

**UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WISCONSIN**

CODY FLACK,  
SARA ANN MAKENZIE,  
MARIE KELLY, and  
COURTNEY SHERWIN,  
*individually and on behalf of all others  
similarly situated,*

Plaintiffs,

v.

WISCONSIN DEPARTMENT OF  
HEALTH SERVICES, *et al.*,

Defendants.

Case No. 3:18-cv-00309-wmc  
Judge William Conley

**PLAINTIFFS' PROPOSED FINDINGS OF FACT  
IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

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## **LIST OF REFERENCED DOCUMENTS AND EXHIBITS**

Plaintiffs cite the following documents in their Proposed Findings of Fact. For documents previously filed in this case, the applicable docket number is indicated. Other documents will be filed concurrently with Plaintiffs' Motion for Summary Judgment.

### **STIPULATIONS**

Joint Stipulation to Findings of Fact (Apr. 23, 2019) ("SFOF")

### **PLAINTIFFS' EXPERT WITNESS REPORTS**

Expert Witness Report of Stephanie L. Budge, PhD, LP (Jan. 14, 2019) ("Budge Rep.")

Expert Witness Report of Loren S. Schechter, MD (Jan. 12, 2019) ("Schechter Rep.")

Expert Witness Report of Daniel Shumer, MD, MPH (Jan. 14, 2019) ("Shumer Rep.")

Expert Witness Report of Jaclyn White Hughto, PhD, MPH (Jan. 14, 2019) ("Hughto Rep.")

Expert Witness Report of Joan C. Barrett and Elaine T. Corrough (Mar. 22, 2019) ("Barrett/Corrough Rep.")

### **DEFENDANTS' EXPERT REPORTS**

Expert Report of David V. Williams (filed Aug. 22, 2018) [ECF No. 74-1]

Supplemental Expert Witness Decl. of David V. Williams (filed Nov. 19, 2018) [ECF No. 122]

### **DECLARATIONS**

#### ***Named Plaintiffs***

Decl. of Cody Flack (May 16, 2018) [ECF No. 22] ("Flack Decl.")

Supp. Decl. of Cody Flack (Oct. 16, 2018) [ECF No. 91] ("Flack Supp. Decl.")

Decl. of Sara Ann Makenzie (May 21, 2018) [ECF No. 23] ("Makenzie Decl.")

Second Supp. Decl. of Sara Ann Makenzie (Oct. 18, 2019) [ECF No. 92] ("Makenzie Supp. Decl.")

Decl. of Marie C. Kelly (Oct. 15, 2018) [ECF No. 93] (“Kelly Decl.”)

Supp. Decl. of Marie C. Kelly (Apr. 22, 2019) (“Kelly Supp. Decl.”)

Decl. of Courtney Sherwin (Oct. 18, 2018) [ECF No. 95] (“Sherwin Decl.”)

Supp. Decl. of Courtney Sherwin (Jan. 25, 2019) [ECF No. 132] (“Sherwin Supp. Decl.”)

***Class Members***

Decl. of Lexie Vordermann (Oct. 16, 2018) [ECF No. 99] (“Vordermann Decl.”)

Decl. of Tori Vancil (Oct. 16, 2018) [ECF No. 97] (“Vancil Decl.”)

Decl. of Emma Grunenwald-Ries (Oct. 15, 2018) [ECF No. 98] (“Grunenwald-Ries Decl.”)

Supp. Decl. of Emma Grunenwald-Ries (Feb. 21, 2019) (“Grunenwald-Ries Supp. Decl.”)

***Medical Providers***

Decl. of Linda Wesp, MSN, RN, APNP, FNP-C, AAHIV-S (Oct. 16, 2018) [ECF No. 94] (“Wesp Decl.”)

Decl. of Kathy Oriel, MD, MS (Oct. 25, 2018) [ECF No. 109] (“Oriel Decl.”)

Supp. Decl. of Katherine M. Gast, MD, MS (Feb. 22, 2019) (“Supp. Gast Decl.”)

Decl. of Amy M. DeGueme, MD, ECNU (May 14, 2018) [ECF No. 29] (“DeGueme Decl.”)

Decl. of Daniel P. Bergman, MS, LPC (May 14, 2018) [ECF No. 28] (“Bergman Decl.”)

Decl. of Clifford King, MD, PhD (May 21, 2018) [ECF No. 30] (“King Decl.”)

Decl. of Trisha E. Schimek, MD (May 21, 2018) [ECF No. 31] (“Schimek Decl.”)

Decl. of Beth E. Potter, MD (May 23, 2018) [ECF No. 33] (“Potter Decl.”)

**DEPOSITION TRANSCRIPTS AND EXHIBITS**

Rule 30(b)(6) Deposition of Wisconsin Department of Health Services (Apr. 16, 2019)

Ex. 1 – Ltr. from J. Sager to L. Wiggins, Jan. 4, 2017 (DHS001099-1101)

Ex. 2 – Timeline of Internal Handling of Gender Conforming Surgical Requests within Wisconsin Medicaid Fee for service

Ex. 3 – Ltr. from J. Sager to DHS Office of Legal Counsel, Sep. 25, 2017 (DHS003006-3007)

#### OTHER EXHIBITS

Declaration of Orly T. May, Esq. (May 23, 2018) [ECF No. 21] (“First May Decl.”):

Ex. 1 – American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, “Gender Dysphoria” 451-459 (5th ed. 2013)

Ex. 20 – Administrative Law Judge B. Schneider Decision in C. Flack’s Administrative Appeal of Defendants’ Denial of Medical Assistance, Nov. 21, 2017

Ex. 23 – Nat’l Ctr. for Transgender Equality, *Exec. Summ. of Report of 2015 U.S. Transgender Survey* (2016)

Ex. 24 – Nat’l Ctr. for Transgender Equality, *2015 U.S. Transgender Survey: Wis. State Report* (2017)

Second Declaration of Orly T. May, Esq. (Apr. 23, 2019) (“Second May Decl.”):

Ex. 1 – Defendants’ Responses to Plaintiffs’ First Set of Interrogatories (Mar. 28, 2019)

Ex. 2 – Movement Advancement Project, *Equality Maps: Healthcare Law and Policies, Medicaid* [http://www.lgbtmap.org/equality\\_maps/profile\\_state/WI](http://www.lgbtmap.org/equality_maps/profile_state/WI) (last visited Apr. 22, 2019)

Ex. 3 – Movement Advancement Project, *Wisconsin Equality Profile*, [http://www.lgbtmap.org/equality\\_maps/profile\\_state/WI](http://www.lgbtmap.org/equality_maps/profile_state/WI) (last visited Apr. 22, 2019)

Ex. 4 – Nat’l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* (2016, updated 2017)

Ex. 5 – Maggie Astor, *Danica Roem Wins Virginia Race, Breaking a Barrier for Transgender People*, N.Y. Times, Nov. 7, 2017, <https://www.nytimes.com/2017/11/07/us/danica-roem-virginia-transgender.html>

Ex. 6 – Antonio Olivo, *Danica Roem of Virginia to be first openly transgender person elected, seated in a U.S. statehouse*, Wash. Post, Nov. 8, 2017, <http://wapo.st/2zEX1aD>

Ex. 7 – Julie Moreau, *Over 150 LGBTQ candidates claim victory in midterm elections*, NBC News, Nov. 7, 2018, <https://www.nbcnews.com/feature/nbc-out/over-100-lgbtq-candidates-claim-victory-midterm-elections-n933646>

Ex. 8 – World Prof'l Ass'n of Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, (7th Version 2011)

Ex. 9 – Wylie C. Hembree, et al., “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” *J. Clinical Endocrinology & Metabolism* (2017) (“Endocrine Society Guidelines”)

Ex. 10 – Email from K. Plunkett to J. Sager & L. Wiggins (Mar. 11, 2019) (attaching spreadsheet entitled Gender Reassignment Procedure Code List (“DHS Gender Reassignment Procedure Code List”) (Mar. 11, 2019) (Bates range DHS000393-94)

Ex. 11 – Email from J. Sager to R. Currans-Henry, et al., Nov. 14, 2016 (DHS001008-1009)

Ex. 12 – Email from J. Sager to L. Wiggins, Jan. 4, 2016 (DHS001099-1100)

Ex. 13 – Wis. Dep't of Health Servs., Biennial Rule Review Document (Jan. 2018) (Bates number DHS000520)

Declaration of Abigail A. Moats (Apr. 23, 2019) (“Moats Decl.”)

Ex. 1 – Plaintiffs' Subpoena to Molina Health Care of Wisconsin

Ex. 2 – HMO Denials Summary Chart

Plaintiffs respectfully submit the following Proposed Findings of Fact (“PFOF”) in support of their Motion for Summary Judgment.

### **INTRODUCTION**

1. Named Plaintiffs Cody Flack, Sara Ann Makenzie, Marie Kelly, and Courtney Sherwin bring this class action lawsuit on behalf of themselves and a proposed class of “[a]ll transgender individuals who are or will be enrolled in Wisconsin Medicaid, have or will have a diagnosis of gender dysphoria, and who are seeking or will seek surgical or medical treatments or services to treat gender dysphoria,” Pls.’ Mot. for Class Cert. 1 [ECF No. 89], challenging Wisconsin Medicaid’s categorical exclusion of coverage for gender-confirming medical and surgical treatments for gender dysphoria. Am. Compl. with Class Action Allegations ¶ 1 [ECF No. 85].

2. Wis. Admin. Code §§ DHS 107.03(23)-(24), 107.10(4)(p) (the “Challenged Exclusion”), a provision of Wisconsin’s Medicaid regulations, categorically excludes coverage for transition-related medical care, including “[t]ranssexual surgery” and “[d]rugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics.” Joint Stip. to Findings of Fact (Apr. 23, 2019) (“SFOF”) ¶¶ 62-63.

3. Although the Wisconsin Department of Health Services (“DHS”), the agency charged with the administration of Wisconsin Medicaid, concedes that untreated or inadequately treated gender dysphoria is associated with serious mental health harms, including psychological distress, depression, anxiety, self-harm, and suicidality, SFOF ¶¶ 18, 57; Rule 30(b)(6) Dep. of Wis. Dep’t of Health Servs. (Apr. 16, 2019) (“DHS Dep.”) 26:9-22, and recognizes that the medical community views gender-confirming surgeries as safe and effective treatments for

gender dysphoria, SFOF ¶ 60, the agency continues to categorically deny coverage for *all* surgical procedures intended to treat gender dysphoria. SFOF ¶ 64; DHS Dep. 20:2-21:7.

Moreover, it is Wisconsin Medicaid's policy to exclude gender-confirming hormone treatments from coverage, SFOF ¶ 80, despite DHS's recognition that hormone therapy is a medically necessary treatment for gender dysphoria for many transgender people. SFOF ¶ 61; DHS Dep. 19:22-20:1, 21:18-25.

4. Wisconsin Medicaid covers the same treatments excluded by the Challenged Exclusion when medically necessary to treat other conditions. SFOF ¶ 81; DHS Dep. 26:5-8, 68:23-70:4.

5. DHS has offered no justification for its policy of excluding treatments for gender dysphoria that are covered for other conditions. In fact, the agency is unaware of any information that the Challenged Exclusion was ever motivated by concerns about the safety, efficacy, or cost of covering gender-confirming treatments, SFOF ¶¶ 70-78, 87-88, and it does not consider the treatments experimental. Op. & Order, July 26, 2018, at 26 n.22 ("PI Op.") (noting party admission by Defendants' counsel at preliminary injunction hearing).

