markedly improved identification of disorders and diseases.[19] Classification may serve as an important and helpful tool for communication for researchers, policy makers, and clinicians so that when they refer to certain features, they mean the same thing.[20] While revising the classification systems, the diagnostic criteria should have a good interrater reliability.[21] Therefore, in successive revisions of the DSM and ICD, field studies have been performed to test the degree of agreement between clinicians on diagnostic categorization of the most prevalent conditions.[22,23]

Gender identity-related diagnostic criteria have never been formally part of the field trials, neither for the DSM-5 nor for previous DSM versions or for the various ICD editions. Only the diagnostic criteria for the childhood diagnosis have been examined in one DSM-III interrater reliability study that used parent reported chart information of gender-referred children.[24]

While preparing the 11th version of the ICD Mental Health Chapter, the WHO put a particular focus on clinical utility, that is, accuracy of description, ease of use, and feasibility of the classification system.[25,26] With regard to the gender identity-related diagnoses, the ICD-11 field studies so far have taken place in low and middle-income countries.[27–29] How they would be experienced in high-income countries with a long tradition of providing transgender care is unknown at present.

While in most countries the ICD is the main classification system used, the DSM is recommended in North America and some other countries. Making a comparison between both systems is of interest especially with regard to the gender identity-related diagnoses, due to the reconceptualization and placement outside of the mental health chapter and deletion of distress as an inherent characteristic of gender incongruence.

The aim of the current study was to test the interrater reliability of the gender identity-related diagnostic categories in a high-income country specialty setting according to current guidelines (ICD-11 and DSM-5) and their previous versions (ICD-10 and DSM-IV). Further, we aimed to study similarities and differences between clinical judgments according to ICD-10, ICD-11, DSM-IV, and DSM-5, with a specific focus on the differences with the reconceptualized GI (ICD-11) diagnosis. A last aim of the present study was to assess the clinical utility of the diagnoses by asking the participating health care providers about their experiences with the different systems and editions.

Method

Setting

The WHO published a draft of the proposed ICD-11 to receive input on the proposed structure and diagnostic criteria.[30,31] The Center of Expertise on Gender Dysphoria (CEGD) of the Amsterdam University Medical Centers, location VUmc in the Netherlands and the Department of Sexology and Gender Problems (DSGP) of Ghent University Hospital in Belgium have been offering gender-affirming treatment since the 1970s. The WHO encouraged these specialized clinics to perform field studies on gender incongruence. The present study was part of a larger project, which was financially supported by three Dutch Ministries (Foreign Affairs; Health, Welfare and Sport; and Education, Culture and Science).[14,17]

The study was approved by the VUmc Medical Ethics Committee and all interviewed persons (and/or their parents depending on age) gave informed consent for use of the video material for this study.

Participants

In total, 64 health care providers participated in the study during one of six sessions that were organized. Some health care providers were specialized in health care related to gender identity/incongruence and some were not. Mental health professionals (psychologists (in training) and psychiatrists (in training)) specialized in gender incongruence were recruited from the CEGD and the DSGP. Health care providers not specialized in transgender health care were recruited during two meetings, one for psychiatry residents specializing in child and adolescent psychiatry and one for team members of a consultative liaison psychiatry service (psychiatrists (in training), psychologists, psychiatric nurses, and medical students).

Procedure

Between December 2014 and June 2015, six sessions for video rating were organized. Each test session had a similar structure and took about 1 hour: a researcher gave a short introduction to the study. This introduction was also provided as one written page before the different sets of diagnostic criteria that were to be rated. Voluntary participation and confidentiality were explained to be secured. Informed consent was signed for each participating health care provider. Two videos were presented and assessed using three of the four different instruments (for convenience reasons making the session not longer than 1 hour); every participant scored in random order the ICD-11 guidelines and the DSM-5 criteria, and a 3rd set of indicators (either the ICD-10 or the DSM-IV). After that, a few general questions about the use of the instruments and a number of background questions had to be answered. Participants watched one of the following

three pairs of videos: adolescent 1 and adult 2; adolescent 2 and adult 1; and child 1 and child 2.

For the adolescent and adult diagnoses, there were 72 ratings in total (of 37 different raters) on ICD-11 and DSM-5, 39 ratings (20 raters) on ICD-10, and 34 ratings (17 raters) on DSM-IV. For the children's diagnoses, 59 ratings (30 raters) were collected on ICD-11 and DSM-5, 32 ratings on ICD-10 (16 raters), and 27 ratings on DSM-IV (14 raters).

Materials

Videos. In total, six diagnostic interviews by a psychologist/psychiatrist (two psychologists, one psychiatrist) were recorded of a person referred to the CEGD. Two individuals were adults, two were adolescents, and two were children. Some background information of each person is available from the authors. In all age categories, an effort was made to select one person without diagnostic difficulties and one person with a more complex gender development history and presentation.

Classification indicators. We used score sheets based on eight (four for adolescents/adults and four for children) classification systems: WHO's ICD-10 (Transsexualism) and the proposed guidelines of ICD-11 (Gender Incongruence) and the APA's DSM-IV-TR (Gender Identity Disorder) and DSM-5 (Gender Dysphoria). Participants had to decide whether indicators were present or not and, based on these indicators, whether the diagnoses were applicable to the persons in the video. When available, official Dutch versions of the Classifications were used. For ICD-11,[31] translations were not yet available and the research team translated the guidelines into Dutch. This translation was not created by the WHO.

Questions regarding utility of classification systems. Two questions were asked to assess the experienced clarity of the diagnostic indicators (answer options on a 5 point scale; 1 = very unclear, 2 = unclear, 3 = neutral, 4 = clear, and 5 = very clear) and the certainty with which a rater thought they made the correct decision (diagnosis present/absent, answer options on a 5 point scale; 1 = very unsure, 2 = unsure, 3 = neutral, 4 = sure, and 5 = very sure). Also, raters were asked which of the instruments they thought was most convenient to use, and which they felt helped them best to come to a correct diagnosis. For each classification system it was asked whether it was easy to use (answer options yes, no, or no opinion).

Analyses

Agreement between raters was calculated by dividing the total number of raters assessing a classification (present) by the total number of ratings. Agreement percentages were chosen for clinical interpretation and due to the large number of raters for each case.[32,33] Chi-square statistics were performed to examine if the agreement between the raters on presence or absence of a diagnosis differed between the respective instruments with a significance set at $p < 0.05$. One-way analyses of variance (ANOVA) were performed to compare mean clarity and certainty scores between instruments. Chi-square statistics were also used to examine whether clinical utility (convenience, ability to diagnose, and ease of use) was assessed differently between the instruments. All analyses were performed for the child and adolescent/adult videos separately.

Results

Adolescent/adult diagnoses

In Table 1, the agreement between the raters is presented on the presence/absence of a diagnosis according to the four instruments. For all adolescent and adult videos, a majority of raters decided a diagnosis was present. The agreement between the raters was always agreement on the presence of a diagnosis. To see if the number of persons who received a diagnosis differed across instruments, the agreement rates between the respective instruments were compared. Only the ICD-11 and DSM-5 raters were significantly different from each other (75.71% vs. 67.65%, $\chi^2 = 10.58$, $p = 0.001$).

Table 2 shows the presence/absence of each indicator of the ICD-11 GI diagnosis.[31] Table 3 shows the presence/absence of each indicator of the DSM-5 GD diagnosis.[7] The agreement between raters on the presence/absence of each indicator of the respective other classification systems ICD-10 and DSM-IV are available from the authors. Agreement was lowest on the DSM-5 subindicators, "A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender that is different from one's assigned gender)" (43/67, 64.18%) and

TABLE 1. AGREEMENT BETWEEN RATERS ON THE PRESENCE OF A DIAGNOSIS ACCORDING TO FOUR DIFFERENT CLASSIFICATION SYSTEMS

	Instrument	*Observations* N	*Diagnosis present and agreement rate* N	*χ^2 between instrument comparison*		
				ICD-11 χ^2 p	*DSM-5 χ^2 p*	*ICD-10 χ^2 p*
Adolescents/ Adults	ICD-11	70	53/75.71%			
	DSM-5	68	46/67.65%	10.578; 0.001*		
	ICD-10	38	30/78.95%	0.145; 0.703	1.534; 0.216	
	DSM-IV-TR	31	20/64.52%	1.345; 0.246	0.094; 0.759	1.782; 0.182
Childhood	ICD-11	56	50/89.29%			
	DSM-5	58	39/67.24%	8.087; 0.004*		
	ICD-10	32	30/93.75%	0.491; 0.483	0.491; 0.483	
	DSM-IV-TR	26	20/76.92%	2.1723; 0.141	0.805; 0.369	3.416; 0.0645

*Significant difference at $p < 0.05$.
ICD, International Classification of Diseases; DSM, Diagnostic and Statistical Manual of Mental Disorders.

TABLE 2. AGREEMENT BETWEEN RATERS FOR EACH VIDEO PER INDICATOR AND THE DECISION ON THE PRESENCE OF A DIAGNOSIS ACCORDING TO THE ICD-11 FOR ADOLESCENTS/ADULTS

		Adolescent 1		*Adolescent 2*		*Adult 1*		*Adult 2*		*Total*	
		n = 14	*%*	*n = 23*	*%*	*n = 22*	*%*	*n = 13*	*%*	*n = 72*	*%*
		Agreement raters									
A1	A strong dislike or discomfort with one's primary and/or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender.	11/14		22/23		22/22		7/13*		62/72	86.11%
A2	A strong desire to be rid of some or all of one's primary and/or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender.	12/14		23/23		22/22		7/13		64/72	88.89%
A3	A strong desire to have the primary and/or secondary sex characteristics of the experienced gender.	13/14		21/23		16/22		10/13		60/72	83.33%
A4	A strong desire to be treated (to live and be accepted) as a person of the experienced gender.	14/14		19/21		15/21		8/13		56/69	81.16%
A total	A marked incongruence between the individual's experienced gender and the assigned sex, as manifested by at least two of the above.	14/14		22/23		21/22		10/13		67/72	93.06%
B	The experienced gender incongruence must have been continuously present for at least several months.	14/14		22/23		22/22		12/13		70/72	97.22%
C	The diagnosis cannot be assigned prior to the onset of puberty.	7/14		17/23		22/22		13/13		59/72	81.94%
Total	Do you consider the person to fulfil all indicators (A, B, and C)?	9/13	69.2%	14/22	63.6%	21/22	95.5%	9/13	69.2%	53/70	75.71%

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*= most people agreed the criterion was not present (in all other cases, most raters agreed that the criterion was present).

"The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning" (48/70, 68.57%), and on the DSM–IV indicators, "Belief that he or she was born the wrong sex" (22/32, 68.75%) and "The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (24/32, 75.00%). The lowest agreement rate of the ICD-10 subindicators was 84.62% (33/39, "Not a symptom of another mental disorder, such as schizophrenia").

Childhood diagnoses

Table 1 also shows the agreement between the raters regarding the four childhood diagnoses according to the different classification systems, ICD-11, ICD-10, DSM-5, and DSM-IV. For both childhood videos, a majority of raters decided a diagnosis was present. Thus, the agreement between the raters was always agreement that a diagnosis was present. To see if the number of raters who assessed a diagnosis to be present differed across instruments, the agreement rates between the respective instruments were compared. Only the ICD-11 and DSM-5 rates were significantly different from each other (89.29% vs. 67.24%, $\chi^2 = 8.08$, $p = 0.004$).

