IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

HUNTINGTON DIVISION

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

Plaintiffs,

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

William Crouch, et al.,

Defendants.

REMOTE DEPOSITION OF COMMISSIONER CYNTHIA BEANE

DATE: March 29, 2022

TIME: 8:00 a.m. CST

PLACE: Veritext Virtual Videoconference

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

JOB NUMBER: 5096149

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

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(Original exhibits attached to original transcript. Copies attached to transcript copies.)

COMMISSIONER CYNTHIA BEANE,
duly sworn, was examined and testified as follows:
EXAMINATION
BY MS. BORELLI:
Q. Good morning, Commissioner Beane. Thank you for your time today. My name is Tara Borelli, I'm an attorney with Lambda Legal and I use she/her pronouns, I represent the plaintiffs in this matter. Can you confirm that your pronouns are she/her?
A. Yes, they are.
Q. Let me explain some ground rules so the court reporter can create a clean transcript today. Because we're not in the same room, I need to know if you refer to any documents in front of you or if you look at any documents on your computer. Can you agree?
A. I agree.
Q. Is there anyone else in the same room as you?
A. No, there is not.
Q. If anyone enters the room while we're on the record will you agree to let me know?
A. I will. But I have posted a sign on my door, so nobody should come in, but in case somebody barges in, I will let you know.
Q. That sounds great. Thank you. If your counsel objects you will still need to answer my questions today

unless your counsel specifically instructs you not to answer. Do you understand?
A. Yes.
Q. And if you don't understand a question that I ask, please let me know and I'm happy to try to rephrase it or make it clearer for you. If you answer I will assume that you understood. Is that agreeable?
A. Yes.
Q. We can take a break today whenever you need, however, if I have asked a question or if I'm in the middle of a line of questions, you will need to provide an answer before we take a break. Do you understand?
A. Yes.
Q. And let's do our best today not to speak over each other, I think we're doing a great job so far. And please use verbal answers so that the court reporter can transcribe your answers accurately. Nodding or shaking your head cannot be captured by the court reporter. Do you agree?
A. Yes.
Q. Do you understand that you are testifying under oath today just as if you were testifying in court?
A. Yes.
Q. Is there anything that would prevent you from testifying truthfully today?

A. No, there is nothing preventing me from telling the truth.
Q. Is there any reason that would prevent you from completely and accurately answering my questions?
A. No, there is no reason that I would not completely and accurately answer the question.
Q. Do you understand that you're giving deposition testimony today in a case called Fain versus Crouch?
A. Yes.
Q. Are you familiar with what this lawsuit is about?
A. Yes.
Q. What is your understanding of what the lawsuit is about?
A. The lawsuit is about the coverage of transgender services.
Q. I'd like to make sure that we're using some common vocabulary for some of the questions I'll be asking you today. We'll be talking today about the West Virginia Department of Health and Human Resources, if I refer to that entity as DHHR, will you know what I mean?
A. Yes.
Q. We'll also be talking about the Bureau for Medical Services within DHHR. If I refer to that entity as BMS, will you know what I mean?

A. Yes.
Q. We'll also be discussing managed care organizations today. What is a managed care organization?
A. Managed care organization is an insurance organization that Medicaid uses to help manage our population and the clients enroll into the managed care organization to, to administer their benefits.
Q. If I refer to a managed care organization by the abbreviation MCO, will you know what I mean?
A. Yes.
Q. We'll also be talking today about the exclusion of care in the West Virginia Medicaid program for transgender people. Are you familiar with the exclusion being challenged in this case?
A. Yes.
Q. What's your understanding of that exclusion?
A. We only exclude the surgery. We cover other transgender services such as the hormones, the counseling that we do, it excludes the transgender surgery.
Q. If I refer to that as exclusion throughout the day today, will you know what I mean?
A. Yes, if you say exclusion of transgender services, I'm going to assume you're talking about the

surgery.
Q. Thank you. I'm also going to ask you questions today about medical treatment that transgender people receive for the purpose of treating gender dysphoria. If I refer to that as gender confirming care or gender affirming care, will you understand what I'm referring to?
A. Yes.
Q. We're here to take your deposition in two capacities, the first is your deposition as an individually named defendant in this case, do you understand that?
A. Yes.
Q. Second we're here to take a deposition of an organizational representative for BMS, do you understand that?
A. Yes.
Q. And you've been designated as the organizational representative to give testimony on certain topics that we're going to discuss today. Do you understand that you've been designated for particular topics?
A. I do.
Q. I'll do my best to make clear when I'm asking you questions in your individual capacity versus your organizational representative capacity or both. If that

distinction is important to your answers, will you agree to clarify that for me?
A. Yes.
Q. In this next set of questions I'll be asking about your professional background for purposes of your individual testimony and as an organizational representative for BMS. What is your current job title?
A. I'm the commissioner for the Bureau of Medical Services.
Q. How long have you held that position?
A. I've been in this position fully appointed since 2017 and before that I was acting commissioner for a couple years.
Q. Did you begin serving as acting commissioner in approximately July 2014?
A. Yeah, I guess I did.
Q. Okay. LinkedIn is a helpful thing. You mentioned being appointed to this role. Let's start with your acting commissioner role beginning in 2014. Were you appointed as acting commissioner?
A. At the time the commissioner had left abruptly and I was a deputy commissioner and I was asked to take the acting role and I did so.
Q. Who asked you to take that role?
A. Deputy Secretary Jeremiah Samples.