6. To the contrary, the medical directors at DHS charged with making clinical coverage determinations for Wisconsin Medicaid beneficiaries consider gender-confirming hormone and surgical treatments for gender dysphoria to be medically necessary, DHS Dep. 44:22-46:6, and that the Challenged Exclusion conflicts with current medical practice and the accepted standards of care for treating gender dysphoria, DHS Dep. 62:24-64:22. As DHS itself admits, its recent enforcement of the Challenged Exclusion has been motivated exclusively by political, not clinical, considerations. DHS Dep. 32:19-33:7, 45:17-19, 50:5-23 & Ex. 3.

7. Nevertheless, DHS enforces the Challenged Exclusion to the present day. SFOF ¶ 11. DHS and the third-party managed care organizations (“HMOs”) that administer Wisconsin Medicaid plans continue to deny coverage to transgender beneficiaries for gender-confirming hormone treatments, surgeries, and related services pursuant to the Challenged Exclusion. SFOF ¶ 89; Defs.’ Resp. to Pls.’ Interrogatory No. 5.

8. Categorical exclusions on gender-confirming health care, including the Challenged Exclusion, are medically harmful and inconsistent with the contemporary medical and scientific understanding of gender identity, applicable peer-reviewed scientific and medical research, and the medical and scientific consensus that this care is medically necessary for transgender people with gender dysphoria. Expert Report of Stephanie L. Budge 18-19 (Jan. 14, 2019) (“Budge Rep.”); Expert Report of Loren S. Schechter, MD 18-19 (Jan. 12, 2019) (“Schechter Rep.”); Expert Report of Daniel Shumer, MD, MPH 16-17 (Jan. 14, 2019) (“Shumer Rep.”); Expert Report of Jaclyn White Hughto, PhD, MPH 25-27 (Jan. 14, 2019) (“Hughto Rep.”); *see also* DHS Dep. 28:14-16, 30:6-15, 33:8-34:3 (recognizing the current medical view that gender-confirming treatments are medically necessary to treat gender dysphoria).

9. Wisconsin is currently one of just nine states with categorical Medicaid exclusions on gender-confirming health care. Movement Advancement Project, *Equality Maps: Healthcare Laws and Policies, Medicaid*, [http://www.lgbtmap.org/equality-maps/healthcare\\_laws\\_and\\_policies](http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies) (click on “Medicaid” tab) (last visited Apr. 22, 2019 [Ex. 2 to Second Decl. of Orly T. May, Esq. (Apr. 23, 2019) (“Second May Decl.”)]).

## **BACKGROUND**

### **Jurisdiction and Venue**

10. The Court has jurisdiction over the claims asserted herein under 28 U.S.C. §§ 1331 and 1343(a)(3)-(4). SFOF ¶ 90.

11. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, 42 U.S.C. § 1983, and Rules 57 and 65 of the Federal Rules of Civil Procedure. SFOF ¶ 91.

12. Under 28 U.S.C. § 1391, venue is proper in the Western District of Wisconsin. SFOF ¶ 1.

### **The Parties**

#### ***The Named Plaintiffs***

13. Plaintiff Cody Flack is an adult resident of Green Bay, Brown County, Wisconsin. SFOF ¶ 92.

14. Plaintiff Sara Ann Makenzie is an adult resident of Baraboo, Sauk County, Wisconsin. SFOF ¶ 93.

15. Plaintiff Marie Kelly is an adult resident of Milwaukee, Milwaukee County, Wisconsin. SFOF ¶ 94.

16. Plaintiff Courtney Sherwin is an adult resident of Janesville, Rock County, Wisconsin. SFOF ¶ 95.

#### ***Defendants***

17. Defendant Wisconsin Department of Health Services ("DHS") is the Wisconsin state agency charged with the administration of Wisconsin Medicaid consistent with federal and state requirements. SFOF ¶¶ 2, 7.

18. DHS is a recipient of federal funds, including Medicaid funding for Wisconsin Medicaid. SFOF ¶ 3.

19. Defendant Andrea Palm, sued in her official capacity, is the Secretary-Designee of DHS. As Secretary, she is responsible for implementing the Medicaid Act consistent with federal Medicaid requirements and state law, Wis. Stat. § 46.014. SFOF ¶ 4.

20. DHS receives federal funding from the U.S. Department of Health and Human Services, including reimbursement of over half of the State of Wisconsin's Medicaid expenditures. SFOF ¶ 8.

### **WISCONSIN MEDICAID**

21. Established in 1965 under Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396w-5 (the "Medicaid Act"), Medicaid is a joint federal-state program that provides medical assistance to eligible low-income individuals. SFOF ¶ 5.

22. Medicaid enables states to furnish medical services to persons whose incomes and resources are insufficient to meet the cost of necessary medical services by reimbursing participating states for a substantial portion of the costs of providing medical assistance. 42 U.S.C. §§ 1396-1, 1396b; SFOF ¶ 6.

23. Wisconsin, like every other state, participates in Medicaid. SFOF ¶ 7.

24. Wisconsin's medical assistance statute, Wis. Stat. §§ 49.43-.65, and its implementing regulations, Wis. Admin. Code § DHS 101.01-109.74, govern Wisconsin Medicaid. SFOF ¶ 9.

25. Currently, Wisconsin Medicaid has approximately 1.2 million enrollees. SFOF ¶ 12; DHS Dep. 22:21-23:3.

26. The current annual Wisconsin Medicaid expenditures are approximately \$9.7 billion, including federal reimbursements. SFOF ¶ 13. The State of Wisconsin pays, on average, 40.6 percent of that total, with the federal government contributing the balance. Expert Report of David V. Williams 3 (Aug. 22, 2018) [ECF No. 74-1]; Expert Witness Report of Joan Barrett & Elaine Corrough 5, 7 (Mar. 22, 2019). Based on current expenditures, Wisconsin's annual portion is approximately 40.6 percent of \$9.7 billion, or approximately \$3.9 billion per year.

27. Wisconsin Medicaid beneficiaries are enrolled in either a fee-for-service plan administered directly by DHS or an HMO Medicaid plan offered through one of 15 third-party managed care organizations. DHS Dep. 14:19-15:16, 18:4-8. Currently, approximately 20 percent of Wisconsin Medicaid beneficiaries are enrolled in a fee-for-service plan. DHS Dep. 15:12-14. The other 80 percent are in an HMO Medicaid plan. DHS Dep. 15:12-17.

28. Fee-for-service plans are administered directly by DHS without the aid of a third-party administrator. DHS Dep. 15:3-11. Prior authorization requests for fee-for-service members are reviewed directly by DHS's prior authorization review staff. DHS Dep. 15:25-16:10.

29. DHS's prior authorization reviewers typically use the agency's published guidelines to determine the clinical appropriateness of a requested service and to make coverage determinations. DHS Dep. 15:25-17:9. Requests for services without published guidelines, including gender-confirming surgeries, are reviewed by medical doctors on the clinical staff of the Bureau of Benefits Management ("BBM") in DHS's Division of Medicaid Services. DHS Dep. 17:10-18:3. BBM is the bureau within DMS that enforces benefits policies and creates clinical coverage guidelines. DHS Dep. 6:21-7:17. BBM is responsible for enforcing the Challenged Exclusion at issue in this case. DHS Dep. 7:18-8:22.

30. Currently, BBM's clinical staff members are Dr. Lora Wiggins (Chief Medical Officer of BBM), Dr. Julie Sager (Medical Director of BBM), and Dr. Steven Tyska (Medical Director of BBM). DHS Dep. 6:16-24; 10:15-11:9; 12:13-21. The job responsibilities of BBM's medical directors include overseeing the clinical appropriateness and content of DHS policies administered by BBM, setting clinical policy, and supporting DHS's prior authorization staff when there are requests outside of the agency's written published guidelines or some clarification of a clinical nature is needed. DHS Dep. 6:25-7:17. Dr. Wiggins, Dr. Sager, and Dr. Tyska are the only doctors in BBM. DHS Dep. 12:13-21.

31. Currently, the following managed care organizations offer one or more Wisconsin Medicaid plans: Anthem Blue Cross Blue Shield of Wisconsin (formerly Community Connect); Dean Health Plan, Inc.; Care Wisconsin Health Plan; Children's Community Health Plan; Group Health Cooperative of Eau Claire; Group Health Cooperative of South Central Wisconsin; MercyCare Insurance Company; MHS Health Wisconsin; Molina Healthcare of Wisconsin (formerly Abri); Network Health Plan; iCare (Independent Health Care Plan); Quartz Health Solutions, Inc.; Security Health Plan of Wisconsin; Trilogy Health Insurance, Inc.; and UnitedHealthcare Community Plan. SFOF ¶ 66; Defs.' Resp. to Interrogatory No. 8. In addition, the following managed care organizations previously offered one or more Wisconsin Medicaid plans from January 1, 2009 to present: Children's Community Health Plan Central; CompCare; CommunityConnect; Physicians Plus Insurance Corporation; Dean Health Plan SE; Gundersen; HTHP; and Unity. *Compare* SFOF ¶ 66 *with* Defs.' Resp. to Interrogatory No. 8.

32. These managed care organizations oversee, manage, and administer Medicaid benefits to the Wisconsin Medicaid beneficiaries enrolled in their respective plans. DHS Dep. 18:9-23. Prior authorization requests are reviewed, and approved or denied, by each managed

care organization's own clinical staff. DHS Dep. 18:9-25. Coverage determinations must meet DHS's minimum standards and are made according to DHS's published guidelines (if any). DHS Dep. 18:9-25.

33. When a managed care organization denies a prior authorization request, the beneficiary has the option of submitting their request to DHS to determine whether it would have been covered by DHS for a fee-for-service beneficiary. DHS Dep. 19:1-10. If DHS determines the requested treatment is medically necessary and would have been covered for a fee-for-service beneficiary, it compels the managed care organization to cover the treatment. DHS Dep. 19:1-21.

34. As prior authorization requests denied by managed care organizations are not reportable to DHS unless the beneficiary seeks DHS's review of the denial, DHS does not have information about all coverage denials made pursuant to the Challenged Exclusion. Defs.' Resp. to Interrogatory No. 5.

### **GENDER IDENTITY**

35. Gender identity is an innate, internal sense of one's sex—*i.e.*, being male or female—and is a basic part of every person's core identity. Shumer Rep. at 3; Budge Rep. at 6; Hughto Rep. at 6.

36. Gender identity is considered an immutable characteristic. Shumer Rep. at 4-11; Budge Rep. at 6; Schechter Rep. at 1 n.1. As Dr. Shumer explains, "where an individual experiences progressive gender dysphoria during or after puberty—and, in turn, consistently and persistently lives in accordance with their gender identity—the permanence of the individual's cross-gender identity is extremely likely." Shumer Rep. at 11. Accordingly, "[g]iven the literature regarding the biological underpinnings of gender identity, adults with a diagnosis of

gender dysphoria have not chosen to be transgender, but rather have an immutable difference in gender.” Shumer Rep. at 16.

37. Everyone has a gender identity. Budge Rep. at 6; Hughto Rep. at 6.

38. Most people’s gender identity is consistent with the sex they were assigned at birth. Budge Rep. at 5; Hughto Rep. at 6.

39. Transgender people have a gender identity that is different from their assigned sex (i.e., the sex designation recorded on an infant’s birth certificate, sometimes referred to as “natal sex”). A transgender man is a man whose assigned sex was female but has a male gender identity. A transgender woman is a woman whose assigned sex was male but has a female gender identity. SFOF ¶ 55.