Table 4 shows the agreement between raters of the presence/absence of each indicator of the ICD-11 GI diagnosis.[31] Table 5 shows the agreement between raters of the presence/absence of each indicator of the DSM-5 GD diagnosis.[7] The agreement between raters on the presence/absence of each indicator of the respective other classification systems ICD-10 and DSM-IV are available from the authors. Agreement was lowest on the DSM-5 subindicators "A strong dislike of one's sexual anatomy" (40/57, 70.18%) and "The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning" (41/56, 73.21%), and on the DSM–IV indicators, "The disturbance is not concurrent with a physical intersex condition" (17/27, 62.96%) and

TABLE 3. AGREEMENT BETWEEN RATERS FOR EACH VIDEO PER CRITERION AND THE DECISION ON THE PRESENCE OF A DIAGNOSIS ACCORDING TO THE DSM-5 FOR ADOLESCENTS/ADULTS

		Adolescent 1	*Adolescent 2*	*Adult 1*	*Adult 2*	*Total*	
		n = *14*	n = *23*	n = *22*	n = *13*	n = *72*	%
		Agreement raters					
A	A marked incongruence between one's experienced/expressed gender and one's assigned gender of at least 6 months duration as manifested by at least two of the following:	14/14	23/23	22/22	10/13	69/72	95.83%
A1	A marked incongruence between one's experienced/expressed gender and one's primary and/or secondary sex characteristics (or in younger adolescents, the anticipated secondary sex characteristics).	14/14	22/23	21/22	10/13	67/72	93.06%
A2	A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in younger adolescents, a desire to prevent the anticipated secondary sex characteristics).	14/14	23/23	22/22	8/13*	67/72	93.06%
A3	A strong desire for the primary and/or secondary sex characteristics of the other gender.	12/14	23/23	15/22	9/13	59/72	81.94%
A4	A strong desire to be of the other gender (or some alternative gender that is different from one's assigned gender).	14/14	23/23	19/22	8/13	64/72	88.89%
A5	A strong desire to be treated as the other gender (or some alternative gender that is different from one's assigned gender).	14/14	21/23	12/21	7/13	54/71	76.06%
A6	A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender that is different from one's assigned gender).	13/14	11/21	11/21	8/11*	43/67	64.18%
B	The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.	8/14*	15/22	18/21	7/13	48/70	68.57%
Specify if: With a disorder of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome). Coding note: Code the disorder of sex development as well as gender dysphoria.							
Specify if: Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).							
Total	Do you consider both the A and B criterion to be present in the video?	7/13 (53.8%)	14/21 (66.7%)	18/21 (85.7%)	7/13 (53.8%)	46/68	67.65%

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* = most people agreed the criterion was not present (in all other cases, most raters agreed that the criterion was present).

TABLE 4. AGREEMENT BETWEEN RATERS FOR EACH VIDEO PER INDICATOR AND THE DECISION ON THE PRESENCE OF A DIAGNOSIS ACCORDING TO THE ICD-11 FOR CHILDREN

		Child 1		*Child 2*		*Total*	
		n = 29	%	n = 30	%	n = 59	%
A1	A strong desire on the child's part to be a different gender than the assigned sex, or insistence that he or she is a gender different from one's assigned gender.	29/29		30/30		59/59	100%
A2	A strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender. For example, a child assigned at birth as a boy says he wants to be rid of his penis or a child assigned at birth as a girl says she does not want to develop breasts when she grows up.	22/29		29/30		51/59	86.44%
A3	Make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. Gender incongruent children assigned as boys reject typically "masculine" toys, games, and activities and avoid rough-and-tumble play. Gender incongruent children assigned as girls reject "feminine" toys, games, and activities and like rough-and tumble play.	28/29		30/30		58/59	98.31%
A total	In pre-pubertal children, a marked incongruence between the child's experienced/expressed gender and the child's assigned sex as manifested by all of the above indicators.	22/28		29/29		51/57	89.47%
B	The incongruence must have persisted for about 2 years.	22/27		30/30		52/57	91.23%
C	The diagnosis can only be assigned to children before puberty.	26/27		27/28		53/55	96.36%
Total	Do you consider the person to fulfil all indicators (A, B, and C)?	20/26	76.92%	30/30	100%	50/56	89.29%

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"The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (20/26, 76.92%). The lowest agreement rate of the ICD-10 subindicators was 87.10% (27/31, "A profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behavior in boys is not sufficient").

Clinical utility

Table 6 shows which of the different classification systems raters found most convenient to use and with which system they felt most able to make a correct diagnosis and if the classification system was considered easy to use.

Clarity. No significant differences were found between the mean clarity-scores of all instruments for the adolescent/adult diagnoses. Scores were 3.63 (standard deviation [SD] 0.76) for the ICD-10, 3.74 (SD 1.01) for the ICD-11, 3.81 (SD 0.91) for the DSM-IV-TR, and 3.83 (SD 0.89) for the DSM-5. For the childhood diagnoses, they were 3.27 (SD 1.03), 3.55 (SD 0.87), 3.90 (SD 0.67), and 3.93 (SD 0.69) for the ICD-10, ICD-11, DSM-IV-TR, and DSM-5, respectively. Post hoc comparisons revealed that differences existed in percentages that chose an instrument as most convenient to use with the exception of the comparison between the ICD-10 and ICD-11 as well as between the DSM-IV-TR and the DSM-5.

Certainty. No significant differences were found for mean certainty scores (regarding coming to a diagnosis), which were 3.25 (SD 1.2) for the ICD-10, 3.58 (SD 1.08) for the ICD-11, 3.37 (SD 1.12) for the DSM-5, and 3.4 (SD 1.07) for the DSM-IV-TR diagnoses of adolescents/adults, and were 3.75 (SD 1.08), 3.64 (SD 1.06), 3.46 (SD 1.09), and 3.77 (SD 0.99), respectively, for the childhood diagnoses.

Ease of use. The majority of the participants (74.3%–84.2%) considered the respective systems easy to use for the adolescent/adult diagnoses. For the childhood diagnoses, these percentages were somewhat lower (ranging from 46.7% to 85.7%). See Table 6. There were no significant between-instrument differences with regard to ease of use.

Discussion

With substantial to almost perfect agreement rates of 75% (53 of 70 raters agree) for the adult/adolescent diagnosis and 89% (50 of 56 raters agree) for the childhood diagnosis,

TABLE 5. AGREEMENT BETWEEN RATERS FOR EACH VIDEO PER CRITERION AND THE DECISION ON THE PRESENCE OF A DIAGNOSIS ACCORDING TO THE DSM-5 FOR CHILDREN

		Child 1	*Child 2*	*Total*	
		n = *29*	n = *30*	n = *59*	%
A	A marked incongruence between one's experienced/expressed gender and one's assigned gender of at least 6 months duration as manifested by at least six of the following (one of which must be Criterion A1).	22/28	30/30	52/58	89.66%
A1	A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender that is different from one's assigned gender).	27/28	30/30	57/58	98.28%
A2	In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.	29/29	30/30	59/59	100%
A3	A strong preference for cross-gender roles in make-believe play or fantasy play.	25/28	25/26	50/54	92.59%
A4	A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.	23/29	30/30	53/59	89.83%
A5	A strong preference for playmates of the other gender.	29/29	28/29	57/58	98.28%
A6	In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.	22/28	30/30	52/58	89.66%
A7	A strong dislike of one's sexual anatomy.	15/27	25/30	40/57	70.18%
A8	A strong desire for the physical sex characteristics that match one's experienced gender.	15/28	30/30	45/58	77.59%
B	The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.	16/26	25/30	41/56	73.21%
Specify if: With a disorder of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome). Coding note: Code the disorder of sex development as well as gender dysphoria.					
Specify if: Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).					
Total	Do you consider both A and B criterion to be present in the video?	15/29 (51.72%)	24/29 (82.76%)	39/58	67.24%

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TABLE 6. CLINICAL UTILITY OF CLASSIFICATION SYSTEMS: FREQUENCIES AND PERCENTAGES OF POSITIVE RESPONSES

	Which classification system did you think was most convenient to use?					*Comparison between different instruments*
Classification used	*ICD-10*	*ICD-11*	*DSM-5*	*DSM-IV-TR*	*No preference – no opinion*	$X,^2$ *p*
Adolescent/adult:	4/18 (22.2%)	7/33 (21.2%)	13/33 (39.4%)	6/15 (40.0%)	3/33 (9.1%)	3.81; 0.283
Childhood:	2/13 (15.4%)	3/24 (12.5%)	12/24 (50.0%)	6/11 (54.5%)	1/24 (4.17%)	11.99; 0.007*
	Which classification system enabled you best to make a correct diagnosis?					
Adolescent/adult:	1/18 (5.6%)	5/32 (15.6%)	15/32 (46.9%)	5/14 (35.7%)	6/32 (18.8%)	8.49; 0.037^
Childhood:	0/12 (0.0%)	4/24 (16.7%)	8/24 (33.3%)	5/12 (41.7%)	7/24 (29.2%)	1.68; 0.432#
	Would the classification system be easy to use in practice? (percentage answering yes)					
Adolescent/adult:	16/19 (84.2%)	27/34 (79.4%)	26/35 (74.3%)	13/16 (81.3%)		0.83; 0.843
Childhood:	7/15 (46.7%)	19/29 (65.5%)	20/29 (69.0%)	12/14 (85.7%)		5.07; 0.166

*Significant difference between classification instruments; post hoc comparisons revealed that differences existed in percentages that chose an instrument as most convenient to use with the exception of the comparison between the ICD-10 and ICD-11 as well as between the DSM-IV-TR and the DSM-5.

^Significant difference between classification instruments; post hoc comparisons revealed that differences existed between the instruments on ability to make a correct diagnosis when comparing between the ICD-10 and DSM-5, ICD-10 and DSM-IV-TR, as well as between ICD-11 and DSM-5.

#Only comparison between ICD-11, DSM-5, and DSM-IV-TR; ICD-10 = 0.

the interrater agreement of both the adult/adolescent and childhood diagnoses can be considered good for the ICD-11.[34] Agreement for the DSM-5 diagnosis was lower, but still considered substantial with agreement rates of 67% (46 of 68 raters agree) for the adult/adolescent diagnosis and 67% (39 of 58 raters agree) for the childhood diagnosis.[34]

These findings are in line with the only other reliability study of the childhood DSM-III Gender Identity Disorder diagnosis that found a high interrater agreement reliability, although with a different design.[24] In that study, two raters independently agreed in 34 of 36 cases with regard to the A criterion (expressed desire to be the other gender) and in 28 of 31 cases for the B criterion (anatomical dysphoria, only assessed in the birth assigned boys). These high agreement rates give confidence that the gender identity diagnoses can reliably be given independent of the system (ICD or DSM) used.

When comparing the different classification systems and editions, the interrater reliability of the ICD-11 diagnoses was not different from earlier versions of the ICD and DSM, but only differed from the DSM-5. An important difference between the ICD-11 and the DSM-5 with regard to gender identity-related diagnoses is the absence of the distress/impairment requirement in the ICD-11. When looking at the agreement rates for every indicator separately, the lower agreement rate for the DSM-5 stemmed mainly from the lower agreement clinicians had with that specific criterion (Tables 3 and 5). Other field studies in lower-income countries (Mexico, South Africa, and Lebanon) interviewed transgender adults and found that experienced distress was more strongly connected with (harsh) social contexts, social rejection, and violence than to gender incongruence.[27–29] The finding adds evidence to justifying the positioning of GI outside the ICD-11 mental health chapter.