Q. And then in 2017 you became the commissioner. Were you appointed to the role of commissioner in 2017?
A. Appointed probably is not maybe the correct word I should have used. I was asked to take the role fully in 2017 by then Secretary Crouch and to come out of the acting role. And the significance of that was it's whether or not you're covered by Civil Service. And so at the time when the commissioner had left abruptly before we were, we get new governors every four years, and so I was kind of like not sure if I wanted to take it knowing that there was a possibility I would not be the chosen commissioner in a year and a half or so.
Q. I see. And so when you were asked to become commissioner by Secretary Crouch you agreed in 2017?
A. Yes.
Q. And you referred to the prior commissioner leaving abruptly. Can you confirm that that didn't have anything to do with the subject of this case?
A. That had nothing to do with the subject of this case.
Q. Prior to becoming commissioner have you held other roles within BMS or DHHR?
A. Yes. I have been with the Department since 2000. Prior to becoming the acting commissioner I was deputy commissioner and then for a number of years prior

to that I was what we call a program manager 2 which I was over several programs here in our home and community based areas and different policy areas. And when I first came to Medicaid I managed several grants for Medicaid and before I came to Medicaid I was with the department, but it was the Department of Behavioral Health Services. That's kind of my history at the department.
Q. That's helpful. Thank you. I would like to see if we can put approximate time frames, this isn't a memory test, and so just do your best to remember the time frames, but if we can establish just a rough chronology for those roles. Is it most helpful to go backwards in time or is it more --
A. Probably backwards since we've already gotten like the commissioner down. So I was acting till 2017, I think I was probably asked to be acting around the 2014 area. Prior to that I would have been deputy, so deputy at least probably three years maybe, I think 2010, 2011 to 2014 I was deputy. And then, and then I was program manager for about a year, year and a half, so that would have taken us to maybe 2009, 2008. And then I was, like I said, I was over some grants for about a year and then prior to that I was at the Bureau for Behavioral Health from like 2000 to 2007 I think.

Q. Okay. That's helpful. Which of these roles -- I'm trying to think of an efficient way to ask about this. Why don't we do them one by one. I'm going to start at the Department of Behavioral Health Services, what were your duties in that role?

A. Yeah, so when I went to the Bureau for Behavioral Health I was with the IDD division, the Developmental Disabilities Division, and I worked a lot with waivers. There was an IDD waiver program that covers a lot of services for individuals with developmental disabilities, I also surveyed day treatment programs in partnership with the Bureau for Medical Services. I also went, at the time the state was in a class action called Hartley and I went with the court monitor around to different facilities in the state that individuals were institutionalized in and offered them fee based services. Those were the main roles I did in the Department of Behavioral Health.

Q. In the Department of Behavioral Health --

A. I mean it's a bureau, I'm sorry, the Bureau of Behavioral Health.

MS. CYRUS: Commissioner Beane, if I could just remind you to wait and try to not speak when someone else is speaking.

THE WITNESS: I'm sorry.

MS. CYRUS: That's okay, I know you're just trying to be helpful and answer.

BY MS. BORELLI:

Q. And I will work on doing the same, so thank you for the corrections. But Bureau of Behavioral Health Services, and is that housed within DHHR or BMS?

A. Within DHHR.

Q. Okay. And you referred to working with waiver services I believe in that role. What are waiver services?

A. That particular waiver program is called the Title XIX waiver program, it's a 1915(c) program and it waives institutional care. So the individuals still need care that you would receive like if you were institutionalized, but in their home and community based setting. So rather than somebody with a developmental disability growing up in an institution, they could grow up in a home with their family that have services and support that come into the home.

Q. I see. And then in the role you described when you were managing grants, can you talk a little bit more about your duties in that role?

A. At the time when I came to Medicaid there were, they were called Real Choice Grants and they were grants that offered opportunities for Medicaid to strengthen

their home and community based services. They were transformation grants, I can't remember now the exact number, but I think we maybe had $60 million worth of grants that provided different opportunities for us to strengthen those services with additional services like offering a self-direct component to our waiver programs was like one of the big grants that we have.

Q. And you just referred to something called self-direct, what was that exactly?

A. So a self-directed option in our waiver programs means, so let's say on the individuals we have three waiver programs, an aged and disabled waiver, a developmental disability waiver, and a TBI waiver at the time. And so you had the right if you self-direct to basically take your waiver budgets and hire and fire your own employees versus them coming through an agency. And then we use a fiscal intermediary that helps you with things such as payroll, taxes, hiring and firing, those types of things that are more difficult for somebody who's not a business, but also wants to direct their own care and have their attendant services be someone that they possibly know, it could be like a friend or a neighbor, that kind of a thing.