#### **DISCRIMINATION AGAINST TRANSGENDER PEOPLE**

40. In Wisconsin, 0.43% of the state’s 4.5 million adult population, or approximately 19,363 people, were estimated to be transgender as of the end of 2017. Hughto Rep. at 18. An estimated 5,000 Wisconsin Medicaid beneficiaries are transgender adults. Hughto Rep. at 18-19.

41. Transgender people have historically been subjected to discrimination in virtually every facet of life and continue to face pervasive discrimination today, including in employment, education, housing, health care, and their own families and communities. Hughto Rep. at 10-17; *see also* Nat’l Ctr. for Transgender Equality, *Exec. Summ. of Report of 2015 U.S. Transgender Survey* (Dec. 2016) (“USTS Exec. Summ.”) [ECF No. 21-23].

42. Wisconsin has no express state-level protections against gender identity discrimination, and only 19 percent of the State’s population lives in a city or county with a local nondiscrimination ordinance prohibiting gender identity discrimination. Movement Advancement Project, *Wisconsin’s Equality Profile*,

[http://www.lgbtmap.org/equality\\_maps/profile\\_state/WI](http://www.lgbtmap.org/equality_maps/profile_state/WI) (last visited Apr. 22, 2019) [Ex. 3 to Second May Decl.]

43. In Wisconsin, more than a quarter of transgender adults live in poverty, more than twice the overall national poverty rate. Nat'l Ctr. for Transgender Equality, *2015 U.S. Transgender Survey: Wisconsin State Report* 1 & n.3 (Oct. 2017) [ECF No. 21-24] (“2015 USTS-WI”).

44. One in five transgender residents in Wisconsin is unemployed. 2015 USTS-WI at 1.

45. Nearly 60 percent of transgender people in Wisconsin have recently experienced mistreatment by law enforcement officers who perceived or knew them to be transgender. 2015 USTS-WI at 2.

46. In the health care context, 30 percent of transgender adults in Wisconsin had been denied insurance coverage for being transgender in the past year; a third of those who had seen a medical provider in the previous year had at least one negative experience related to being transgender; and nearly a quarter had opted not to see a doctor when needed out of fear of mistreatment in the past year. 2015 USTS-WI at 3.

47. More than half of transgender respondents to the 2015 U.S. Transgender Survey who sought insurance coverage for gender-confirming surgery in the previous year were denied that coverage. Hughto Rep. at 16; Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 93 (Dec. 2016) [Ex. 4 to Second May Decl.].

48. Transgender people in the United States experience widespread stigma resulting from the incongruence between their gender identity and the gender typically associated with their assigned birth sex. Hughto Rep. at 10.

49. Physical harassment, verbal harassment, sexual assault, and violence against transgender people is common. Hughto Rep. at 12.

50. Transgender people are a politically powerless minority. Currently, only three openly transgender people have ever held a seat in a state legislature (all currently in office), none in Wisconsin. Maggie Astor, *Danica Roem Wins Virginia Race, Breaking a Barrier for Transgender People*, N.Y. Times, Nov. 7, 2017, <https://www.nytimes.com/2017/11/07/us/danica-roem-virginia-transgender.html> (last visited Apr. 23, 2019) [Ex. 5 to Second May Decl.]; Antonio Olivo, *Danica Roem of Virginia to be first openly transgender person elected, seated in a U.S. statehouse*, Wash. Post, Nov. 8, 2017 (last visited Apr. 23, 2019) [Ex. 6 to Second May Decl.]; Julie Moreau, *Over 150 LGBTQ candidates claim victory in midterm elections*, NBC News, Nov. 7, 2018, <https://www.nbcnews.com/feature/nbc-out/over-100-lgbtq-candidates-claim-victory-midterm-elections-n933646> (last visited Apr. 23, 2019) [Ex. 7 to Second May Decl.]. To Plaintiffs' knowledge, no openly transgender person has been elected to any statewide or national office in the United States.

## **GENDER DYSPHORIA AND ITS TREATMENT**

### **Overview of Gender Dysphoria**

51. Gender dysphoria is a condition experienced by transgender people marked by distress related to the incongruence between the person's assigned sex and gender identity, SFOF ¶ 56; DHS Dep. 26:9-25, which can be alleviated when the person is able to live, and be treated by others, consistently with the person's gender identity. Budge Rep. at 9-10; Hughto Rep. at 8-10. Many, although not all, transgender people with gender dysphoria require medical

treatments, including hormone therapy and surgery, as part of their gender transition. DHS Dep. 26:23-27:5; Budge Rep. at 11-16; Hughto Rep. at 9-10.

52. Gender dysphoria is the clinically significant distress or impairment in social, occupational, or other areas of function associated with the incongruence between a transgender person's gender identity and assigned sex. SFOF ¶ 56; DHS Dep. 26:9-25.

53. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition ("DSM-5"), published in 2013, defines and describes "gender dysphoria" as follows:

*Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* 451 (2013) ("DSM-5") [relevant excerpts at ECF No. 21-1] ; SFOF ¶ 16. A true and correct copy of the Gender Dysphoria chapter of the DSM-5 is attached as Exhibit 1 to the Declaration of Orly May (May 23, 2018.) [ECF No. 21-1] ("First May Decl."); SFOF ¶ 16.

54. The DSM-5 contains the diagnostic criteria for Gender Dysphoria in Adolescents and Adults (302.85 (F64.1)) and the diagnostic features of this diagnosis. SFOF ¶ 17; *see also* Budge Rep. at 7-9; Hughto Rep. at 7-8.

55. Many transgender individuals experience gender dysphoria at some point in their lives. Schechter Rep. at 5.

56. Individuals who are diagnosed with gender dysphoria present with a variety of symptoms, and typically indicate an intense need to present themselves and be viewed by others

in accordance with their gender identity (that differs from their sex assigned at birth). Budge Rep. at 8.

57. Untreated or inadequately treated gender dysphoria is associated with serious mental health harms, including serious mental distress, depression, anxiety, self-harm, and suicidality, SFOF ¶¶ 18, 57; *see also* Budge Rep. at 8-9, 13-14, including psychological distress that causes dysfunction socially and in employment. DHS Dep. 26:9-22.

58. Symptoms of gender dysphoria can be mitigated, and often prevented altogether, for transgender people with access to appropriate individualized medical care as part of their gender transitions, including hormone and surgical treatments for gender dysphoria. Budge Rep. at 11-16; Hughto Rep. at 9-10; DHS Dep. 26:23-27:5.

59. While the most current research shows positive psychosocial outcomes for patients who obtained medically necessary hormone therapy and gender confirmation surgery for gender dysphoria, including improved mental health, reduced suicidal ideation, and improved quality of life, research also shows that the failure to provide transition-related medical care can lead to significant harm. Budge Rep. at 13-16.

60. Failure to provide medically necessary treatments for gender dysphoria is medically harmful and unethical. Shumer Rep. at 16.

61. The World Professional Association of Transgender Health's *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version* (2011) ("WPATH Standards of Care") are clinical guidelines for the treatment of gender dysphoria. SFOF ¶ 58; WPATH Standards of Care [Ex. 8 to Second May Decl.]. Under the WPATH Standards of Care, accepted treatment options for gender dysphoria include

psychotherapy, hormone therapy, and various surgical procedures. SFOF ¶ 59; Schechter Rep. at 6-10; Shumer Rep. at 11-12; WPATH Standards of Care at 9-10.

62. The Endocrine Society's clinical practice guidelines, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017) (the "Endocrine Society Guidelines"), are guidelines for the treatment of gender dysphoria, specifically hormone treatments. DHS Dep. 27:6-28:1; Wylie C. Hembree, *Endocrine Society Guidelines* [Ex. 9 to Second May Decl.]; Shumer Rep. at 12.

63. DHS's clinical officials in the Bureau of Benefits Management consider the WPATH Standards of Care and the Endocrine Society Guidelines to be appropriate standards for assessing the medical necessity of gender-confirming hormone treatments and surgical procedures. DHS Dep. 27:6-28:1. Dr. Sager, the BBM medical director, considers the WPATH Standards of Care and the Endocrine Society Guidelines to be generally accepted in the medical community based on her medical practice. DHS Dep. 28:14-16, 30:6-15, 33:8-34:3.

### **Gender-Confirming Treatments are Medically Necessary in Many Transgender People**

#### ***Hormone Treatments***

64. For many transgender people with gender dysphoria, hormone therapy is a medically necessary treatment for gender dysphoria. SFOF ¶ 61; DHS Dep. 19:22-20:1; *see also* Budge Rep. at 11-13. DHS admits that when hormones are used to treat gender dysphoria, they are not medically unnecessary. DHS Dep. 21:18-25.

65. Hormone treatments, while effective, may be insufficient on their own to treat gender dysphoria adequately in many transgender people. Budge Rep. at 12-13; Schechter Rep. at 7; Shumer Rep. at 12, 14-16. Peer-reviewed research indicates that transgender individuals who have undergone both hormone therapy and gender confirming surgery have less gender

dysphoria, depression, psychological distress, and suicidal ideation than individuals who had only undergone hormone therapy or received no gender-confirming care at all. Budge Rep. at 13.

### *Gender-Confirming Surgeries*

66. Gender confirming surgical procedures as part of a medical transition are safe and effective treatments for gender dysphoria. Budge Rep. at 16-18; Schechter Rep. at 11-18.

67. Gender-confirming surgical procedures include a wide range of surgical procedures and do not refer to one particular surgery. DHS Dep. 25:23-26:4.

68. The American Medical Association, American Psychological Association, American Psychiatric Association, Endocrine Society, and other major medical organizations take the position that surgeries are an accepted and effective medical treatment for gender dysphoria. SFOF ¶ 60; *see also* Budge Rep. at 10-11; Shumer Rep. at 13; Hughto Rep. at 8.

69. Not all transgender people need surgery to alleviate their gender dysphoria; however, for many transgender people, surgery is the only medically effective treatment to alleviate symptoms of the condition. Schechter Rep. at 7; Shumer Rep. at 15-16; Budge Rep. at 13-16; Hughto Rep. at 9-10; WPATH Standards of Care at 54-55.

70. The WPATH Standards of Care explicitly state that “sex reassignment surgery is effective and medically necessary” for many transgender individuals. WPATH Standards of Care at 54; Shumer Rep. at 16.

71. DHS’s clinical staff in the Bureau of Benefits Management consider the WPATH Standards of Care and the Endocrine Society Guidelines to be appropriate standards for assessing the medical necessity of gender-confirming hormone treatments and surgical procedures. DHS Dep. 27:6-28:1. Dr. Sager, the BBM medical director, considers the WPATH Standards of Care

and the Endocrine Society Guidelines to be generally accepted in the medical community based on her medical practice. DHS Dep. 28:14-16, 30:6-15, 33:8-34:3.

72. The medical community considers surgical treatments for gender dysphoria to be reconstructive, not cosmetic, in nature, because, when performed in accordance with the WPATH Standards of Care, they are clinically indicated to treat the underlying medical condition of gender dysphoria. Schechter Rep. at 10-11; DHS Dep. 28:5-13.

73. The goals of transition-related medical interventions, including hormone treatments and surgeries, include prevention or elimination of the development of unwanted secondary sex characteristics of the assigned sex; promotion or reconstruction of the development of desired secondary sex characteristics of the sex associated with one's gender identity; reduced gender dysphoria and related symptoms; and the enhanced ability to "pass" as the sex associated with one's gender identity. Shumer Rep. at 14.

74. Since transgender people who are visibly gender nonconforming experience more discrimination and worse health outcomes than those whose appearance matches their gender identity, gender-confirming medical treatments can also reduce the discrimination, mistreatment, and harassment that transgender people suffer for being visibly gender nonconforming. Hughto Rep. at 11-13. The experienced stigma for being transgender—which is heightened for transgender individuals unable to "pass" because of visibly gender-nonconforming features—frequently results in a higher risk of violence, mistreatment, chronic stress, and ensuing long-term psychological and physical harms. Hughto Rep. at 10-17.