With regard to utility (i.e., its goodness of fit, accuracy of description, and feasibility), many health care providers from this Dutch/Belgium sample picked the DSM classifications as most convenient to use and most enabling to make a correct diagnosis compared to the ICD. The preference for the DSM is probably due to the fact that in the Netherlands and Belgium, the DSM is the main system used. In ease of use, clarity, and felt certainty while making a diagnosis, there were no differences between the four systems. This provides confidence that both systems have the chance to be implemented faithfully and consistently.[35]

Limitations

The study has several limitations that should be addressed. First, for determining reliability and agreement rates, the

relatively small number of assessed cases was a limitation. For feasibility reasons, we could only include six cases of three age groups. A future study should use a more heterogeneous sample of cases, including a better balance between different genders (e.g., also incorporating nonbinary and gender fluid identities).

The study was further limited by the fact that video-recorded specialist clinical interviews were rated, which could lead to interviewers guiding the raters by probing or pausing in a certain direction and causing undue high agreement.[9]

Importantly, this study was performed in a specialized transgender clinic setting with a long history of care and research. Whether the findings are also true in other contexts, where it is less likely that health care workers are highly educated and specialized, is yet unknown.

In this regard, it is important to note that in comparison with other field trials, for example, ICD-11 and DSM 5, that aimed to get large enough (also for relatively rare conditions) representative patient samples in general clinical settings using usual clinical interviews,[22,23] the current study followed a different design. Because the aim of the study was to investigate reliability and utility in a specialty setting, as it is often organized in high income countries, the results may not be generalizable to other settings. The selected patient sample was therefore, in contrast to other field studies, more homogeneous, making power analyses or providing confidence intervals of little use. We therefore choose to report on agreement rates. In addition, compared to other field studies, the study made use of a much larger sample of raters for each case, a mix of transgender health care specialists and nonspecialists, although most of the raters were mental health specialists skilled in detecting distress. This high number of raters was another reason to report agreement rates and no kappa statistics, as other field studies do.[22,23,32,33] Other future studies could focus on patients presenting to nonspecialty non mental health settings; for example, endocrinology, surgery, or other medical specialties that provide medical care to more heterogeneous gender diverse populations, possibly with less distress. This would ensure more generalizability, although the probable still low prevalence rates of GI/GD would make a design comparable to other field studies a challenge.

Conclusion

In conclusion, the present study showed that the interrater agreement rates for gender identity-related diagnoses can be considered good or very good, regardless of the classification system that was used (ICD-10, ICD-11, DSM-IV-TR, or DSM-5), both for the adolescence/adulthood diagnosis and for the childhood diagnoses. The revisions in the ICD-11 and in the DSM-5 did not change these agreement rates. Clinicians further assessed the utility of the various classification systems as easy to use and few differences between the former, current, and proposed ICD and DSM classifications existed with regard to the ability to make a correct diagnosis. Future work should assess whether these results are generalizable to other settings and should also show whether the reconceptualization of the ICD-11 is helpful in solving controversies and diminishing stigma around gender identity-related diagnoses.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

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Address correspondence to:
Annelou L.C. de Vries, MD, PhD
Department of Child and Adolescent Psychiatry
Center of Expertise on Gender Dysphoria
Amsterdam University Medical Centers, Location VUmc
PO Box 7057
1007 MB Amsterdam
The Netherlands

E-mail: alc.devries@amsterdamumc.nl

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Christopher Fain, individually and on behalf of all others similarly situated, et al.,

Plaintiffs,

vs. CIVIL ACTION NO. 3:20-cv-00740

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF DR. JAMES BECKER

DATE: March 30, 2022
TIME: 7:00 a.m. CST
PLACE: Veritext Virtual Videoconference

REPORTED BY: KELLEY E. ZILLES, RPR (Via Videoconference)
JOB NUMBER: 5096167

APPEARANCES

On Behalf of the Plaintiffs (Via Videoconference):

CARL CHARLES, ESQ.
TARA L. BORELLI, ESQ.
Lambda Legal Defense and Education Fund, Inc.
158 West Ponce De Leon Ave., Suite 105
Decatur, Georgia 30030
470.225.5341
ccharles@lambdalegal.org
tborelli@lambdalegal.org

AVATARA SMITH-CARRINGTON, ESQ.
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

NICOLE J. SCHLADT, ESQ.
Nichols Kaster PLLP
80 South 8th Street, Suite 4700
Minneapolis, Minnesota 55402-2224
612.256.3291
nschladt@nka.com

On Behalf of Defendants William Crouch; Cynthia Beane; and West Virginia Department of Health and Human Resources, Bureau for Medical Services (Via Videoconference):

KIMBERLY M. BANDY, ESQ.
LOU ANN S. CYRUS, ESQ.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street East, Suite 200
Charleston, West Virginia 25301
304.345.1400
kbandy@shumanlaw.com
lcyrus@shumanlaw.com

NOTE: The original deposition transcript will be delivered to Attorney Smith, Esq., as the taking attorney.

I also review pharmacy and pharmacy cases. Pharmacy appeals come to me with great regularity. We cover about a million prescriptions each month and so there will be some that need to be reviewed, so they do come to me. I have interaction with other agencies like CMS, I have interaction with various support groups that state Medicaid programs rely on, things like the Medicaid Medical Director Network, ASTHO, which is the State Health Officers Organization, a variety of those kind of agencies. So as you can tell, it's highly variable.

Q. Okay.

A. And it's grown. When I first began the only obligation I had when I first began working for Medicaid was to, was to look at files regarding surgical procedures that didn't match normal codes, and that's still a part of my job, but it's not much of a job.

Q. I understand that. And so just a quick follow-up on that. So you said that you've been with BMS for 14 years, am I correct?

A. That's correct.

Q. And have you been with BMS in your capacity now, so as the medical director for 14 years?

A. Yes.

Q. Okay. Dr. Becker, who is your direct

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096167
CASE NAME: Fain, Christopher, et al. v. Crouch, William
DATE OF DEPOSITION: 3/30/2022
WITNESS' NAME: Dr. James Becker

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

5/16/2022
Date

Dr. James Becker

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 16 day of May, 2022.

Lisa J Maynard
Notary Public

July 22, 2026
Commission Expiration Date

LISA J MAYNARD
Notary Public Official Seal
State of West Virginia
My Comm. Expires Jul 22, 2026
1400 Medical Center Drive Suite 3407 Huntington WV 25701

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHRISTOPHER FAIN, individually and on behalf of all others similarly situated, Plaintiffs, vs. WILLIAM CROUCH, et al., Defendants.	Case No. 3:20-cv-00740

REMOTE 30(b)(6) DEPOSITION OF
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

by and through their corporate representative

FREDERICK LEWIS

DATE: April 4, 2022
TIME: 9:00 a.m. (Eastern)
PLACE: Veritext Virtual Videoconference

JOB NO.: MW 5129863
PAGES: 1 to 136
REPORTED BY: Merilee Johnson, RDR, CRR, CRC, RSA

A P P E A R A N C E S
(All appearing remotely via videoconference)

ON BEHALF OF THE PLAINTIFFS:

NICHOLS KASTER, PLLP
BY: Anna P. Prakash, Esq.
Nicole J. Schladt, Esq.
4700 IDS Center
80 South Eighth Street
Minneapolis, Minnesota 55402
Phone: (612) 256-3200
Email: APrakash@nka.com
Email: NSchladt@nka.com

-and-

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
BY: Tara L. Borelli, Esq.
158 West Ponce De Leon Avenue
Suite 105
Decatur, Georgia 30030
Phone: (470) 225-5341
Email: TBorelli@LambdaLegal.org

-and-

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
BY: Avatara Smith-Carrington, Esq.
3500 Oak Lawn Avenue
Suite 500
Dallas, Texas 75219
Phone: (214) 219-8585
Email: ASmithCarrington@LambdaLegal.org

ON BEHALF OF DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES:
SHUMAN McCUSKEY SLICER, PLLC
BY: Kimberly M. Bandy, Esq.
Lou Ann S. Cyrus, Esq.
1411 Virginia Street East
Suite 200
Charleston, West Virginia 25301
Phone: (304) 345-1400
Email: KBandy@ShumanLaw.com
Email: LCyrus@ShumanLaw.com

A P P E A R A N C E S
(Continued)

ON BEHALF OF DEFENDANT JASON HAUGHT:
THE EMPLOYMENT LAW CENTER, PLLC
BY: Walt Auvil, Esq.
1208 Market Street
Parkersburg, West Virginia 26101
Phone: (304) 485-3058
Email: Auvil@TheEmploymentLawCenter.com

Q. And are you the person at BMS who is in charge of contracting with the consulting actuaries?

A. I'm one of them. I feel like I share this with Becky Manning, the Deputy of Finance. We have overlap in this area. But, yeah, Becky and I are over this contract. I think I actually signed the SOWs this time around.

Q. And do you know if BMS has ever asked or -- asked for or received from the actuaries any calculations on how much it would cost to provide surgery as a treatment for gender dysphoria?

A. We have not asked for that in my time here.

Q. Are you aware of BMS asking for it at any point in time prior to you coming to the agency?

A. I am not aware. I'm not aware of a lot of things, though, so...

Q. All right. So I understand that the MCOs must follow coverage limitations required by Medicaid and can't use Medicaid dollars to authorize noncovered care. Is that right?

A. I think they could use Medicaid dollars as long as, you know, they're coming from profit or something. But that's right. We're not providing -- we're not providing funding to them

for the purpose of providing anything more than what is basically our -- what we recognize as our base level bene- -- our fee-for-service benefit is sort of the guiding issue.

Q. Okay. And so that -- just so I'm clear, that benefit does not include surgical care for the purpose of treating gender dysphoria, correct?

A. Correct.

Q. Okay. And so the MCOs could not use Medicaid dollars for the purpose of treating gender -- surgical care for the purpose of treating gender dysphoria, correct?

A. They could, as a value-add benefit, which means, you know, they -- it's not our expectation that they will pay for it, but, you know, maybe they have a marketing strategy or something: They want to differentiate their plan from the others by providing a benefit -- a benefit that wouldn't otherwise be covered. They could do that, but it would be from -- it would not be something we have built into that capitation, that budget, as you'd say --

Q. Okay.

A. -- for them to pay for. It would be coming from their managed care savings, for example. When

you manage a member, you're going to identify some services that -- you're going to avoid services, first of all, because you're going to keep the member healthier. And you're going to be able to manage the services and provide for those that are medically necessary and not services that aren't medically necessary.

So there are savings that come from all of that. That and profits -- you know, there's profit-building with the capitation. All of that could be used by the MCO to pay for the value-add service.

Does that make sense?

Q. Well, let me ask you this: Has any MCO -- any of the three that BMS contracts with, have any of them used that -- those savings or created a value-added benefit that is surgery for the treatment of gender dysphoria?

A. No, none of them have, to date, provided for those dollars to be used for those surgeries, to the best of my knowledge.

Q. All right. How would you describe value-added benefit? You've said that a few times so I just want to know how you're defining that.

A. It is a benefit that is not considered --

the cost of which is not considered in building the capitation rate and a benefit that is not available to the Medicaid fee-for-service population. It's sort of an extra.

Q. Got it. When you say, "Medicaid fee-for-service," is that -- I guess I'm a little bit confused because we talked about Mountain Health Trust and the three MCOs and that sort of managed care program. When you're talking about fee-for-service, are you still talking about that or are you talking about something else?

A. No, I'm talking about the non-Medicaid part -- the nonmanaged care part of program.

Q. Got it.

A. When I say, "fee-for-service," I'm typically talking about those members that are not in Mountain Health Trust --

Q. Got it.

A. -- or Mountain Health Promise.

Q. Okay. So if we go back to the managed care program, Mountain Health Trust, is it true that the MCOs there cannot use Medicaid dollars to authorize noncovered care?