75. Transgender individuals who are unable to access or afford gender confirming procedures, which would increase gender conformity, are at greater risk of discrimination and other harms. Hughto Rep. at 11-13, 17.

76. Without access to gender-confirming care, the majority of individuals needing hormone therapy or gender confirmation surgery will experience severe psychological distress and some individuals will die by suicide if they are not able to obtain this care. Budge Rep. at 18-19; Hughto Rep. at 17.

77. Increased availability of gender-confirming care is associated with public health benefits, including improved psychological functioning and quality of life in transgender people, reductions in suicide and suicide attempts, lower levels of substance use, reductions in sexual assault and interpersonal violence, increased access to HIV prevention services, and reduced gender dysphoria, resulting in associated benefits to the general public in the form of reduced social, economic, and health-related costs. Hughto Rep. at 17-26.

#### **BACKGROUND OF THE CHALLENGED EXCLUSION**

78. DHS has not provided any justification for the Challenged Exclusion, either at the time of its adoption in 1997 or at any time since. Despite labeling “transsexual surgery” and related “[d]rugs, including hormone therapy” to be “not medically necessary,” DHS is unaware of any evidence suggesting this characterization was based on any review of the applicable scientific or medical literature at the time, or that DHS’s predecessor agency, the Department of Family and Health Services (“DHFS”), considered any or all of the excluded procedures to be unsafe, or ineffective at treating gender dysphoria (or the previous diagnosis of gender identity disorder), or medically unnecessary in all instances. SFOF ¶¶ 70-73. Nor is it aware of any evidence to suggest the agency has ever considered the safety, efficacy, or medical necessity of gender-confirming treatments in its enforcement of the exclusion over the past 22 years. SFOF ¶¶ 74-78, 87-88.

79. The Challenged Exclusion was adopted as an amendment to the Medicaid regulations in 1996 and went into effect on February 1, 1997. *See* Wis. Dep’t of Health & Fam. Servs., Clearinghouse Rule 96-154, 1 (Dec. 11, 1996) (“CR 96-154”); SFOF ¶ 10.

80. The DHS regulations governing Wisconsin Medicaid do not define the term “transsexual surgery.” SFOF ¶ 14. Indeed, DHS currently considers the term “transsexual surgery” to be “outdated” and inconsistent with modern medical terminology. DHS Dep. 20:2-14. Nevertheless, DHS currently interprets “transsexual surgery” to mean *any* surgical procedure intended to treat gender dysphoria, including chest surgeries, genital surgeries, and other surgical procedures to treat gender dysphoria. SFOF ¶ 64; DHS Dep. 20:2-21:7.

81. At the time the policy was promulgated, DHFS labeled “transsexual surgery” and related “[d]rugs, including hormone therapy” as “not medically necessary,” along with other services including “tattoo removal,” “ear lobe repair,” “services related to surrogate parenting,” and “non-medical food.” CR 96-154, at 1.

82. DHS is not aware of information indicating that when the Challenged Exclusion was promulgated, DHFS’s determination that the excluded services were “not medically necessary” was based on any systematic study or review of relevant peer-reviewed scientific or medical literature relating to the excluded services conducted by or on behalf of DHFS. SFOF ¶ 70.

83. DHS is not aware of information indicating that prior to its implementation on February 1, 1997, the Challenged Exclusion was based on a determination by DHS or DHFS that any or all of the excluded services were experimental, unsafe, or ineffective at treating gender dysphoria (or, as the condition was known at the time, gender identity disorder). SFOF ¶¶ 71-73.

84. Prior to the implementation of the Challenged Exclusion, DHFS predicted that exclusions added in the 1996 Amendments, including the Challenged Exclusion, would result in nominal cost savings to the State. DHFS, Fiscal Estimate: Medical Assistance: Medically Unnecessary Services 1 (Sept. 27, 1996) (“DHS Fiscal Est.”) [ECF No. 21-14].

85. DHS is not aware of information indicating that, between the Challenged Exclusion’s implementation on February 1, 1997 and April 29, 2018 (the day before this lawsuit was filed), either DHS or DHFS undertook any study or review of any of the following:

- a. the fiscal impact of enforcing, amending, or eliminating the Challenged Exclusion, SFOF ¶ 74;
- b. the safety or efficacy of medical or surgical treatments for gender dysphoria, SFOF ¶ 76; or
- c. the public health effects of enforcing, amending, or eliminating the Challenged Exclusion, SFOF ¶ 78.

86. DHS is not aware of information indicating that it undertook any review or consideration of the applicability of the Challenged Exclusion to medical treatments for gender dysphoria following the publication of the WPATH Standards of Care in 2011. SFOF ¶ 87.

87. DHS is not aware of information indicating that it undertook any review or consideration of the applicability of the Challenged Exclusion to medical treatments for the diagnosis of Gender Dysphoria in Adolescents and Adults announced in the DMS-5 in 2013. SFOF ¶ 88.

88. DHS does not consider surgical treatments for gender dysphoria to be experimental. PI Op. at 26 n.22 (referencing party admission by Defendants’ counsel at preliminary injunction hearing).

89. From April 30, 2018 (the date this lawsuit was filed) to present, DHS has not undertaken any study or review of:

- a. the fiscal impact to Wisconsin Medicaid, DHS, or the State of Wisconsin of enforcing, amending, or eliminating the Challenged Exclusion other than the reports of David Williams prepared and submitted to the Court in connection with this lawsuit, dated August 22, 2018 and November 16, 2018, SFOF ¶ 75; or
- b. the safety or efficacy of medical or surgical treatments for gender dysphoria, other than the reports of Lawrence Mayer, Chester Schmidt, Daniel Sutphin, and Michelle Ostrander prepared for and/or submitted to the Court in connection with this lawsuit, SFOF ¶ 77.

90. The only documents DHS has identified as being considered, reviewed, or relied on by DHS relating to the Challenged Exclusion are the WPATH Standards of Care, the Endocrine Society Guidelines, and coverage criteria from other state Medicaid agencies, including from Oregon, which were reviewed by Dr. Julie Sager, Wisconsin Medicaid's medical director, as recently as July 2018 when reviewing an HMO denial of a request for gender confirming surgery for an individual that was under 21 years of age. Defs.' Resp. to Interrogatory No. 10. In that instance, Dr. Sager determined that the requested surgery was medically necessary and recommended approval for coverage under Wisconsin Medicaid. DHS Dep. 58:8-60:4.

91. Even if DHS had considered the potential cost impact of ending the Challenged Exclusion prior to this lawsuit, which it did not, Defendants' estimated cost impact of covering gender-confirming surgeries (ranging from \$300,000 to \$1.2 million annually, or 0.008 percent

to 0.03 percent of the State's \$3.9 billion share of the \$9.7 billion annual Wisconsin Medicaid budget), is immaterial from an actuarial perspective. Barrett & Corrough Rep. at 4-8.

### **ENFORCEMENT OF THE CHALLENGED EXCLUSION**

92. Pursuant to the Challenged Exclusion, Wisconsin Medicaid coverage for medical and surgical treatments for gender dysphoria has been denied by DHS and/or by one or more of the HMOs that offer Wisconsin Medicaid since the implementation of the exclusion on February 1, 1997, including since the preliminary injunction entered in this case on July 25, 2018. SFOF ¶ 89.

93. Based on the Challenged Exclusion, from January 1, 2009 to present, DHS has denied Wisconsin Medicaid coverage to ten fee-for-service beneficiaries for the following gender-confirming surgical procedures: removal of testis; reduction of large breast; enlarge breast with implant; mastectomy (simple complete and subcutaneous); breast reconstruction; and repair brow defect. Defs.' Resp. to Interrogatory No. 5. Wisconsin Medicaid covers each of these procedures for other diagnoses. Email from K. Plunkett to J. Sager & L. Wiggins (Mar. 11, 2019) (attaching spreadsheet entitled Gender Reassignment Procedure Code List ("DHS Gender Reassignment Procedure Code List")) (Mar. 11, 2019) (Bates range DHS000393-94) [Ex. 10 to the Second May Decl.]. Since 2014, HMOs that administer Wisconsin Medicaid have, based on the Challenged Exclusion denied numerous requests for gender-confirming surgical procedures, hormone treatments, and other medical treatments and services (e.g., office visits, psychotherapy) including chest reconstruction and genital reconstruction, as well as related

procedures such as anesthesia and office consultations, based on the Challenged Exclusion. Decl. of Abigail Moats ¶ 12 (Apr. 23, 2019) (“Moats Decl.”).<sup>1</sup>

94. DHS has no published coverage guidelines for gender-confirming health care. DHS Dep. 17:10-20. Nor has DHS ever provided any formal guidance to Wisconsin Medicaid HMOs on what treatments and services are, or are not, covered by the Challenged Exclusion. SFOF ¶¶ 68-69. As a result, Wisconsin Medicaid HMOs have, under the Challenged Exclusion, denied coverage for a range of surgical treatments, hormone treatments, and other medical services for transgender beneficiaries. Moats Decl. ¶ 13.

95. DHS admits that hormone treatments are medically necessary treatments for gender dysphoria for many people. SFOF ¶ 61; DHS Dep. 19:22-20:1, 21:18-25.

96. DHS’s clinical staff in Wisconsin Medicaid’s Bureau of Benefits Management (“BBM”), the office charged with making and reviewing medical necessity determinations for requested treatments, consider gender-confirming surgeries to be medically necessary treatments for gender dysphoria when clinically indicated under the WPATH Standards of Care, DHS Dep. 44:22-46:6, and that the Challenged Exclusion conflicts with current medical practice and the accepted standards of care for treating gender dysphoria, DHS Dep. 62:24-64:22. Accordingly, BBM’s medical director has determined—in her clinical judgment and consistent with DHS’s

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<sup>1</sup> DHS currently interprets the Challenged Exclusion to apply only to beneficiaries age 21 and above. SFOF ¶¶ 62-63. DHS considers requests for coverage by such beneficiaries under 21 that otherwise would be affected by the Challenged Exclusion under the Medicaid Act’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions. See 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(4)(b); Wis. Admin. Code § DHS 107.22; SFOF ¶ 65. DHS is aware of one beneficiary whose prior authorization request for surgery was denied by the person’s managed care organization pursuant to the Challenged Exclusion. DHS Dep. 58:8-60:20. DHS determined, on appeal from the HMO’s denial, that the requested procedure was medically necessary for that beneficiary, although it is unclear whether DHS and/or the HMO ever approved coverage following that determination. DHS Dep. 58:8-59:17.

practice for making medical necessity determinations in the absence of internally published guidelines—that surgeries for transgender Medicaid beneficiaries (including Plaintiff Cody Flack) were medically necessary. DHS Dep. 51:17-52:15.

97. DHS’s recent enforcement of the Challenged Exclusion has been motivated purely by political, not clinical, factors. DHS Dep. 32:19-33:7, 45:17-19, 50:5-23 & Ex. 3. DHS admits that, even with respect to the original denial of coverage for surgery for Named Plaintiff Cody Flack, the denial was not based on any review of his individual medical needs or any clinical considerations, SFOF ¶ 42; DHS Dep. 50:5-23, and that once the preliminary injunction in this case required it, the agency determined that the requested procedures were indeed medically necessary for Mr. Flack and approved them. DHS Dep. 50:24-51:20.