A. They could, but only to the extent they're deriving those dollars from either their profit

administrative savings or from -- or from managed care savings, which is coming through, you know, providing -- preventing disease, providing for the -- whatever it takes, to keep their member healthy. But that's it.

They could, in the technical sense, use Medicaid dollars, but it would -- it would have to come from one of those other sources for there to be money available.

Q. I see. And so I think I asked this question with respect to -- and you answered with respect to fee-for-service, but the same question within the managed care program: You're not aware of any MCO using that extra money for the purpose of covering surgery for the treatment of gender dysphoria?

A. Yes, I am not aware of any of the plans providing for the treatment of -- well, providing for the treatment of -- for the surgery for these members and it's not their -- it's -- since we provide pharmacy on the -- and I'm going to use "fee-for-service" in a different context this time. Our pharmacy benefit is fee-for-service.

Q. Right.

A. It's carved out of managed care.

Q. Got it.

A. Since we provide for that through the fee-for-service program, that's not their responsibility, either.

Q. Okay.

A. But I am not aware of an MCO providing for surgery or providing for hormone therapy. Doesn't mean that it couldn't have happened somewhere. You know, maybe -- maybe there was a mastectomy that was provided and -- but it's not -- it's not their intent to provide for -- those services for that purpose -- the surgical services for that purpose.

Q. Got it. Have you ever -- are you aware of any of the MCOs pushing back against the exclusion on coverage for surgery related to gender dysphoria?

A. No.

Q. Are you aware of any of the MCOs raising compliance concerns with respect to the lack of coverage for surgical care related to gender dysphoria?

A. No. And nor have we gotten such from CMS, to the best of my knowledge.

Q. When you say "CMS," that's the Center for Medicaid Services?

part of that bigger conversation. So here's Tadd saying, "Here is what the people in our organization think we need to do to collect this other data and we absolutely have to get there."

I don't know that what Anthem is proposing here is the end-all be-all, that this is exactly how we need to collect it, but we need this or something a lot like it. And we're moving in this direction.

But there's a lot of juggling here -- happening here and we have not yet had the meeting that Tadd was propo- -- in fact, I don't know if Cindy responded to this or not. I was waiting for her to respond since it was addressed to her. But I would like to have this meeting and move on with the bigger conversation.

Right now, we collect gender in a binary field. It's male or female. That's how it comes from CMS. And so I don't know if we could -- we may have to ask CMS permission to change it and to make some of these responses mandatory, but maybe give an option to decline to say what race somebody is, or ethnicity, give options for them. I think that's the sticking point. But we're trying to sort these things out so that we can move forward

with it.

And we've -- we've had a vacancy in the director's role for this office for an extended time and we are currently struggling with that too. So that's been a little bit of a factor for us, frankly, as well.

Q. In the second paragraph of that email, there is a reference to members from Maximus. Do you know what that means?

A. Maximus is our enrollment broker that we talked about early in the call.

Q. Got it.

A. Maximus is administering, in addition to their work as an enrollment broker, like a seven-question social determinants of health questionnaire.

And they're tracking that for us and they're passing the data about our members on social determinants on to the MCOs so the MCOs can know that a member has food insecurity, or is homeless, or whatever it might be, and take that into account when they're helping to manage the member's health.

Q. Got it. So --

A. So Tadd is proposing that we add these

questions or these items to that social determinants questionnaire that's being administered by Maximus at that stage.

Q. Do you know what the current questionnaire administered by Maximus asks for?

A. I've seen it. But like I said, it -- well, it's been a while. It's been like seven social determinants of health-type questions. It was very carefully crafted to try to maximize response rate, but, I mean, it -- there's a question relating to food security, a question relating to housing security, one about employment. I mean, things like that. And I can't recite off the top of my head what they are. I have it somewhere.

Q. Does the current questionnaire ask about gender identity?

A. No, it does not.

Q. How long has the current questionnaire been in place?

A. Two or three years. Something like that. And it was a new process when we implemented it.

Q. Okay. And it's implemented across all MCOs through the broker?

A. Yes. And that's a disadvantage to this approach in that we wouldn't be able to provide the

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

I hereby certify that I reported the remote deposition of FREDERICK LEWIS, on April 4, 2022, via Veritext Virtual Videoconference, and that the witness was by me first duly affirmed to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was preserved.

WITNESS MY HAND AND SEAL THIS 12th day of April, 2022.

Merilee Johnson

Merilee S. Johnson, RDR, CRR, CRC, RSA
Notary Public, Hennepin County, Minnesota
My commission expires January 31, 2026

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5129863
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/4/2022
WITNESS' NAME: Frederick Lewis , 30(b)(6)

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

April 27, 2022
Date

Frederick Lewis , 30(b)(6)

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 27 day of April 2022.

Kimberly O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St. Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5129863

PAGE/LINE(S) /	CHANGE	/REASON
23 /4 /	strike "plan" and insert "benefit design" in lieu thereof	/ clarity
24/23 /	add "ADDENDUM: Rate cells typically represent an age band, gender, eligibility type (TANF, Pregnant Women, Delivery Kick Payments, CSHCN, SSI, Expansion), and region (North, East, South). Age bands for children 14 and younger are not broken out by gender and for the SSI eligibility type, there is no gender specificity in the rates for the <20 age band."	/ Supplementing response because gender is even a more significant demographic in the identification of rate cells than I recalled in the deposition.
73/6 and subsequent references		/ The former Office of Pharmacy Services Director's name is Peggy King / Completeness
117/17 /	"insurance" not "assurance"	/ Correction

April 27, 2022 [signature]

Date Frederick Lewis , 30(b)(6)

SUBSCRIBED AND SWORN TO BEFORE ME THIS 27th

DAY OF April , 2022 .

[signature]

Notary Public

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St. Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

July 28, 2026

Commission Expiration Date

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHRISTOPHER FAIN, individually and on behalf of all others similarly situated, Plaintiffs, vs. WILLIAM CROUCH, et al., Defendants.	Case No. 3:20-cv-00740

REMOTE 30(b)(6) DEPOSITION OF
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

by and through their corporate representative

BECKY MANNING

DATE: April 12, 2022
TIME: 9:59 a.m. (Eastern)
PLACE: Veritext Virtual Videoconference

JOB NO.: MW MW 5096193
PAGES: 1 to 85
REPORTED BY: Merilee Johnson, RDR, CRR, CRC, RSA

A P P E A R A N C E S
(All appearing remotely via videoconference)

ON BEHALF OF THE PLAINTIFFS:
NICHOLS KASTER, PLLP
BY: Nicole J. Schladt, Esq.
Anna P. Prakash, Esq.
4700 IDS Center
80 South Eighth Street
Minneapolis, Minnesota 55402
Phone: (612) 256-3200
Email: NSchladt@nka.com
Email: APrakash@nka.com
-and-
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
BY: Tara L. Borelli, Esq.
158 West Ponce De Leon Avenue
Suite 105
Decatur, Georgia 30030
Phone: (470) 225-5341
Email: TBorelli@LambdaLegal.org
-and-
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
BY: Avatara Smith-Carrington, Esq.
3500 Oak Lawn Avenue
Suite 500
Dallas, Texas 75219
Phone: (214) 219-8585
Email: ASmithCarrington@LambdaLegal.org
ON BEHALF OF DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES:
SHUMAN McCUSKEY SLICER PLLC
BY: Kimberly M. Bandy, Esq.
Lou Ann S. Cyrus, Esq.
1411 Virginia Street East
Suite 200
Charleston, West Virginia 25301
Phone: (304) 345-1400
Email: KBandy@ShumanLaw.com
Email: LCyrus@ShumanLaw.com

A P P E A R A N C E S

(Continued)

ON BEHALF OF DEFENDANT JASON HAUGHT:

THE EMPLOYMENT LAW CENTER, PLLC

BY: Walt Auvil, Esq.

1208 Market Street

Parkersburg, West Virginia 26101

Phone: (304) 485-3058

Email: Auvil@TheEmploymentLawCenter.com

ALSO APPEARED:

Nicholas Guillory, Law Fellow

purposes.

Because, as you can see for 2022 and 2023, the very last line shows that Medicaid has a surplus for those years, the $343 million, the very last line, and the $117 million. Those funds are used to save -- to save money for future years when things don't look as positive.

For example, if you look at 2024, we are set to hit our first -- what we term as our Medicaid cliff, when we will be in the negative situation. Meaning if we still cover the services that we are required to cover at the current rates that we cover them, with the current membership enrollment, we will be at a negative situation of $128.3 million.

Q. And to be clear, that $128 million number under 2024 on the spreadsheet we're looking at, that is the bottom line of where the budget would look if everything is as the estimates are entered here?

A. This would assume that we do not receive any future funding cuts or future funding cash injections for Medicaid. We have also made assumptions within our budget about utilization membership trend.

For example, one of the biggest impacts to our budget will be the unwinding of the public health emergency where West Virginia saw a significantly large amount of members come on to the Medicaid rolls. And we were waiting to see what that unwinding will look like when we are allowed to unenroll members who are no longer Medicaid eligible.

Q. Okay. And so this $128 million deficit, that is the amount of money that West Virginia Medicaid believes it will --

A. We will --

Q. -- need -- oh, go ahead.

A. Correct. We will need that money from the legislature in 2024 in order to be able to maintain services at the current level, without cutting services or rates to providers.

Q. Okay. And is that amount included -- if you go back up to the 2024 column there, is that amount included in the state match required to meet expenditures or not?

A. It is -- it is included that we will need it.

Q. Okay. So that $128 million number, that is part of the $1,167,000,000?

A. Mm-hmm. Yeah.
Q. Okay.
A. But if you look at the total match available from below, we don't have it. So if you subtract the 1.1 -- the $1,167,772,000 minus $1,039,452,000, that's how you come up with our deficit. Like we don't have it from below.
Q. Okay. And so that's -- that's where you get the $128 million number at the bottom there?
A. Yeah. Yes, ma'am.
Q. Okay.
A. And these six-year projections assume that in some way, shape, or form, that that negative is taken care of by the end of the year. That we either make provider cuts, which is reducing rates; we reduce benefits; one-time funding is given; and that that deficit is not carried forward to future years.
Q. Does the agency always get as much money as it requests from the legislature?
A. No, there's no guarantee. No.
Q. Why would it not receive the full amount of money requested?
A. It's not available. The appropriation is based upon the amount taken in from taxes. So if

the state doesn't have it, we wouldn't get it.

Q. What happens if West Virginia Medicaid doesn't receive all of the money it requests from the state.

A. We will have to make decisions about what will be cut and where.

Q. Has that had to happen during your tenure at DHHR?

A. Not during my tenure, no. And one of the things to keep in mind is that we received an additional 6.2 in FMAP from the federal government with the public health emergency, so that was able to provide some additional relief to states who were currently struggling and to cover those members that we cannot take off the Medicaid roles and so that people would have healthcare during the public health emergency.

Q. And what does FMAP stand for?

A. Federal Matching Participation. It's the amount we get from the federal government that -- when we put up against state funds, that we get in return for our state dollar.

Q. And you mentioned you received an additional 6.2.

A. Mm-hmm.

Q. Was that $6.2 billion or million?
A. It is -- I'm sorry. It's 6.2 percent --
Q. Okay.
A. -- in addition to our current percentage of 74.18 percent.
Q. Okay. Got it.
Does the State of West Virginia perform any audits on the DHHR BMS system?
A. Yes. We are audited by the single audit and the consolidated -- it's known as the CAFR, when they consolidate the audited financial statements.
Q. And if --
A. We are considered a major -- major program. So they do look at the Medicaid program in depth.
Q. In exchange for state funding, does BMS agree to any conditions?
A. We agreed to provide healthcare, you know, to -- to handle funds appropriately, to make the maximum use of federal dollar. We have federal guidelines that we must follow. We agree to follow those.
Q. Does the State of West Virginia impose any kind of nondiscrimination obligations on BMS related to the state funding of West Virginia

Medicaid?

A. That would not be my area of expertise.

Q. Do you know whether West Virginia Medicaid makes any other types of representations that we haven't discussed already to receive state funding?

A. Not that I'm aware of.

Q. Okay. I'm going to ask us to turn back to the first exhibit, BM0001, which is Plaintiffs' Second Amended Notice of 30(b)(6) Deposition. If you could pull that up, Ms. Manning, and scroll down to page 4 for me and then let me know when you're there.

A. Okay. I'm here.

Q. Do you see Topic 11 at the top of the page?

A. I do.

Q. Topic 11 reads, "Any government interests that you contend support the exclusion and their factual bases."

Did I read that correctly?

A. Yes, ma'am.

Q. Can you confirm that you are prepared to discuss this topic as the organizational representative for BMS?

A. I am.

Q. Do you know what a governmental interest is

for purposes of this deposition?

A. I do.

Q. What's your understanding of what a governmental interest means?

A. It is my understanding that governmental interest is the fact that we pay for services as a state agency.

Q. So maybe I'm getting a little bit confused, but you just testified that a governmental interest means that you pay for services as a state agency. What do you mean by that?

A. We can only pay for services that we have approval to pay for regardless of what we think as individuals. It's based upon the opinion -- not opinion, but it's based upon what we are allowed to do, based upon laws and facts, not personal views and opinions. So...

But we are held to the standards of, in this case, CMS and the policies that we are given to operate the Medicaid program.

Q. In the context of Topic 11, what is a governmental interest?

MS. BANDY: I'll just object to the fact that she's already answered that question.

But you can go ahead and answer.

BY MS. SCHLADT:

Q. Let me ask a different question. Is it fair to say that in the context of this topic, a governmental interest is a reason?

A. Like when I think of governmental interest, I think of being a good steward with taxpayer dollars, following rules, law and policy that have been set before me.

Q. So here, if we're looking at Topic 11, and it states, as we already went over, "Any government interests that you contend support the exclusion and their factual bases," would you agree that that topic would read similarly, if not the same, if we replaced "government interest" with "reason"? So that it read, "Any reason that you contend support the exclusion and their factual bases"?

MS. BANDY: Let me just object to the form of the question. And also to the extent that Commissioner Beane was also designated as a witness on this topic, as well, and has already provided testimony on this topic, but -- just --

But you can answer.

A. Yes. You could use "reason." "Any reason."

Q. And would you agree with me that there are

reasons for covering or not covering a service that West Virginia Medicaid could cover?

A. From a financial standpoint.

Q. So you're -- oh, go ahead.

A. The reason that I might look at those reasons and the reasons that someone else might look at that are different. I'll look at that from, Can we afford it? I think it's other people's responsibility to determine: Is that within the scope? Is that within policy? Is that within CMS guidelines?

It is my responsibility to say, if we do this, can we afford this? Is it something that we can support in an ongoing basis? What does this do to our budget as a Medicaid agency?

Q. Okay. So --

A. Because --

Q. Oh, go ahead.

A. One of the things that you have to contend when you ask CMS for a service, to cover a service, is that you have the funding.

Q. Okay. I'm going to pull up another document so give me just a second to do that. I'm going to mark this document as Exhibit BM0003.

A. Okay.

Q. And it should be popping up in your folder shortly.

(Exhibit 3 was marked for identification.)

A. Okay. I have it.

Q. This document is titled Defendants' Response to Plaintiff's First Set of Interrogatories to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Did I read that correctly?

A. Yes.

Q. Please take a moment to review this document and let me know when you're ready to move on. I've got a couple questions about it.

A. (Reviewing document.)

Q. Also, I'm realizing now it's a fairly long document and so to the extent we'll be talking about it, I'm going to direct your attention to page 2 and number 2. So I'm not sure if you were reviewing the full thing because that's what I asked or not.

A. (Reviewing document.) Okay. I'm ready.

Q. Do you recognize this document?

A. I do.
Q. Is this document a copy of Defendants' Responses to Plaintiff's First Set of Interrogatories?
A. It is.
Q. So I directed your attention to page 2 where you'll see text that reads as follows: Number 2, "Describe in detail the factual basis for each governmental interest that defendants contend supports the exclusion.
"Response: These defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations."
Did I read that text accurately?
A. Yes.
Q. So the second sentence there states that BMS is constrained by budgetary/cost considerations. Does that response describe what you were just explaining to me?
A. Yes, ma'am.
Q. Okay. Do you agree with that response?
A. I do.
Q. As the organizational representative, can

you describe how this governmental interest supports the exclusion?

A. We can't -- we cannot afford it. At this point, we will be struggling to provide for services that we are already obligated to provide. And by "obligated," I mean that we have -- we have already committed to providing.

Q. And when you say you cannot afford it, what are you -- what does "it" mean?

A. "It" means, like, whether it be at -- the service at the current rate that we are currently providing. So in that sentence, "it" could be we cannot afford the service at all, so we will no longer be able to provide the service if it's optional.

We would have to look at, will we keep providing -- will Medicaid keep providing the service in the future, if it's optional? Will we keep providing the service at a decreased rate by the provider? How will Medicaid maintain a balanced budget in the future?

Q. And so the decision whether BMS can afford surgical services for gender affirming care, that decision has been made for all such services, right?

A. I can say that we are not adding new services at this time without further appropriation from our legislature.

Q. And is the reason cost?

A. Yes.

Q. As the organizational representative, what can you tell me about the factual basis for BMS's reliance on budgetary or cost considerations to support the exclusion?

A. Okay. We always have to look, when we are providing a service, not just what it will cost in the current year, but what it will cost in our six-year projection, and is it something that we can maintain.

So it's not necessarily whether we support the idea or not or whether we think it would be beneficial. It's whether we can afford it from a finance standpoint.

And I have two examples from legislative session just recently. We had two pieces of legislation that normally, if, in the six-year projection, we had been in a good place, it might have been possible for us to say -- us being BMS -- to say we can absorb these costs because they are minimal in our current budget.

And one was blood pressure cuffs for individuals with uncontrolled hypertension. We looked to price this out because the department wanted to be able to support this bill for health of individuals. We didn't want to -- if anything, we wanted to stay neutral.

It is a well-known fact at the legislature: If you attach a high cost to a fiscal note, that it could be perceived that you're trying to kill the bill with a fiscal note, especially if it's something that in the past you might have said or they perceived that you could cover within your own budget.

So our hope was to stay budget neutral, but it was not possible. Even pricing the budget -- pricing out the blood pressure cuffs at the lowest price, assuming that we found a vendor that could provide blood pressure cuffs at $40, which was the lowest price we found, and we limited our population to only members who we felt, based upon their condition, was uncontrollable.

That it wasn't temporary, it wasn't -- they didn't have a condition to which they -- we felt that it would resolve itself, and it would come back under control.

The bill also said that we would provide training and pay for that. It also stated that we would develop a database to bring back reporting. So in order to stay within a balance-neutral approach, to not say we will absorb it, we support it, or we'll -- you know, we want to put a high cost on there because we disagree, we still had to put a price, but we said we'll work with our MCOs to come out with value-based agreements and other workarounds because we simply just couldn't afford the blood pressure cuff alone and we would only be paying approximately 25 percent of the cost of the blood pressure cuff, of the $40.

Q. So you mentioned pricing out the blood pressure cuffs. You also said you had two examples.

A. Mm-hmm

Q. Did the blood pressure cuffs constitute both of those examples?

A. No.

Q. Okay. What was the second example?

A. The second example -- that legislation didn't pass because it had a cost on it, and the governor wanted a flat budget. The legislature realized, too, even without putting it forward,

that we didn't have money.

The second one was they wanted to pass legislation around collecting and preparing pregnancy termination data. And they needed to provide an FTE in order to do that, because we don't have extra FTEs in order to provide -- you know, just a person to say, okay, we already had someone.

So the proposed legislation said that we would collect the data, hire an FTE, and provide the software to prepare the report.

We already have the data. We already have software that will prepare the report. However, we could not absorb the FTE within our current budget. So it would still cost us approximately $75,000 for the FTE salary, which is full-time equivalent for one person, and their benefits to prepare those reports and present them to the Legislative Oversight Committee of Health and Human Resources.

Q. So it sounds like you -- in both of these examples, you priced out blood pressure cuffs and then you obviously have a price for the cost of an FTE salary and benefits, right?

A. Correct. And we are given those salaries -- like, for example, for the full-time

equivalent, the Department of Personnel puts out the cost that we'll use for each pay grade type so that's not a sub- -- you know, it's not a subjective cost. It wouldn't be what I wanted to pay them.

So they give us the -- like the type of position and then the market salary that we would use for the purpose of fiscal notes and then the benefit percentages. So that way each agency within state government is using apples-to-apples comparisons.

Q. Has BMS priced out the cost of providing gender affirming care?

A. I have not. In order to do that, I would need a list of codes that I would be pricing.

Q. So are you saying that you personally haven't researched the cost of providing gender affirming care?

A. Correct.

Q. Do you know of anybody else at BMS who has researched the cost of providing gender affirming care?

A. I do not.

Q. If you wanted to get a list of codes related to gender affirming care, could you do

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

I hereby certify that I reported the remote deposition of BECKY MANNING, on April 12, 2022, via Veritext Virtual Videoconference, and that the witness was by me first duly affirmed to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was preserved.

WITNESS MY HAND AND SEAL THIS 20th day of April, 2022.

Merilee Johnson

Merilee S. Johnson, RDR, CRR, CRC, RSA
Notary Public, Hennepin County, Minnesota
My commission expires January 31, 2026

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096193
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/12/2022
WITNESS' NAME: Becky Manning , 30(b)(6)

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

May 12, 2022 — Becky Manning, 30(b)(6)
Date — Becky Manning , 30(b)(6)

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 12th day of May, 2022.

Kimberly M O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 5096193

PAGE/LINE(S) /	CHANGE	/REASON
Pg 59 Lines 6-8	'My answer was to gender affirmirming Surgery	
	Since that is what is excluded from Medicaid coverage.	
Pg 73 Lines 10-16	My answer was to gender affirming surgery since	
	that is what is excluded from Medicaid coverage.	
Pg 75 Lines 18-21	my answer was as to gender affirming surgery	
	Since that is what is excluded from Medicaid coverage.	
Pg 75 Lines 25	My answer was as to gender affirming surgery,	
	since that is what is excluded from Medicaid coverage.	
Pg 76 Lines 1-9	My answer was as to gender affirming Surgery,	
	Since that is what is excluded from Medicaid coverage.	
Page 80 Lines 12-19	My answer was as to gender affirming services	
	Since that is what is excluded from Medicaid coverage	
Pg 81 Line 12-18	My answer was as to gender affirming services,	
	since that is what is excluded from Medicaid.	
	Coverage.	

May 12-2022 Becky Manning, 30(b)(6)

Date Becky Manning , 30(b)(6)

SUBSCRIBED AND SWORN TO BEFORE ME THIS 12th

DAY OF May , 2022 .