### **Gender-Confirming Treatments and Services Subject to the Exclusion**

#### ***Surgical Treatments***

98. Surgical treatments for gender dysphoria that are categorically excluded from coverage by the Challenged Exclusion, regardless of whether prior authorization is required for the procedure, include penectomy, orchiectomy, vaginoplasty, feminizing genitoplasty, breast reconstruction, chondrolaryngoplasty, phalloplasty, metoidioplasty, masculinizing genitoplasty, mastectomy, reduction mammoplasty, hysterectomy, oophorectomy, salpingo-oophorectomy, intersex surgery (male to female), and intersex surgery (female to male). SFOF ¶ 79.

99. All of these surgeries are recognized as safe and effective treatments for gender dysphoria in transgender people. Schechter Rep. at 11-17; WPATH Standards of Care at 55.

#### ***Hormone Treatments***

100. Pursuant to the Challenged Exclusion, it is Wisconsin Medicaid’s policy that some hormone therapy treatments for gender dysphoria are excluded from coverage, regardless

of whether prior authorization is otherwise required for the treatment, although DHS covers certain hormone treatments in practice because of the difficulty in enforcing the exclusion for drugs. SFOF ¶ 80; Defs.' Resps. to Interrogatory No. 12, 14; DHS Dep. 22:17-23:3.

101. Because managed care organizations offering Wisconsin Medicaid plans may use their own procedures for drug coverage, coverage for certain hormone treatments for transgender patients may be denied pursuant to the Challenged Exclusion. DHS Dep. 68:16-22.

102. In fact, managed care organizations have denied coverage for hormone treatments on multiple occasions in recent years, including denials of testosterone, estradiol, and leuprolide. Moats Decl. ¶ 12.

#### **Wisconsin Medicaid Covers the Same Treatments for Other Conditions**

103. Pursuant to the Challenged Exclusion, it is Wisconsin Medicaid's policy to exclude from coverage certain medical services, treatments, and/or procedures when deemed medically necessary by a beneficiary's medical provider to treat gender dysphoria, but to cover the same procedures when they are deemed medically necessary by a beneficiary's medical provider to treat certain conditions other than gender dysphoria. SFOF ¶ 81; DHS Dep. 26:5-8, 68:23-70:4.

104. For example, Wisconsin Medicaid covers mastectomy, reduction mammoplasty, breast reconstruction, hysterectomy, oophorectomy, and salpingo-oophorectomy for Medicaid beneficiaries when medically necessary to treat conditions other than gender dysphoria, but pursuant to the Challenged Exclusion, it is Wisconsin Medicaid's policy to exclude those services from coverage for beneficiaries 21 and over when they are deemed medically necessary by the beneficiary's medical provider to treat gender dysphoria. SFOF ¶¶ 82-83.

105. In addition, Wisconsin Medicaid covers breast reconstruction, orchiectomy, penectomy, and vaginoplasty for Medicaid beneficiaries when medically necessary to treat conditions other than gender dysphoria, but pursuant to the Challenged Exclusion, it is Wisconsin Medicaid's policy to exclude those services from coverage for beneficiaries 21 and over when they are deemed medically necessary by the beneficiary's medical provider to treat gender dysphoria. SFOF ¶¶ 82, 84.

106. All of these procedures are covered by Wisconsin Medicaid to treat conditions other than gender dysphoria. DHS Gender Reassignment Procedure Code List at 3-4, 7.

**Recent Enforcement of the Challenged Exclusion to Deny Coverage for Gender-Confirming Surgeries Has Not Been Motivated by Medical Considerations**

***DHS's Clinical Staff Consider the Challenged Exclusion to Conflict with Accepted Medical Practice and Applicable Standards of Care***

107. It is the clinical opinion of Dr. Julie Sager, Wisconsin Medicaid's medical director in BBM, that ending the Challenged Exclusion would be consistent with medical practice and the medically accepted standards of care. DHS Dep. 62:24-64:22. Testifying for the agency, she assumes DHS's current position is the same. DHS Dep. 62:24-64:22. Both she and BBM's Chief Medical Officer, Dr. Lora Wiggins, consider gender-confirming surgeries to be medically necessary treatments for gender dysphoria. DHS Dep. 46:22-47:8.

108. Nevertheless, DHS has continued to vigorously enforce the Challenged Exclusion in recent years without regard to the clinical views of its medical staff. SFOF ¶¶ 79-84; DHS Dep. 46:14-47:8.

***DHS Has Not Defined or Clarified the Scope of the Challenged Exclusion to Beneficiaries or the HMOs that Administer Medicaid Plans***

109. Publicly, DHS states that “medical interventions such as hormones and surgery” for transgender people are not covered under Wisconsin Medicaid. SFOF ¶ 15. The agency’s website contains the following statement:

For people who need medical interventions such as hormones or surgery, these might be covered under private insurance plans. Currently, Wisconsin BadgerCare, BadgerCare Plus, Medicaid, and State of Wisconsin employee health insurance (ETF) do not cover gender reassignment surgery or drugs related to gender reassignment or hormone replacement. Please contact your health insurance company to learn more details about what services are covered by your insurance.

*LGBT Health – Transgender Persons*, Wis. Dep’t of Health Servs.,

<https://www.dhs.wisconsin.gov/lgbthealth/transgender.htm> (last visited Apr. 23, 2019);

SFOF ¶ 15.

110. Although the HMOs that administer Wisconsin Medicaid are primarily responsible for enforcing the Challenged Exclusion for beneficiaries enrolled in their respective plans, including denying requests for prior authorization for treatments and services excluded by the Challenged Exclusion, DHS has never provided formal or specific guidance to the HMOs that administer Wisconsin Medicaid plans for 80 percent of the State’s Medicaid beneficiaries on how to interpret the Challenged Exclusion. SFOF ¶¶ 67-69; DHS Dep. 15:12-16.

111. The agency has never provided formal guidance to HMOs on the agency’s definition of the terms “transsexual surgery” and “[d]rugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics” contained in the Challenged Exclusion, SFOF ¶ 68, nor has it provided formal guidance to those HMOs on what treatments and services are specifically excluded from coverage by the Challenged Exclusion. SFOF ¶ 69.

112. The only written communication DHS has made to participating HMOs pertaining to the Challenged Exclusion was a letter, dated January 4, 2017, sent from former Wisconsin Medicaid Director Michael Heifetz, a political appointee, to contract administrators at the managed care organizations offering Wisconsin Medicaid plans. DHS Dep. 31:5-32:18 & Ex. 1. The letter stated that DHS would continue to enforce the Challenged Exclusion and “*will not reimburse* entities for procedures that fall outside the Department’s regulations.” DHS Dep. Ex. 1 (emphasis added). That letter stated that a federal court had issued a preliminary injunction against the portion of the U.S. Department of Health and Human Services (“HHS”) final rule implementing Section 1557 of the Affordable Care Act (“Section 1557 Final Rule”) prohibiting discrimination on the basis of gender identity. DHS Dep. Ex. 1. The letter, citing the Challenged Exclusion, stated that:

The Department will continue to abide by its own regulations related to covered services under Medical Assistance/Medicaid (“MA”). Specifically, under the Department’s MA regulations, transsexual surgery and medically unnecessary hormone therapy are not covered services. (*See* Wis. Admin. Code §§ DHS 107.03(23), (24); 107.10(4)(p)). . . . The Department will continue to make coverage decisions under its regulations, and will not reimburse entities for procedures that fall outside the Department’s regulations.

DHS Dep. Ex. 1.

The letter did not define “transsexual surgery” or “medically unnecessary hormone therapy.”

DHS Dep. Ex. 1. The Bureau of Benefits Management was not consulted on the letter. DHS Dep. 32:19-24. The letter was not based on clinical practice, but on DHS’s legal position. DHS Dep. 33:3-7.

***DHS’s Enforcement of the Exclusion Since 2016 Has Been Motivated by Politics, Not Medicine***

113. Prior to 2016, DHS sporadically covered chest surgeries to treat gender dysphoria based on a provision of the State’s Medicaid regulations allowing coverage for procedures to

treat a condition that significantly interferes with a person's personal or social adjustment, or employability. DHS Dep. 35:25-37:10 & Ex. 2. DHS did not consider these surgeries cosmetic when intended to treat gender dysphoria. DHS Dep. 35:25-37:14.

114. After the Section 1557 Final Rule went into effect in 2016, BBM's clinical staff wrote to DHS management to share their position that the Challenged Exclusion conflicted with federal law and inquired, in writing, about whether gender-confirming surgeries should now be approved. DHS Dep. 39:6-41:6 & Ex. 2; Email from J. Sager to R. Currans-Henry, et al., Nov. 14, 2016 (Bates range DHS001008-1009) [Ex. 11 to Second May Decl.]. BBM never received a written response to this inquiry. DHS Dep. 41:7-8. However, mid-level DHS management, who were political appointees, notified the BBM medical directors that, under the instructions of DHS's "upper management" (also political appointees), they "were not to approve the surgeries, and . . . to remain mute and neither approve or deny, just leave them," offering no further explanation. DHS Dep. 41:9-18. They were told that they should let prior authorization requests for surgeries "sit and 'age out,'" which they understood to mean to neither approve nor deny within the prescribed timelines to render an action under state law. DHS Dep. 42:14-43:7 & Ex. 2. They had never received a similar direction for any other types of coverage determinations. DHS Dep. 43:8-10.

115. At that time, BBM's clinical staff were given no written clarification from DHS's political appointees or executive management as to what procedures were subject to the Challenged Exclusion. DHS Dep. 32:10-16.

116. BBM subsequently received no further direction from DHS management regarding the enforcement of the Challenged Exclusion. DHS Dep. 44:22-45:12. According to Dr. Sager, "when we saw this black-and-white kind of in writing direction to the HMOs, I felt that

we were quite vulnerable to continue the compassionate allowing of transgender surgeries. They were sporadic at that point, almost exclusively top procedures in the way them before given the Department really coming to a position that they pushed out to the HMOs” through Mr. Heifetz’s letter. DHS Dep. 44:7-45:12; Email from J. Sager to L. Wiggins, Jan. 4, 2017 (“Jan. 2017 Email from J. Sager”) (Bates range DHS001099-1100) [Ex. 12 to Second May Decl.].

117. Contrary to their shared clinical opinion that gender-confirming surgeries were medically necessary and should be allowable under the current standard medical guidelines, including the WPATH Standards of Care and Endocrine Society Guidelines, Dr. Sager and Dr. Wiggins decided the best option would be to deny all requests for gender-confirming hormones and surgery moving forward to comply with the Department’s directives to the HMOs. Jan. 2017 Email from J. Sager; DHS Dep. 44:22-46:6. This was not based on a clinical determination, but instead was motivated by “the increased number of requests for gender conforming [sic] surgeries since Medicare lifted its moratorium on the same in 2014, the increased political spotlight on the issue, the lack of clear direction or guidance from upper Medicaid management and the seemly [sic] clear stance of the state of WI not to cover such surgeries.” Timeline of internal handling of Gender Conforming Surgical Requests within Wisconsin Medicaid [sic] Fee for service, J. Sager, July 8, 2018 (DHS Dep. Ex. 2); DHS Dep. 45:17-19. Indeed, Dr. Sager wrote at the time, “In my opinion, I think it is a more transparent and reasonable option to deny all these requests for gender-confirming treatment hormones and surgery, not that I believe this to be ethically or morally right, but in order to catalyze a better solution through the appropriate legislative or legal channels . . . .” Jan. 2017 Email from J. Sager; DHS Dep. 44:22-46:6.

118. Consistent with this assumption, internal DHS documents indicate that the Division of Medicaid Services wishes to eliminate one part of the Challenged Exclusion, Wis.