Kimberly M O'Brien

Notary Public

July 28, 2026

Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
Kimberly Michelle O'Brien
WV DHHR Bureau for Medical Services
350 Capitol St, Rm 251, Charleston, WV 25301
My Commission Expires July 28, 2026

CONFIDENTIAL

Bureau For Medical Services
SFY 2022 - 2027 Expenditure Estimate

			-0.079027265	0.021323694	0.021758048	0.022203873	0.022661078
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated Expenditures	e)	5,490,588,806	5,056,682,591	5,164,509,745	5,276,879,398	5,394,046,560	5,516,281,471
State Match Required to meet estimated expenditures	c)	889,042,890	1,136,419,758	1,167,772,034	1,194,000,169	1,221,370,898	1,249,948,903
Total State Match available (from below)		1,232,212,052	1,254,302,680	1,039,452,205	1,060,334,742	1,076,927,428	1,099,254,028
Increase in State Match needed from prior year					128,319,828	133,665,427	144,443,469
Beginning Balance		148,313,125	343,169,161	117,882,923			
General Revenue (0403/18900)		318,512,213	308,117,213	308,117,213	308,117,213	308,117,213	308,117,213
General Revenue (0403/18900) - Prior year avail July							
General Revenue Reduction/increase							
Expirations to Medical Services Fund (SB589)							
Medical Service Surplus (0403/63300)							
IDD Waiver (0403/46600 - New in 2010)		108,541,736	108,541,736	108,541,736	108,541,736	108,541,736	108,541,736
IDD Waiver (0403/46699 - 2019 Surplus)							
Rural Hospitals Under 150 Beds (0403/94000)		2,596,000	2,596,000	2,596,000	2,596,000	2,596,000	2,596,000
Tertiary Funding (0403/54700)		6,356,000	6,356,000	6,356,000	6,356,000	6,356,000	6,356,000
Traumatic Brain Injury (0403/83500)		800,000	800,000	800,000	800,000	800,000	800,000
Transfer to Division of Human Services for Health Care and Title XIX Waiver for Senior Citizens-Surplus (0420/76500)							
Title XIX Waiver for Senior Citizens (0403/53300)		13,593,620	13,593,620	13,593,620	13,593,620	13,593,620	13,593,620
Title XIX Waiver for Senior Citizens (0403/52600)							
CHIP State Share							
O Lottery Waiver (Less 600,000) (5405/53900)		4,015,503	13,603,501	13,603,501	13,603,501	13,603,501	13,603,501
O Lottery Waiver (0420/53900)		29,950,955	19,612,957	19,612,957	19,612,957	19,612,957	19,612,957
O Lottery Transfer (5405/87100)		16,400,070	16,400,070	16,400,070	16,400,070	16,400,070	16,400,070
O Lottery Surplus (5405/68199)		16,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000
Excess Lottery (5365/18900)		16,302,960	26,697,960	26,697,960	26,697,960	26,697,960	26,697,960
Excess Lottery (5365/18900) (prior year balance)							
Excess Lottery Surplus (5365/68100)		17,000,000	16,200,000	16,200,000	16,200,000	16,200,000	16,200,000
Excess Lottery Surplus (5365/68100) (prior year balance)							
Trust Fund Appropriation (5185/18900)	b)	36,570,424	33,129,424	33,129,424	33,129,424	33,129,424	33,129,424
Provider Tax (5090/18900)	a)	400,030,608	228,557,713	237,057,713	245,757,713	255,057,713	264,757,713
Provider Tax-Eligible Acute Care Tax (5090/18900)		35,300,000	36,600,000	38,000,000	39,400,000	40,900,000	42,400,000
Provider Tax-Eligible Acute Care Tax - Practitioner (5090/18900)		6,100,000	6,300,000	6,600,000	6,800,000	7,100,000	7,300,000
Provider Tax-MCO Tax (5090/18900)		44,400,000	45,700,000	45,700,000	45,700,000	45,700,000	45,700,000
O Certified Match		11,428,838	14,327,325	14,563,089	14,708,720	14,855,807	15,004,365
O NSGO State Share		0	0	0	0	0	0
O MWIN		0	0	0	0	0	0
Net State Match Available		**1,232,212,052**	**1,254,302,680**	**1,039,452,205**	**1,060,334,742**	**1,076,927,428**	**1,099,254,028**
State Match (Surplus/(Deficit))	d)	**343,169,161**	**117,882,923**	**(128,319,828)**	**(133,665,427)**	**(144,443,469)**	**(150,694,875)**

Provider Tax Estimate:

Fiscal Year	Total (million $)	Prov Tax	Acute Care - Provider	Acute Care - Practitioner	MCO Tax
2022	306,400,000	220,600,000	35,300,000	6,100,000	44,400,000
2023	317,400,000	228,800,000	36,600,000	6,300,000	45,700,000
2024	285,700,000	237,300,000	38,000,000	6,600,000	3,800,000
2025	292,200,000	246,000,000	39,400,000	6,800,000	-
2026	303,300,000	255,300,000	40,900,000	7,100,000	-
2027	314,700,000	265,000,000	42,400,000	7,300,000	-

Green cells indicate estimated figures.

Exhibit
BM0002

EXHIBIT
171

DHHRBMS021558

CONFIDENTIAL

Bureau For Medical Services
SFY 2022 - 2027 Expenditure Estimate

FOOTNOTES

SFY2022-SFY2027

a) The provider tax estimates reflect updated information supplied by the State Tax Department in Sept 2021. The amounts above exclude the administrative portion indicated in the Budget Bill (5090/78900). Assumes eligible acute care tax continues and includes est for MCO tax through expiration. If MCO tax is extended past SFY2023, revenues would be adjusted accordingly.

b) The Medicaid Trust Fund receives approximately $28M per year in receipts from the hospitals, special revenue appropriations, and interest.

c) FMAP - FFY2022 reflects a final FMAP rate of 74.68% as published in FFIS Issue Brief which is a 0.31% decrease from FFY2021. July 2020-March 2022 qtrs reflect increased FMAP of 6.2% due to COVID-19. FFY2023 reflects a FMAP rate of 74.02% per FFIS Issue Brief (a 0.66% decrease from FFY2022). SFY2024-SFY2027 reflect flat FMAP at FFY2023 FMAP. A 0.10% change in FMAP for a $3,700,000,000 (non-expansion) budget equates to $3,700,000.

d) If funding for deficit amount from prior year is not received, then the deficit in the following year will be higher. (Ex. If SFY2024 showed a deficit of $227.3M. If $227.3M of funding is not received for SFY2025, then the deficit for SFY2025 will be $227.3M plus the deficit showing in SFY2025.)

e) Scenario reflects 1% inflation used for SFY2024-SFY2027. 5% for Nursing Facilities and Prescribed Drugs

Prepared: 01/10/2022

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL;BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.**

Defendants.

DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES'S FIRST SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

DOCUMENT REQUESTS

27. To the extent not already produced, all Documents relating to any governmental interest that Defendants contend supports the Exclusion of Gender-Confirming Care.

SUPPLEMENTAL RESPONSE: Please see the attached budget and expenditure-related documents, Exhibits 60 - 85, Bates Numbers DHHRBMS002863 – DHHRBMS012160.

Exhibit
BM0010

29. All contracts, letters of agreement, and other memorialization of policies, practices, and procedures as between you and the Rational Drug Therapy Program.

SUPPLEMENTAL RESPONSE: Please see Exhibits 58 and 59, Bates Numbered DHHRBMS002785 – DHHRBMS002862.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

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Defendants.

CERTIFICATE OF SERVICE

I, Kimberly M. Bandy, counsel for Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, do hereby certify that on the 30th day of November, 2021, a true and exact copy of **DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' FIRST SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
(404) 897-1880
(404) 506-9320 (fax)
ccharles@lamdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

Stuart A. McMillan (WVSB#6352)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
600 Quarrier Street
Charleston, WV 25301
(304) 347-1110
(304) 347-1746 (fax)
smcmillan@bowlesrice.com

Aaron C. Boone (WVSB#9479)
Counsel for The Health Plan of West Virginia, Inc.
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, P.O. Box 49
Parkersburg, WV 26102
(304) 420-5501
(304) 420-5587 (fax)
aboone@bowlesrice.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, individually
and on behalf of all others
similarly situation, et al.,

Plaintiffs,

vs. CIVIL NO. 3:20-cv-000740

WILLIAM CROUCH, et al.,

Defendants.

VIDEOCONFERENCE DEPOSITION OF JENNIFER MYERS

30(b)(6) Representative for Defendant
West Virginia Department of Health and Human Resources,
Bureau for Medical Services

DATE: April 8, 2022
TIME: 7:58 a.m.
PLACE: Charleston, West Virginia
(via videoconference)
JOB NO.: MW 5096186

REPORTED BY: Dawn Workman Bounds, CSR

A P P E A R A N C E S
(ALL APPEARANCES VIA VIDEOCONFERENCE)

ON BEHALF OF PLAINTIFFS:

ANNA P. PRAKASH, ESQUIRE
NICOLE J. SCHLADT, ESQUIRE
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4700
Minneapolis, MN 55402
612.256.3200
aprakash@nka.com
nschladt@nka.com

AVATARA SMITH-CARRINGTON, ESQUIRE
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
214.219.8585
asmithcarrington@lambdalegal.org

TARA L. BORELLI, ESQUIRE
Lambda Legal Defense and Education Fund, inc.
158 West Ponce De Leon Avenue, Suite 105
Decatur, GA 30030
470.225.5341
tborelli@lambdalegal.org.

WALT AUVIL, ESQ.
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, West Virginia 26101
304.485.3058
auvil@theemploymentlawcenter.com

(APPEARANCES CONTINUED ON NEXT PAGE)

ON BEHALF OF DEFENDANTS WILLIAM CROUCH; CYNTHIA BEANE; and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES:

KIMBERLY M. BANDY, ESQUIRE
LOU ANN S. CYRUS, ESQUIRE
Shuman McCuskey Slicer PLLC
1411 Virginia Street East
Suite 200 (25301)
P.O. Box 3953
Charleston, WV 25339-3953
304.345.1400
kbandy@shumanlaw.com
lcyrus@shumanlaw.com

NOTE: The original deposition transcript will be delivered to Anna P. Prakash, Esq., as the taking attorney.

Q. Any other way that you know of?

A. There is a list that a provider can sign up for to be personally -- personal e-mail to their e-mail address if an update is done.

Q. Okay. And at the bottom of that page that we're on, which is 199, there's a date. It says revised 1-15-2016.

Do you know if there have been revisions since that date?

A. There have not.

Q. Okay. Could you scroll down to the next page on covered services, and because there have not been updates, I assume that that section is still accurate. Is it?

A. Yes.

Q. And then the same for the prior authorization section that starts at the bottom of that page and goes into the next page, that is still accurate, right?

A. Yes.

Q. And then finally the noncovered services, which are at the bottom of page 201, that is still accurate, correct?

A. Yes.

Q. Okay. On page 201, in the middle, there's a note that says, "Mastectomy or related covered

reconstructive procedures will not require prior authorization for individuals diagnosed with breast cancer."

Do you see that?

A. Yes.

Q. Are there -- what are the other covered reconstructive procedures that it is referring to here?

A. I can't answer that.

Q. Okay. Do you know --

A. That would be -- that would be a medical decision, a medical, and that's just not within my purview.

Q. Okay. And do you know whether mastectomy or related covered procedures are covered for any reason other than breast cancer?

A. Not -- no, I do not know.

Q. Okay. Who would know that?

A. Can you restate the question one more time?

Q. Sure. My question was whether mastectomy or related reconstructive procedures are covered for any reason other than breast cancer?

A. It would -- a request would have to go through the UM vendor, which is the utilization management vendor which is Kepro. They have a list they could review for medical necessity to determine if that would be covered

or not under our policy.