Admin. Code § DHS 107.10(4)(p), which excludes hormone treatments from coverage, based on DHS's view that the provision conflicts with federal law and denies medically necessary care to transgender people. An internal document entitled, "BIENNIAL RULE REVIEW: Division of Medicaid Services (DMS), Proposed Findings," and most recently circulated within DHS on February 14, 2019, contains the following statement:

107.10(4)(p) Conflicts with federal law. Section 1557 of the Affordable Care Act prohibits discrimination based on gender identity. There are an estimated 1.4 million adults in the US that identify as transgender. It is more acceptable today for a person to identify as a different sex than what they were born as. Major medical associations in the US have described transition-related surgeries as "medically necessary" for both the physical and mental health of transgender people. More and more insurance plans and Medicare are covering these surgeries. As these surgeries become more frequent, the rule has become outdated by not allowing coverage for these types of drugs. Section 1557 of the Affordable Care Act prohibits discrimination based on gender identity. Recommendation is to delete this rule or revise the rule to allow coverage of drugs for trans-sexual surgeries or alteration of sexual anatomy or characteristics.

Wis. Dep't of Health Servs., Biennial Rule Review Document (Jan. 2018) (Bates number DHS000520) [Ex. 13 to Second May Decl.).

119. Earlier this year, in response to Dr. Sager's request for a formal discussion with DHS leadership about coverage for gender-confirming treatments, Dr. Sager was asked by DHS executive management to prepare a briefing document about what an appropriate policy would look like. DHS Dep.64:23-66:6. In preparation for such discussions, Dr. Sager requested and received a spreadsheet from BBM's medical coder, Kathleen Plunkett, identifying various gender-confirming procedures and Wisconsin Medicaid's coverage policies for those procedures, including coverage for the treatment of conditions other than gender dysphoria. DHS Dep. 65:12-66:6; Gender Reassignment Procedure Code List. That spreadsheet reveals that the large majority of procedures that are part of gender-confirming surgeries are covered for other conditions. DHS Dep. 65:12-66:6; Gender Reassignment Procedure Code List.

120. Further discussions between BBM and DHS management about potential policy changes have not yet occurred. DHS Dep. 65:13-66:8.

**EXPERIENCES OF THE NAMED PLAINTIFFS AND  
MEMBERS OF THE PROPOSED CLASS**

**Harm to All Members of the Proposed Class**

121. The Challenged Exclusion contributes to and exacerbates the rampant discrimination and mistreatment transgender Wisconsin residents suffer, including pervasive health care discrimination and mistreatment by the police and others, as well as the high poverty rates in the transgender community. Hughto Rep. at 21-24; *see also* USTS Exec. Summ.; 2015 USTS-WI.

122. The Challenged Exclusion prevents medical providers in Wisconsin from providing clinically appropriate, adequate treatments for gender dysphoria to their transgender patients by categorically denying coverage for necessary care to those patients. Decl. of Linda Wesp, MSN, RN, APNP, FNP-C, AAHIV-S ¶ 16 (Oct. 16, 2018) [ECF No. 94] (“Wesp Decl.”); Decl. of Kathy Oriel, MD, MS ¶ 14 (Oct. 25, 2018) [ECF No. 109] (“Oriel Decl.”); Supp. Decl. of Katherine Gast, MD, MS ¶¶ 3-4 (Feb. 22, 2019) (“Gast Supp. Decl.”). For example, Dr. Gast, the UW Health surgeon who performs many gender-confirming surgeries on transgender patients, has seen 25 transgender patients on Wisconsin Medicaid seeking gender-confirming surgeries between April 30, 2018 and February 22, 2019. Gast Supp. Decl. ¶ 3. Dr. Gast submitted prior authorization requests for eight of those patients, all of which were denied. Gast Supp. Decl. ¶ 4. Her office did not submit prior authorization requests for the others because they knew they would be denied. Gast Supp. Decl. ¶ 4.

123. All transgender Wisconsin Medicaid beneficiaries who need gender-confirming treatments for gender dysphoria, including the Named Plaintiffs and other members of the

Proposed Class, will continue to suffer serious gender dysphoria and related harms because of the Challenged Exclusion. Decl. of Lexie Vordermann ¶¶ 7, 13 (Oct. 16, 2018) [ECF No. 99] (“Vordermann Decl.”); Decl. of Tori Vancil ¶¶ 10-14 (Oct. 16, 2018) [ECF No. 97] (“Vancil Decl.”); Decl. of Emma Grunenwald-Ries ¶¶ 14-16, 18 (Oct. 15, 2018) [ECF No. 98] (“Grunenwald-Ries Decl.”); Wesp Decl. ¶¶ 13, 16; Oriel Decl. ¶¶ 6, 9-10, 13; Budge Rep. at 18-19; Hughto Rep. at 10-17.

### **Enforcement of the Exclusion Against the Named Plaintiffs**

#### ***Cody Flack***

124. Cody Flack, a Wisconsin Medicaid beneficiary, is a transgender man with gender dysphoria who has been denied surgical treatments for gender dysphoria based on the Challenged Exclusion. SFOF ¶ 20-21; Decl. of Cody Flack ¶¶ 2-4 (May 16, 2018) [ECF No. 22] (“Flack Decl.”). After the preliminary injunction in this case issued, DHS, for the first time, considered whether the chest reconstruction surgeries he sought were medically necessary, and, under generally accepted medical standards, determined that they were. DHS Dep. 50:24-52:15. DHS admits that the agency’s previous denial of coverage to Mr. Flack for these surgeries was not based on a clinical determination, but a legal one. DHS Dep. 49:7-50:9. Having now obtained these surgeries, Mr. Flack’s gender dysphoria has diminished significantly. Supp. Decl. of Cody Flack ¶ 4 (Oct. 16, 2018) [ECF No. 91] (“Flack Supp. Decl.”).

125. Mr. Flack’s gender is male. SFOF ¶ 19. While he was assigned female at birth and raised as a girl, he has known himself to be male since early childhood. Flack Decl. ¶ 4.

126. At age 18, Mr. Flack took steps to begin his gender transition. Flack Decl. ¶ 7. He began seeing a gender therapist, adopted a traditionally male name, and took other steps to outwardly present as the male he is. Flack Decl. ¶ 7. Due to a lack of support and resources, and

fears that coming out as transgender might isolate him from his family and others, Mr. Flack felt unable to undergo a full transition for several more years—despite experiencing significant gender dysphoria. Flack Decl. ¶ 7.

127. In 2012, after moving to Wisconsin and feeling more supported in his gender identity, Mr. Flack resumed his gender transition. Flack Decl. ¶ 8. He took steps to socially transition to living and presenting as a man in all aspects of his life, including exclusively using his chosen traditionally male name, wearing traditionally men’s clothing, and cutting his hair. Flack Decl. ¶ 8. He legally changed his name to Cody Jason Flack. SFOF ¶ 22. He also obtained a corrected Wisconsin state identification card listing his legally changed name and male sex. Flack Decl. ¶ 9.

128. Mr. Flack has received care for his gender dysphoria from his psychotherapist and physicians. SFOF ¶¶ 23-24, 30. Since 2015, Mr. Flack has seen a psychotherapist, Daniel Bergman, who has treated him for gender dysphoria and other mental health conditions. SFOF ¶ 23. Since August 2016, Mr. Flack has been receiving hormone therapy (testosterone) under the supervision of Dr. Amy DeGueme, an endocrinologist. SFOF ¶ 24. As a result of the testosterone, he developed facial and body hair, a deeper voice, and a more masculine appearance. SFOF ¶ 25.

129. In October 2016, Mr. Flack had a hysterectomy with bilateral salpingo-oophorectomy—the total removal of his uterus, cervix, fallopian tubes, and ovaries. SFOF ¶ 26. These surgeries were performed primarily to treat two serious medical conditions: dysmenorrhea, a condition characterized by pelvic or lower abdominal pain during menstruation, and premenstrual dysphoric disorder (“PMDD”), a severe form of premenstrual syndrome. SFOF

¶ 26. As Mr. Flack’s hysterectomy with bilateral salpingo-oophorectomy was necessary to treat his PMDD and dysmenorrhea, Wisconsin Medicaid covered the procedure. SFOF ¶ 26.

130. Mr. Flack’s hysterectomy with bilateral salpingo-oophorectomy, which Wisconsin Medicaid covered to treat his PMDD and dysmenorrhea, helped significantly reduce his gender dysphoria by better aligning his body with his male identity. Flack Decl. ¶ 13; Decl. of Amy M. DeGueme, MD, ECNU ¶ 8 (May 14, 2018) [ECF No. 29] (“DeGueme Decl.”).

131. While the October 2016 surgeries and the hormone therapy helped reduce his gender dysphoria, Mr. Flack continued to experience severe gender dysphoria related to the presence of female-appearing breasts on his body. Flack Decl. ¶¶ 14-17; Decl. of Daniel P. Bergman, MS, LPC ¶ 9 (May 14, 2018) [ECF No. 28] (“Bergman Decl.”). Because of his breasts, Mr. Flack was regularly mistaken as female and mistreated as a result. Flack Decl. ¶¶ 14-17. As his breasts cause people to mistake him as female, Mr. Flack avoided social situations whenever possible. Flack Decl. ¶ 29. Mr. Flack was ashamed of his breasts. Flack Decl. ¶ 29. Despite his efforts to present as the man he is, he considered the breasts an undesired visible marker of something he is not—female—and a source of significant distress. Flack Decl. ¶¶ 16-17.

132. In an effort to conceal his breasts from public view, Mr. Flack engaged in a technique called “binding,” which flattens or reduces the appearance of breasts. SFOF ¶ 27. Mr. Flack finds binding extremely painful and, because of his disabilities, difficult to do himself. SFOF ¶ 28. He has suffered respiratory distress, skin irritation, and sores as a result. SFOF ¶ 28.

133. To treat his gender dysphoria associated with his breasts, and to avoid the distress, social anxiety, and physical pain and discomfort he suffered from trying to hide them from others, Mr. Flack’s doctors recommended that he obtain surgery to remove them and create a

male-appearing chest. Bergman Decl. ¶¶ 9-10, 12, 14; DeGueme Decl. ¶ 9; Decl. of Clifford King, MD, PhD ¶¶ 4-5 (May 21, 2018) [ECF No. 30].

134. Mr. Flack sought to obtain chest reconstruction surgery; specifically, a double mastectomy and male chest reconstruction. SFOF ¶ 29.

135. The applicable standards of care recognize the procedures Mr. Flack was seeking—double mastectomy and male chest reconstruction—as effective procedures in treating gender dysphoria in transgender men. Schechter Rep. at 9; Shumer Rep. at 15; WPATH Standards of Care at 57.

136. Mr. Flack consulted with Dr. Clifford King, a plastic surgeon, about obtaining a double mastectomy and male chest reconstruction. SFOF ¶ 30. Mr. Flack provided Dr. King with letters of support from four medical providers—his primary care doctor, therapist, endocrinologist, and the physician who performed his hysterectomy and oophorectomy. SFOF ¶ 31. In each of those letters, the provider stated that Mr. Flack has gender dysphoria and meets the criteria for surgery. SFOF ¶ 31. Dr. King determined that Mr. Flack was eligible for male chest reconstruction under the WPATH Standards of Care. SFOF ¶ 32. On July 18, 2017, Dr. King submitted a request for prior authorization to DHS for Wisconsin Medicaid coverage of the chest reconstruction surgery for Mr. Flack. SFOF ¶ 33.

137. On August 2, 2017, DHS denied the prior authorization request made by Dr. King. SFOF ¶ 34. DHS's denial was based on the Challenged Exclusion. SFOF ¶ 35.