Q. And does Kepro utilize guidelines from InterQual?

A. Yes.

Q. So to the extent there are InterQual guidelines that allow for mastectomy or other reconstructive procedures, Kepro would be following those to determine medical necessity?

A. Yes.

Q. But I understand that -- that surgical care for the treatment of gender dysphoria is a noncovered service; is that right?

A. Yes, that's right.

Q. Okay. All right. You can exit out of that document.

(Exhibit No. 3 marked.)

BY MS. PRAKASH:

Q. And I'm going to introduce another one, since you're designated to talk about written responses, so we're going to have a lot of exhibits to look through.

Sometimes it takes a little while for the documents to load. Thanks for your patience. Okay.

So in the marked exhibits folder, you should see Exhibit JM3. Could you let me know when you have that open, please?

A. I have it open.

Q. Okay. And so these are BMS and William Crouch and Cynthia Beane's First Supplemental Response to Plaintiff's Second Set of Interrogatories; is that right?

A. Yes.

Q. Okay. And Interrogatory 8 which starts on that first page asks about conditions, diagnostic codes, or instances where coverage for hysterectomies or oophorectomies are available through Medicaid, including diagnostic codes, procedure codes, and medical necessity.

Is that your understanding?

A. Yes.

Q. Then if you scroll to the second page, the supplemental response says: Without waiving any objection, see Exhibits 10 through 26, Bates Numbered DHHRBMS001009 through DHHRBMS001112, which are used as part of the review process.

Do you see that?

A. Yes.

Q. Okay. So if you scroll down, I have attached the documents that correspond with those Bates numbers. And I believe they start on page 6 of the pdf or -- 6 or 7 of the pdf.

So let me know when you're there. The top, just so -- well, actually the bottom number says

DHHRBMS001009.

A. I'm there.

Q. Okay. Great.

So is this an example of the InterQual guidelines that Kepro would use to determine medical necessity?

A. Yes.

Q. Okay. I want to walk through this first one just to better understand it.

So at the top it has a trademark that says InterQual. Can you tell me what InterQual is?

A. InterQual is a nationally recognized UM software, which is utilization management software, that is -- can be purchased/leased to be used to determine medical necessity.

Q. And does BMS purchase that software?

A. No. It's purchased by the UM vendor Kepro.

Q. Okay. And Kepro has a contract with BMS, correct?

A. Yes.

Q. Okay. And then it says, "October 2021 Release CP: Procedures" at the top.

I understand that to mean that these guidelines were issued in October of 2021; is that right?

A. Yes.
Q. Okay. And do you know what CP procedures means?
A. No.
Q. Okay. And then the requested service lists hysterectomy and a few other procedures, correct?
A. Yes.
Q. Okay. Do you know how Kepro -- well, do you know whether Kepro, fills out forms like this, whether in paper or online or just refers to them?
A. I do not know that.
Q. Okay. And then halfway down the page, it references ICD-10 and CPT.
Do you know what those references are to?
A. Yes.
Q. Okay. And what are they references to?
A. ICD-10 is a diagnosis code and CPT is the procedure code.
Q. Okay. And does BMS utilize those specific codes with respect to insurance coverage determinations?
A. Yes.
Q. Okay. And then a little further down the page there are instructions. And it looks like it's basically asking the reader to choose which -- to answer those questions to determine medical necessity; is that right?

A. That's my understanding.
Q. Okay. And does anybody at BMS go over these with Kepro, or is it entirely left to Kepro?
A. It's entirely left to Kepro.
Q. Okay. And is there somebody at BMS that's in charge of overseeing Kepro to make sure that they're following these guidelines correctly?
A. Yes, that would be all of the supervisors at BMS.
Q. And which department are those supervisors in?
A. We -- medical would fall under Sarah Young.
Q. Okay. And how many supervisors are there that fall into that category?
A. Approximately seven.
Q. Okay. And do you know their names?
A. Yes.
Q. Could you list them out, please?
A. Okay. Jennifer Myers, Cynthia Parsons, Randy Hill, Brian Thompson, Brandon Lewis.
Q. Is that seven? I wasn't keeping track.
A. No, I think that's five.
Q. Okay. If you remember the others, will you tell me when they come to you?
A. Yes.
Q. Okay. And you listed yourself, right?

A. Yes.

Q. So can you tell me what you do to oversee Kepro to make sure they're following these guidelines correctly?

A. I review monthly reports that are -- they're actually summary reports. And then if requested, I will request -- I will request additional information from them to dig down deeper into reviews.

Q. And when you say "if requested," who makes the request?

A. I request through Kepro.

Q. I see. And what would cause you to make a request?

A. Usually it would be led by either a provider inquiry that would make me question something, or an inquiry from our fiscal processor which is at this time Gainwell. If they see -- sometimes they may bring something to my attention that they think is possibly incorrect.

Q. And has that ever happened in either of those instances with respect to insurance cover -- coverage for gender-confirming care?

A. No.

Q. Okay. Can you keep scrolling, please, to the next page. At the top it says notes and then there's a

numbered list of paragraphs?

A. Yes, I'm there.

Q. Okay. So just for the record, I'm on page DHHRBMS001011.

And could you please take a minute to read to yourself that first paragraph, and just let me know when you're ready to talk about it.

A. Okay, I'm finished.

Q. Thank you. That third sentence in that paragraph says, "At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria."

Do you know how those factors affect the applicability of InterQual criteria?

A. No.

Q. And is that something that anybody at BMS would know?

A. No, I don't believe so.

Q. And is that something someone at Kepro would know?

A. Possibly.

Q. And if somebody at Kepro were to know that, what do you think that person's job title would be?

A. Clinical reviewer.

Q. Okay. And are there specific clinical reviewers that you work with?

A. No.

Q. Approximately how many clinical reviewers does BMS work with at Kepro?

A. I'm not -- I don't know.

Q. Okay. And in your oversight of Kepro's application of the InterQual guidelines, have you ever had reason to question or ask whether Kepro is taking into account the information in Note 1 here?

A. No.

Q. Okay. And then there are several, several - more than a hundred - more pages, and they -- they're -- they encompass the Bates range or the page number range that defendants identified in their written response, which, again, is 1009 through 1112.

And you are welcome to scroll through these, but I understand that all of these are InterQual guidelines that Kepro would utilize.

And my question to you is going to be: Is that your understanding? And you can take as much time as you want to answer.

A. Yes, that is my understanding also.

Q. All right. Thank you.

And then do you know whether InterQual has guidelines for similar procedures as those identified here with respect to hysterectomy and oophorectomy that are used for the treatment of gender dysphoria?

A. I believe that they do.

Q. Okay. And in its work for BMS, does Kepro utilize those guidelines?

A. No.

Q. And why is that?

A. Because it's not a covered service under BMS.

Q. Okay. All right. You can exit out of that document.

And just back on the question of InterQual, the guidelines whether or not key point -- sorry -- Kepro utilizes them are meant to determine medical necessity, right?

A. Yes.

Q. Okay. So I'm going to introduce another exhibit.

(Exhibit No. 4 marked.)

BY MS. PRAKASH:

Q. So it should appear in the marked folder as JM4.

A. I have it open.

Q. Great. So these are Defendants' Second

Supplemental Response to Plaintiffs' Second Set of Interrogatories to Defendants Crouch, Beane, and BMS.

Do you agree with me on that?

A. Yes.

Q. Okay. So Interrogatory 8 we already -- we just talked about with respect to the last exhibit.

But this one has a supplemental response. So if you scroll down to the second page, there is a list of diagnostic codes. Do you see that?

A. Yes.

Q. Okay. So in the response itself it says, "Below is a sample listing of the approved diagnoses since 2016." And then it goes on.

But can you tell me what sample listing means in this context?

A. Yes. This would not be an all-inclusive list.

Q. Okay. Do you know what is missing or how it was determined that certain things would be excluded?

A. There wasn't actually anything excluded. What -- there was no good way to come up with a list of approved diagnoses because a lot of it is determined by medical history, previous treatment, the severity and the combination of other symptoms and conditions.

So what I did to get this list is take the procedure codes, put them in the system at Gainwell to

run a report for any diagnosis that we had on file that was approved for the procedures.

Q. I see. And so these codes that appear on page 2 of this exhibit are codes -- diagnostic codes for which a corresponding procedure was approved by BMS; is that right?

A. Yes.

Q. Okay. And do you know where these codes come from? Like is there a universal system or are they specific to BMS? Could you just help me out with that?

A. No, there's a universal system and it's the ICD-10 codes, and it's used around the world.

Q. Okay. And then if you scroll to the third page, procedure codes are listed there starting with CPT. What does CPT mean?

A. I don't know.

Q. Okay. And then how did BMS determine that these are the procedure codes that are responsive to the request?

A. CPT is also a universally known coding system, and we -- BMS utilizes the Optimum software for coding; and it's basically an online version where you can put in the name of a procedure, and it will tell you the corresponding CPT codes for that procedure.

Q. Okay. And so in this instance in responding to

this request, you would have put in hysterectomy and oophorectomy, right?

A. Yes.

Q. Great. And then none of the codes that are on page 2 for diagnoses would be for gender dysphoria, right?

A. Correct.

Q. Okay. And let's see...

Part C on page 3 talks about medical necessity.

How does BMS determine what needs prior authorization versus what is just automatically covered?

A. Most surgeries -- any inpatient surgery needs prior authorization. Outpatient surgeries are determine -- director --

THE REPORTER: I didn't hear the whole -- the end of the answer.

BY MS. PRAKASH:

Q. Could you just start that answer again, please.

A. Sure. Basically everything goes through the medical director and he determines if a PA is required or not.

Q. Is that the medical director at BMS?

A. Yes.

Q. And -- but -- but that determination is not

made each time that there is an outpatient surgery, right?

A. No. The medical director will determine the -- if -- based on the code, not based on the patient.

Q. I see.

A. So -- okay.

Q. So -- so that sounds like a one-time determination, though, because the codes don't change; is that right?

A. It can be, unless a provider requests a review, then it will go back to the medical director with whatever information they submit with it that they consider it to be -- not need a PA. So it can be reviewed additionally.

Q. Got it. So if you keep scrolling down, Interrogatory 9 asks the same questions but with respect to vaginoplasty. Do you see that?

A. Yes.

Q. And then the supplemental response about diagnostic codes says: We have no claims or approvals for this service?

What does that mean?

A. I used the same procedure for each of the different procedures to get the diagnostic codes, but we don't have any -- we, as in Medicaid, do not have any

claims or requests for those codes, at least since 2016, which is as far back as I went.

Q. And when you say you have no claims or approvals, that includes denials, right?

A. Correct.

Q. So there have been no denials or approvals?

A. Correct, yes.

Q. Got it.

Okay. And then I have, if you scroll down to page 10 -- sorry -- Interrogatory 10 on page 4, it asks the same questions with respect to different procedures, right?

A. Yes.

Q. And the same process for coming up with these responses that you testified to with respect to the previous two interrogatories was used with respect to Interrogatory 10, right?

A. Yes.

Q. Thank you. Okay. Back out of that document.

(Nicole Schladt enters the Zoom room.)

Q. Okay. If you refresh the marked exhibits folder, JM5 should be in there now.

(Exhibit No. 5 marked.)

A. Okay. I'm in.

BY MS. PRAKASH:

Q. Okay. And this says Defendants' Response to Plaintiffs' Second Set of Interrogatories to Defendants' Crouch, Beane, and BMS.

Is that what you understand this to be?