138. In a letter from DHS to Dr. King, dated August 2, 2017, DHS stated that each surgical procedure sought by Mr. Flack—mastectomy simple complete and breast reconstruction—“is not a covered benefit.” SFOF ¶ 36. The letter contained the following notation: “08/02/17: Per WI administrative code DHS 107.03(24) transsexual surgery is a non-

covered service. BA.” SFOF ¶ 36. The Parties stipulate that ECF No. 21-18 is a true and correct copy of the full August 2, 2017 letter from DHS to Dr. King, and refer the Court to that document for a complete representation of its contents. SFOF ¶ 36.

139. In a letter from DHS to Mr. Flack, dated August 2, 2017, DHS stated that Mr. Flack’s prior authorization requests for mastectomy simple complete and breast reconstruction were denied because, for each, “THE SERVICE REQUESTED IS NOT A COVERED BENEFIT. THE REQUEST DOES NOT MEET ONE OR MORE OF THE CRITERIA FOUND IN WISCONSIN ADMINISTRATIVE CODE.” SFOF ¶ 37. DHS cited “DHS 107.03 WISCONSIN ADMINISTRATIVE CODE” as “[t]he specific regulation(s) that support the reason for the denial/modification of your provider’s request for services.” SFOF ¶ 37. The Parties stipulate that ECF No. 21-19 is a true and correct copy of that letter, and refer the Court to that document for a complete representation of its contents. SFOF ¶ 37.

140. DHS considered the surgical procedures Mr. Flack was seeking (double mastectomy and male chest reconstruction) to be excluded by Wis. Admin. Code § DHS 107.03(24). SFOF ¶ 38.

141. Accordingly, DHS did not review Mr. Flack’s prior authorization request for medical necessity prior to the August 2, 2017 denial. DHS Dep. 51:5-12.

142. Mr. Flack administratively appealed DHS’s decision. SFOF ¶ 39. An administrative law judge denied Mr. Flack’s appeal of DHS’s denial of the preauthorization request on November 21, 2017, and denied Mr. Flack’s request for reconsideration on December 11, 2017. SFOF ¶ 40. The administrative law judge stated that he based his decision on the Challenged Exclusion. SFOF ¶ 41; Decision by Administrative Law Judge B. Schneider, at 1 (Nov. 21, 2017) [Ex. 20 to First May Decl.] [ECF No. 21-20].

143. A September 25, 2017 letter from Julie Sager, MD, Medical Director, Bureau of Benefits Management, Division of Medicaid Services, Wisconsin Department of Health Services, submitted to the Division of Hearing and Appeals as part of Mr. Flack's administrative appeal of DHS's denial of prior authorization for the requested surgeries, stated the following:

Mr. Flack is seeking the aforementioned services [a bilateral complete mastectomy (service code 19303) and breast reconstruction (nipple graft-service code 19350)] as part of gender confirmation surgery. The primary diagnosis listed with the prior authorization request is transsexualism (F64.0). Mr. Flack also carries a diagnosis of gender dysphoria which is an accepted medical indication for the surgical treatment requested.

This request was denied by DMS as Wis. Admin. Code DHS 107.03(24) specifically lists 'transsexual surgery' as a non-covered service under medical assistance.

The medical necessity of the services requested was not taken into account as reimbursement by Medicaid for this type of surgery is currently excluded by DHS regulations.

Furthermore, please take notice of the attached federal court decision staying enforcement of Section 1557 of the Affordable Care Act regulations related to gender identity.

SFOF ¶ 42; DHS Dep. Ex. 3.

144. This letter was drafted primarily by DHS's Office of Legal Counsel. DHS Dep. 49:19-22. Dr. Sager, against her wishes, was directed to sign it. Because it did not reflect a clinical determination, she initially refused to sign it because, as she explained, "I wanted the political appointees to sign it because it was a -- felt to me like it was a nonclinical adjudication, and I felt disingenuous signing something that was outside of my clinical jurisdiction." DHS Dep. 50:5-23. Nevertheless, she ultimately signed the letter. DHS Dep. Ex. 3.

145. After being denied coverage for surgery, Mr. Flack's gender dysphoria worsened considerably. Flack Decl. ¶¶ 27-28; Bergman Decl. ¶ 11. Without the means to pay for surgery, he felt hopeless and experienced profound depression and distress because of the denial and his

inability to complete his gender transition. Flack Decl. ¶¶ 27-31. He even contemplated suicide and the possibility of performing chest surgery himself, but did not act on those thoughts. Flack Decl. ¶ 28.

146. Following the preliminary injunction entered in this case on July 25, 2018, DHS reviewed Mr. Flack's prior authorization request for medical necessity for the first time. DHS Dep. 51:5-16.

147. Dr. Sager, in her role as the medical director of BBM, determined, following a review of Mr. Flack's medical records, that the surgeries he was seeking were medically necessary to treat his gender dysphoria. DHS Dep. 51:17-20. Dr. Sager reviewed the request using the same protocol as requests for other treatments without published coverage guidelines, including consideration of other payers' standards, standards in the medical community, and cost effectiveness. Using the WPATH Standards of Care and the Endocrine Society Guidelines as indicia of what is consistent with the prevailing standards of care and accepted in the medical community, Dr. Sager determined that Mr. Flack's requested surgeries met the definition of medically necessary services. DHS Dep. 51:21-52:15.

148. Dr. Sager would apply that same type of review to other prior authorization requests and denials, including for gender-confirming surgeries if the Challenged Exclusion were not in place. DHS Dep. 52:16-20; 71:11-17.

149. On September 25, 2018, Dr. Clifford King performed the double mastectomy and male chest reconstruction on Mr. Flack. Flack Supp. Decl. ¶ 3.

150. Immediately after the surgeries, Mr. Flack felt a sense of relief that his outward appearance would now match his male gender and that he would no longer be misgendered because of his chest. Flack Supp. Decl. ¶ 4. He began looking forward to attending public events

he previously avoided and to going out in public without extra clothing to hide his chest. Flack Supp. Decl. ¶ 4. He began to feel like “a different person” and “more upbeat and hopeful about [his] life in general.” Flack Supp. Decl. ¶ 4.

151. Mr. Flack is considering obtaining a phalloplasty as a gender dysphoria treatment in furtherance of his gender transition. Flack Supp. Decl. ¶ 4.

*Sara Ann Makenzie*

152. Sara Ann Makenzie is a transgender woman enrolled in Wisconsin Medicaid. SFOF ¶¶ 43-44; Decl. of Sara Ann Makenzie ¶¶ 2-3 (May 21, 2018) [ECF No. 23] (“Makenzie Decl.”). Because of the Challenged Exclusion, she was unable to obtain Wisconsin Medicaid coverage for chest and genital reconstruction surgeries needed to treat her gender dysphoria. Makenzie Decl. ¶¶ 18-21. She was compelled to pay out of pocket for a chest surgery that helped alleviate her gender dysphoria, but was unable to afford or obtain genital surgery until the preliminary injunction in this case issued last year. Makenzie Decl. ¶¶ 18-20. After the injunction, Ms. Makenzie’s Medicaid HMO reviewed her prior authorization request for genital reconstruction surgery, determined it was medically necessary for her, and approved coverage for the treatment. DHS Dep. 53:15-54:25.

153. Ms. Makenzie’s gender identity is female. SFOF ¶ 45. While she was assigned male at birth and raised as a boy, she has understood herself to be female since childhood and has experienced gender dysphoria for most of her life. Makenzie Decl. ¶¶ 5-7. She has lived consistently as a woman since at least 2012. Makenzie Decl. ¶¶ 3, 8.

154. Ms. Makenzie has been diagnosed with gender dysphoria, and began seeking medical treatments and therapy for gender dysphoria in approximately 2012. SFOF ¶¶ 46, 48.

155. Since 2013, Ms. Makenzie has been on hormone therapy to treat gender dysphoria. SFOF ¶ 49. Hormone therapy has helped diminish Ms. Makenzie's symptoms of gender dysphoria. Makenzie Decl. ¶¶ 13-16; Decl. of Trisha E. Schimek, MD ¶ 5 (May 21, 2018) [ECF No. 31]; Decl. of Beth E. Potter, MD ¶ 6 (May 23, 2018) [ECF No. 33].

156. In 2017, Ms. Makenzie sought to obtain chest reconstruction surgery, in the form of breast augmentation, because her lack of a developed chest was exposing her to frequent misgendering. Makenzie Decl. ¶ 18. When Ms. Makenzie contacted DHS to inquire whether Wisconsin Medicaid would cover the chest reconstruction, DHS advised her that the procedure was not a covered benefit. Makenzie Decl. ¶ 19. After learning that chest reconstruction would not be covered by Wisconsin Medicaid, Ms. Makenzie obtained a personal loan from her bank of approximately \$5,000 to pay out-of-pocket for the procedure. Makenzie Decl. ¶ 20. Dr. Venkat Rao, a plastic surgeon at UW Health in Madison, performed the surgery in August 2016. Makenzie Decl. ¶ 21.

157. The chest reconstruction procedure has been an effective treatment for Ms. Makenzie's gender dysphoria, and she has experienced fewer instances of being mistaken as male or of being mistreated for having masculine features. Makenzie Decl. ¶ 22. However, Ms. Makenzie continued to experience profound distress at the sight of her male-appearing genitalia, which negatively impacts her social life, sexuality, and occupational functioning. Makenzie Decl. ¶¶ 23-24.

158. Ms. Makenzie's medical providers recommended that she obtain genital reconstruction in the form of a bilateral orchiectomy and vaginoplasty, which would create female-appearing external genitalia. SFOF ¶ 51. In 2014, Ms. Makenzie consulted with her

primary care physician, Dr. Trisha Schimek, about obtaining genital reconstruction surgery. Dr. Schimek told Ms. Makenzie that Wisconsin Medicaid would not cover the surgery. SFOF ¶ 50.

159. In February 2018, on the referral of her primary care doctor, Dr. Beth Potter, Ms. Makenzie consulted with Dr. Katherine Gast, a plastic surgeon, about obtaining genital reconstruction surgery. SFOF ¶ 52. Dr. Gast informed Ms. Makenzie that Wisconsin Medicaid would not cover this procedure. SFOF ¶ 53.

160. The applicable standards of care recognize the procedures Ms. Makenzie was seeking—bilateral orchiectomy and vaginoplasty—as effective procedures in treating gender dysphoria in transgender women. Schechter Rep. at 9; Shumer Rep. at 15; WPATH Standards of Care at 57.

161. DHS considers the surgical procedures Ms. Makenzie was seeking (bilateral orchiectomy and vaginoplasty) to be excluded by the Challenged Exclusion. SFOF ¶ 54.

162. Without coverage from Wisconsin Medicaid, Ms. Makenzie lacked the means to pay for genital reconstruction surgery. Makenzie Decl. ¶ 33.

163. Learning that Wisconsin Medicaid would not cover her procedure caused Ms. Makenzie extreme distress, including thoughts of suicide and removing her genitals herself. Makenzie Decl. ¶ 33. Her inability to obtain this necessary care exacerbated her gender dysphoria and caused significant emotional distress, particularly related to her genitalia. Makenzie Decl. ¶¶ 23, 33-34. She also engaged in self-harm. Makenzie Decl. ¶ 34. She was constantly afraid that someone would be able to see her genitals through her clothing. Makenzie Decl. ¶ 23. To minimize the chance that someone would notice her genitals through her clothing, she wore multiple pairs of underwear and engaged in a practice called “tucking” to hide her genitals, which she found very painful and uncomfortable. Makenzie Decl. ¶ 23. Despite these

efforts to conceal her genitals, she was constantly worried that someone might notice them—and then mistreat or attack her once they realized she is transgender. Makenzie Decl. ¶ 24.

164. Following the preliminary injunction entered by the Court on July 25, 2018, Ms. Makenzie’s Medicaid HMO, Care Wisconsin, reviewed her prior authorization requests for Wisconsin Medicaid coverage for her genital reconstruction surgery and related procedures. Second Supp. Decl. of Sara Makenzie ¶ 2 (Oct. 18, 2018) [ECF No. 92]. Care Wisconsin, in consultation with DHS, determined that the requested surgeries were medically necessary for Ms. Makenzie. DHS Dep. 53:15-54:25.

***Marie Kelly***

165. Marie Kelly is a transgender woman with gender dysphoria who has been unable to obtain surgical treatments for gender dysphoria because of the Challenged Exclusion. Decl. of Marie Kelly ¶¶ 3, 19-21 (Oct. 15, 2018) [ECF No. 93] (“Kelly Decl.”).

166. Ms. Kelly was assigned male at birth, but she has a female gender identity and has known herself to be female for nearly all of her life. Kelly Decl. ¶¶ 3, 6. Ms. Kelly has lived fully in accordance with her female gender identity since 2010. Kelly Decl. ¶¶ 3, 9.

167. Ms. Kelly has a diagnosis of gender dysphoria. Kelly Decl. ¶ 4.

168. Ms. Kelly was continuously enrolled in Wisconsin Medicaid from 2014 to February 28, 2019, and she expects to be re-enrolled in the near future. Kelly Decl. ¶ 5; Supp. Decl. of Marie Kelly ¶¶ 2-6 (Apr. 22, 2019) (“Kelly Supp. Decl.”).<sup>2</sup>

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<sup>2</sup> Ms. Kelly, who works as a temporary administrative assistant through a staffing agency, has a variable monthly income that has consistently been under the Wisconsin Medicaid income limits for many years. However, she was placed by her staffing agency in a temporary position in January 2019 that caused her unexpectedly to exceed the monthly income limits for Wisconsin Medicaid, resulting in temporary ineligibility for Medicaid coverage. Kelly Supp. Decl. ¶¶ 2-4. She is no longer at that job placement and has significantly fewer hours of work. She expects her

169. To further her gender transition and treat her gender dysphoria, Ms. Kelly has taken feminizing hormone treatments under the supervision of her primary care providers since 2011. Kelly Decl. ¶ 12.

170. Although the hormone treatments have helped reduce Ms. Kelly's gender dysphoria, she still experiences exacerbated symptoms of gender dysphoria and daily anxiety related to her male-appearing genitalia, male-appearing chest, and facial hair. Kelly Decl. ¶¶ 12, 14-17.

171. Ms. Kelly's medical providers have determined that female genital reconstruction, female chest reconstruction, and electrolysis for facial hair removal are medically necessary treatments for her gender dysphoria. Kelly Decl. ¶ 18; Wesp Decl. ¶ 14.

172. Ms. Kelly has sought Wisconsin Medicaid coverage for gender-confirming surgical treatments, including female genital reconstruction (orchiectomy and vaginoplasty), female chest reconstruction, and electrolysis for facial hair removal, to further her gender transition and treat her daily symptoms of gender dysphoria and related anxiety and distress. Kelly Decl. ¶ 18.

173. Ms. Kelly has inquired with her Wisconsin Medicaid managed care organizations several times over the years, including as recently as August 2018, about whether Wisconsin Medicaid would cover gender-confirming procedures. Kelly Decl. ¶¶ 19-20. She was told each time she inquired that these procedures are not covered because of the Challenged Exclusion.

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monthly income in April will again fall below the Wisconsin Medicaid income limits, which would make her income-eligible for Medicaid again, and she intends to re-enroll as soon as possible. Kelly Supp. Decl. ¶¶ 5-6. If she is income-eligible for Medicaid based on her April income, the effective date of her re-enrollment would be retroactive to April 1, 2019. In addition, in March 2019, she applied for disability-based Medicaid. Kelly Supp. Decl. ¶¶ 5-6. If approved, a process that may take several months, her coverage would be retroactive to March 1, 2019, which would mean she had no actual lapse in coverage. Kelly Supp. Decl. ¶¶ 7-8.

Kelly Decl. ¶¶ 19-20. Because she could not afford to pay for gender-confirming procedures herself, she was unable to obtain those or any gender-confirming surgeries and suffered ongoing gender dysphoria as a result. Kelly Decl. ¶¶ 20-21.

*Courtney Sherwin*

174. Courtney Sherwin is a transgender woman who has been on Wisconsin Medicaid for about two years. Decl. of Courtney Sherwin ¶¶ 3-4 (Oct. 18, 2018) [ECF No. 95] (“Sherwin Decl.”). Ms. Sherwin has been enrolled in Wisconsin Medicaid through several third-party HMOs. Sherwin Decl. ¶¶ 17, 22. Her current HMO, Quartz, has denied her coverage for several gender-confirming surgical treatments for gender dysphoria deemed medically necessary by her doctors based on the Challenged Exclusion. Supp. Decl. of Courtney Sherwin ¶¶ 2-3, 5-8 (Jan. 25, 2018) [ECF No. 132] (“Sherwin Supp. Decl.”). Ms. Sherwin suffers severe gender dysphoria because of the male-appearing parts of her body and her male-sounding voice, and has experienced significant depression, anxiety, and suicidality resulting from her inability to obtain gender-confirming surgeries. Sherwin Decl. ¶¶ 30, 33; Sherwin Supp. Decl. ¶ 9.

175. Ms. Sherwin’s gender identity is female. Sherwin Decl. ¶¶ 3, 6. She was assigned male at birth and raised as a boy, but has known herself to be female since around age 10. Sherwin Decl. ¶¶ 3, 6.

176. Ms. Sherwin has been diagnosed with gender dysphoria. Sherwin Decl. ¶ 5.

177. Ms. Sherwin came out as transgender in late 2017 and began her gender transition in early 2018, at which time she began living full-time as a woman. Sherwin Decl. ¶ 6. Before coming out as transgender, Ms. Sherwin suffered significant gender dysphoria (including anxiety, depression, stress, and suicidal ideation) resulting from the incongruence resulting from her identity as a woman and being perceived as a man by others. Sherwin Decl. ¶ 8.

178. After coming out as transgender and starting her gender transition, Ms. Sherwin began wearing traditionally women's clothing, began using the name Courtney instead of her traditionally male birth name, and started a medical transition to further her transition and treat her gender dysphoria. Sherwin Decl. ¶ 9.

179. Since March 2018, Ms. Sherwin has taken feminizing hormone treatments under the care of her primary care doctor. Sherwin Decl. ¶ 11. Ms. Sherwin has been denied Wisconsin Medicaid coverage for certain hormone treatments for gender dysphoria prescribed by her doctors because of the Challenged Exclusion, and has had to pay out-of-pocket for the hormone treatments for which she was denied coverage. Sherwin Decl. ¶¶ 11-13.

180. While the hormone treatments have reduced Ms. Sherwin's gender dysphoria, she continues to experience significant dysphoria related to her masculine voice and her male-appearing chest, genitals, and facial hair. Sherwin Decl. ¶¶ 10, 12, 19, 21, 23. Indeed, Ms. Sherwin has been harassed when others discover her transgender status as soon as they hear her voice. Sherwin Decl. ¶ 24.

181. Ms. Sherwin's medical providers have determined that gender-confirming surgeries, including genital reconstruction (orchiectomy, penectomy, and vaginoplasty) and chest reconstruction (breast augmentation), are medically necessary treatments for her gender dysphoria. Sherwin Decl. ¶¶ 16-17, 22, 26-27. Ms. Sherwin's doctors have determined that her need for an orchiectomy, a gender-confirming surgery that would stop her body's natural production of testosterone, is particularly urgent as it is medically necessary for her because of her gender dysphoria, and to prevent the adverse and dangerous side effects she experiences from one of her hormone treatments, the testosterone blocker spironolactone. Sherwin Decl. ¶¶ 14-17.

182. Notwithstanding Ms. Sherwin's doctors' recommendations that she obtain these surgeries, her Wisconsin Medicaid HMO, Quartz, has denied her coverage for these surgeries based on the Challenged Exclusion. Sherwin Supp. Decl. ¶¶ 2-3, 5-8; Exs. A and B to Sherwin Supp. Decl. (Nov. 22, 2018 and Jan. 22, 2019) [ECF Nos. 132-1, 132-2].

183. Because Ms. Sherwin cannot afford these treatments herself, she is experiencing significant gender dysphoria and consequences of that dysphoria, including severe social anxiety, adverse physical health symptoms, and other distress. Sherwin Decl. ¶¶ 19-21, 23-25, 30-31, 33.

#### **Enforcement of the Exclusion Against Other Members of the Proposed Class**

184. In addition to the Named Plaintiffs, other transgender Wisconsin Medicaid beneficiaries with gender dysphoria are being denied coverage for gender-confirming surgeries pursuant to the Challenged Exclusion. *See, e.g.*, Grunenwald-Ries Decl. ¶ 18; Supp. Decl. of Grunenwald-Ries ¶¶ 3-5 (Feb. 21, 2019) ("Grunenwald-Ries Supp. Decl."); Vordermann Decl. ¶¶ 9-12, 14; Vancil Decl. ¶ 14; Wesp Decl. ¶¶ 13, 16; Oriel Decl. ¶¶ 13, 14; Gast Supp. Decl. ¶¶ 3-4.

185. For example, Emma Grunenwald-Ries, a transgender Wisconsin Medicaid beneficiary, is seeking genital reconstruction, chest reconstruction, and facial feminization surgery to treat her gender dysphoria, on the recommendation of her primary care doctor. Grunenwald-Ries Supp. Decl. ¶ 2. Dr. Katherine Gast, a surgeon at UW Health who performs gender-confirming surgeries, agreed to perform the first of those procedures, genital reconstruction, but will not submit a prior authorization request since she knows it will be denied based on the Challenged Exclusion. Grunenwald-Ries Supp. Decl. ¶ 5. Ms. Grunenwald-Ries experiences significant gender dysphoria related to her genitalia, chest, and voice, experiences daily anxiety, stress, and worry about her inability to obtain this medically necessary care, and

finds it upsetting that the Challenged Exclusion is the only barrier to her completing her medical transition. Grunenwald-Ries Supp. Decl. ¶¶ 5- 6.

186. As another example, Lexie Vordermann, another transgender Wisconsin Medicaid beneficiary who is 19, was denied coverage for an orchiectomy by her Medicaid HMO, Quartz, in early 2018 based on the Challenged Exclusion. Vordermann Decl. ¶ 9. She appealed that decision but it was denied. Vordermann Decl. ¶ 10. A second prior authorization request submitted by her doctor was also denied by Quartz, by letter dated September 2018, which also cited the Challenged Exclusion. Vordermann Decl. ¶ 11. As a beneficiary under 21, it is DHS's position that the Challenged Exclusion does not apply to Ms. Vordermann, DHS Dep. 56:5-57:8, but Quartz's denials nevertheless cited the Challenged Exclusion as the sole basis for the denials. Vordermann Decl. ¶¶ 9-11.

187. There are hundreds, or even thousands, of transgender Wisconsin Medicaid beneficiaries who may be denied gender-confirming treatments at some point in their lives if the Challenged Exclusion remains in place. Hughto Rep. at 18-19.

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The proposed undisputed facts stated above support Plaintiffs' motion for summary judgment.

Dated: April 23, 2019

Respectfully submitted,

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