A. Yes.

Q. So I'd like you to scroll down to page 3 which is Interrogatory 11. It starts at the bottom of that page.

A. Okay. I'm there.

Q. Okay. And so this asks to identify the number of health plan participants who have submitted one or more claims with a diagnosis code for gender dysphoria or gender incongruence, and then lists those specific diagnoses that are included in this request.

The response says upon information and belief, and then on page 4 lists numbers per year.

Do you know why the response starts with upon information and belief?

A. No.

Q. And do you have any doubt that these numbers are accurate?

A. I do not.

Q. Okay. And do you know where these numbers were pulled from?

A. I pulled the numbers from the Gainwell system.

Q. Okay. And how did you go about doing that?

A. I ran a report for all claims with the listed diagnosis codes that were listed in the number 11, and then I excluded duplicate members and just used the unique number of members for each year.

Q. Okay. If you could answer one more question about this.

Are these numbers all approved claims, or all claims, whether they were approved or denied, or how -- what do these numbers represent?

A. They are all claims approved or denied.

Q. Okay. If you wanted to, you would be able to use the system to separate out the numbers of denied versus approved claims, right?

A. I could separate it out for the fee-for-service claims.

Q. Okay. And what about the claims that fall under managed care?

A. That would need to be requested from the managed care company.

Q. Okay. Why is it that BMS doesn't have access to that?

A. We -- I don't know why we don't have access to their systems.

Q. Okay. But you would agree with me that none of

the numbers listed here represent approvals for surgical procedures, right?

A. I can't guarantee that.

Q. Well, are you aware of any instance in which surgical procedures have been approved for any of the diagnoses listed in Interrogatory 11?

A. Can you repeat the question?

Q. Are you aware of any instance in which surgical procedures have been approved for any of the diagnoses in Interrogatory 11?

A. No, I'm not aware of any.

Q. Okay. And so it's fair to say that the numbers that are listed in response to Interrogatory 11 do not include approvals for surgical care, right?

A. Again, I can't guarantee that.

Q. Why can't you?

A. Can I explain?

Q. Yes.

A. Okay. When the report was pulled, it was pulled based on the diagnosis code, in the diagnosis code that was billed on the claim.

A diagnosis -- one of the diagnosis codes listed in number 11 could be on the claim, but not be actually completely related to the service. So I can't guarantee that there was not a claim that was submitted

for surgery, any type of surgery, that had a diagnosis of gender dysphoria as a diagnosis that was not the primary diagnosis.

Q. I see. Okay. So it may be that surgery was approved for a diagnoses that is not listed in Interrogatory 11, but the patient had that diagnosis in addition to something else?

A. Correct.

Q. Got it. Okay. Thank you. You can exit out of that document.

Okay. If you refresh the marked exhibits folder, you should have JM6 in there. Just let me know when you've got that open.

(Exhibit No. 6 marked.)

A. Okay. It's open.

BY MS. PRAKASH:

Q. This is -- it looks like the third supplement response. It's just some of the interrogatories that we've been looking at, specifically Interrogatory 11, right?

A. Yes.

Q. And then on the second page of this document, it refers us to an e-mail from Aetna and two attachments, right, in the supplemental response?

A. Yes.

A. Yes.

Q. Okay. And with respect to medical necessity criteria for the services that are listed in number 10, those criteria would be reflected in the InterQual guidelines that Kepro uses in its work for BMS, right?

A. Yes.

Q. And I think you testified earlier that Kepro doesn't utilize the guidelines for the diagnosis of gender-affirming care with respect to surgical services; is that right?

A. Correct, yes.

Q. Okay. And then if you bear with me, I will introduce the next written response.

(Exhibit No. 12 marked.)

BY MS. PRAKASH:

Q. It's a little bit larger, so it's taking some time. Okay. It should appear in the marked exhibits folder now as JM12.

A. I have it.

Q. Great. And this, at least the beginning of it, appears to be Defendants' Third Supplemental Response to Plaintiffs' First Set of Requests for Production.

Do you agree?

A. Yes.

Q. Okay. And if you go to number 10, which is on

the second page of that document, we just looked at that specific request, but this is a supplemental response.

And that supplemental response references Bates numbers DHHRBMS001009 through BMS -- sorry -- through DHHRBMS001112 as well as another set of Bates numbers which is DHHRBMS002754 through 2784.

Do you see that?

A. Yes.

Q. Okay. And the first set 1009 through 1112 were the InterQual guidelines that we looked at earlier.

So I have attached those to this exhibit, but I would like to go to the second set of Bates numbers that start with 2754, and I believe that's page 110 of the pdf.

I know that requires a lot of scrolling. Just let me know when you're there.

A. Okay. Okay, I'm there.

Q. Okay. Are these -- well, so on this first page, 2754, these are also InterQual guidelines, correct?

A. Yes.

Q. And these would be utilized by Kepro for BMS, correct?

A. Yes.

Q. Okay. And they would be utilized in the same way that we discussed with respect to the first set of

InterQual guidelines that we looked at earlier; is that right?

A. Yes.

Q. And just so I'm clear - and you can take as much time as you need - the remainder of this exhibit that goes all the way through page 2784 are InterQual guidelines that Kepro would utilize in its work for BMS?

And just a yes or no on that is fine. And take some time to scroll through so that you're sure.

A. Yes.

Q. Okay. So please exit out of that. And I will introduce another exhibit.

(Exhibit No. 13 marked.)

BY MS. PRAKASH:

Q. In the marked exhibits folder, Exhibit JM13 should appear. Please let me know when you've got that.

A. Yes, I have it up.

Q. Okay. So this is an e-mail that was sent to you as well as a couple people at Kepro, right?

Just for --

A. Yes. Yes.

Q. And for the record, the Bates number on this document is DHHRBMS015365 through 391.

And it looks like the e-mail came from Karen Wilkinson. Who is that?

A. She is a team leader at Kepro.

Q. Okay. And it looks like -- and you can scroll down and look -- that she is -- actually, let's do this.

Can we scroll to page 15367, which should be the third page of that exhibit.

A. I'm there.

Q. Okay. And partway near the top of the page but partway down starts an e-mail from you to Emily Proctor, Karen Wilkinson and Alicia Perry at Kepro, right?

A. Uh-huh. Yes.

Q. And there you're requesting criteria for certain procedures, right?

A. Yes.

Q. Okay. And why did you make that request?

A. It was requested in the interrogatories.

Q. Okay. And so you made that request for the purpose of responding to discovery in this case?

A. Yes.

Q. And in response, if you scroll up, it -- to the very top of that exhibit, so back to the first page, which is 15365, it looks like what Karen sent you, if you look at the first part of that e-mail right under the attachments, it looks like she sent you the InterQual guidelines for gender affirmation surgery, right?

A. Correct.

Q. If you scroll down, I've included that attachment, which starts with Bates label 15368.

Can you let me know when you're there?

A. I'm there.

Q. Okay. And from that page down, these look like InterQual guidelines for gender affirmation surgery.

Do you agree with that?

A. Yes.

Q. Okay. These are InterQual guidelines for gender affirmation surgery that Kepro had, correct?

A. Yes.

Q. And I think you testified earlier that guidelines such as these for gender affirmation surgery would not be utilized by Kepro in its work for BMS, right?

A. Correct.

Q. So do you know why Kepro had access to these guidelines?

A. Kepro has clients other than West Virginia Medicaid.

Q. I see. Okay.

And the purpose of these guidelines is to determine medical necessity for various procedures, right?

A. Yes.

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

I hereby certify that I remotely reported the videoconference deposition via Zoom of JENNIFER MYERS 30(b)(6) Representative for Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services on the 8th day of April, 2022, in Charleston, West Virginia, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was not waived.

WITNESS MY HAND AND SEAL THIS 22nd day of April, 2022.

Dawn Workman Bounds, CSR 6129
Notary Public, Hennepin County, Minnesota
My commission expires January 31, 2024

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096186
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 4/8/2022
WITNESS' NAME: Jennifer Myers

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

5/13/2022 Jennifer Myers
Date Jennifer Myers

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this 13th day of May, 2022.

Samuel J. Sutherland
Notary Public
11/20/24
Commission Expiration Date

OFFICIAL SEAL
NOTARY PUBLIC, STATE OF WEST VIRGINIA
Samuel T. Sunderland
350 Capitol St., Room 156
Charleston, WV 25301
My Commission Expires November 20, 2024

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.,**

Defendants.

DEFENDANTS' THIRD SUPPLEMENTAL RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

11. Taking necessary steps to comply with applicable privacy laws, for each year since 2016 through the present identify the number of Health Plan participants who have submitted one or more claims with a diagnosis code for Gender Dysphoria or Gender Incongruence. This

Exhibit
JM 6

includes, but is not limited to, the following diagnosis: F64.0, Transsexualism (ICD-10-CM); F64.2, Gender identity disorder of childhood (ICD-10-CM); F64.8, Other gender identity disorders (ICD-10-CM); F64.9, Gender identity disorder, unspecified(ICD-10-CM); HA60, Gender incongruence of adolescence or adulthood (ICD-11); and HA61, Gender incongruence of childhood (ICD-11).

SUPPLEMENTAL RESPONSE: Please see email from Aetna and two attachments, including a spreadsheet and a copy of Plaintiff's Second Set of Interrogatories to Defendants Williams Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, Exhibit 106, Bates Numbered DHHRBMS016321-16331, and Exhibit 107, Bates Numbered DHHRBMS016332.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,
By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esquire (WVSB #6558)
Roberta F. Green, Esquire (WVSB #6598)
Caleb B. David, Esquire (WVSB #12732)
Kimberly M. Bandy, Esquire (WVSB #10081)
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

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Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 24th day of February 2022, a true and exact copy of **DEFENDANTS' THIRD SUPPLEMENTAL RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

Walt Auvil (WVSB#190)
Counsel for Plaintiffs
The Employment Law Center, PLLC
1208 Market Street
Parkersburg, WV 26101-4323
(304) 485-3058
(304) 485-6344 (fax)
auvil@theemploymentlawcenter.com

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
Counsel for Plaintiffs
Nichols Kaster, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
(612) 256-3200
(612) 338-4878 (fax)
aprakash@nka.com
nschladt@nka.com

Sasha Buchert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
(202) 804-6245
(202) 429-9574 (fax)
sbuchert@lambdalegal.org

Avatara Smith-Carrington, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
3500 Oak Lawn Avenue, Suite 500
Dallas Texas 75219-6722
(214) 219-8585
(214) 219-4455 (fax)
asmithcarrington@lambdalegal.org

Nora Huppert, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
(213) 382-7600
(213) 351-6050
nhuppert@lambdalegal.org

Carl. S. Charles, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 300030
(404) 897-1880
(404) 506-9320 (fax)
ccharles@lambdalegal.org

Tara L. Borelli, Visiting Attorney
Counsel for Plaintiffs
Lambda Legal Defense and Education Fund, Inc.
1 West Court Square, Suite 105
Decatur, GA 30030
tborelli@lambdalegal.org

Perry W. Oxley (WVSB#7211)
David E. Rich (WVSB#9141)
Eric D. Salyers (WVSB#13042)
Christopher K. Weed (WVSB#13868)
Oxley Rich Sammons, PLLC
Counsel for Jason Haught
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
(304) 522-1138
(304) 522-9528 (fax)
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esq. (WVSB #6558)
Roberta F. Green, Esq. (WVSB #6598)
Caleb B. David, Esq. (WVSB #12732)
Kimberly M. Bandy, Esq. (WVSB #10081)
Counsel for William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services
SHUMAN MCCUSKEY SLICER PLLC
P.O. Box 3953
Charleston, WV 25339
(304) 345-1400; (304) 343-1826 (fax)
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com