Q. And then you also described serving in a capacity as a program manager. What department or

bureau was that for?

A. So that would still have been with the Bureau for Medical Services. So after I was down here for a while with grants I moved up into a different position where some of those grants that I was over where they directed some of those waiver programs, I had more of a role in developing and directing some of those home and community based services versus just doing the grant work to support.

Q. I see. And then in your role as deputy commissioner, what were your duties as deputy commissioner?

A. So as deputy commissioner I was over kind of like all of the different policy units that we would have, the pharmacy unit was under me as deputy commissioner. At one time in my, right before I became acting commissioner the MCO unit was moved under me. And that's about it.

Q. And all of the roles we just discussed were within the DHHR or BMS, correct?

A. Yes.

Q. Did you hold any professional positions prior to working at BMS and/or DHHR?

A. Yes, I was a rehab counselor for the Division of Rehab Services, that was my first foray in state

government, and I think I was there about eight months starting up until the end of '99. And as my role as a rehab counselor at the time I started up a traumatic brain injury, spinal cord injury program.

Q. And what was the government entity that employed you in that role?

A. The Division of Rehab Services.

Q. And is that, is that housed within any other entity within Virginia state government?

A. It's a division of its own, it has its own cabinet secretary.

Q. I see. And did you hold any other professional positions prior to that?

A. Prior to coming to work for the state I worked for a large community behavioral health center, it was called Shawnee Hills at the time, it no longer exists, it was, I can't remember, it went bankrupt at some time, and then it is now called Prestera Services, but they covered Kanawha, Putnam and Clay County for comprehensive community behavioral health services.

Q. And what was the approximate time frame that you worked for that agency?

A. '94 till coming to the state in '99.

Q. And did you have any professional positions prior to that?

A. I taught school for nine months following finishing my education degree at Marshall.

Q. And you have a master's of social work degree, correct?

A. Correct.

Q. Do you have any other graduate school degrees?

A. That is my only graduate school degree.

Q. What year did you obtain your master's of social work degree?

A. '98.

Q. And where did you obtain that degree, I think you may have said it a moment ago, but can you repeat it for clarity?

A. The social work degree through West Virginia University.

Q. And where did you graduate from college?

A. My bachelor's degree is from Marshall University.

Q. And what was your bachelor's degree, give me more details about what kind of bachelor's degree it was and what your major was?

A. It was education and I was secondary education, I was a history teacher.

Q. And what year did you graduate from college?

A. '92.

Q. And you are also a licensed clinical social worker, correct?

A. Correct.

Q. And is your license active?

A. Yes.

Q. When did you become a licensed clinical social worker?

A. So it was, once you get your degree you can test for the licensed graduate social worker test, so I did that. So I finished that degree in '98, I would have taken the test, and then you have to be an LGSW for two years before you can test for the LCSW. After my two years I tested for the LCSW, so probably around 2000 I was an LCSW.

Q. And you referred to the acronym LGSW, what does that stand for?

A. It's called licensed graduate social worker. That means that you have a graduate, like a master's level degree of social work, but you haven't had enough experience to test for the higher level of social work certification, which is the LCSW. So you have to do some level of social work for two years before you test for the LCSW.

Q. During the two years that you had to do social work, is it correct that that was a requirement to

complete licensure hours?

A. Yes. It's, it's not the same, there's another level of license that I do not have which is called the LCISW, and those are specifically for therapy if you want to be a therapist. So I do not have that level of, of social work license, I just have the LCSW.

Q. While you were working towards becoming an LCSW did you specialize in working with any particular population?

A. I worked with a variety of populations. I did a lot of work with the developmentally disabled population and then I did some work with youth sex offenders as well.

Q. Do you have any other professional licenses?

A. I do not.

Q. Have you been deposed before?

A. I have.

Q. How many times have you been deposed?

A. Can I ask a clarifying question on that?

Q. Yes, please.

A. And this is my ignorance of the legal proceedings. So I've testified actually like in a hearing before, is that the same as the deposition?

Q. Was that hearing part of a legislative process?

A. No, this is a different type of court hearing.

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So any time you testify is that called being deposed I guess is my answer, because I've had like this remote thing a couple times now, and so I'm just trying to figure out if it's the same thing.
Q. It may be different.
A. Okay.
Q. For the proceeding that you were referring to, was there a judge or judicial officer of any kind present?
A. A judge.
Q. A judge, okay. So that would be a different kind of proceeding, and we will also talk about times that you have been part of official court proceedings with a judge. Setting aside proceedings that involve judicial officers, have you been deposed, meaning have you been part of another proceeding where you were giving answers to questions under oath in connection with a legal case?
A. Yes, I've had other proceedings like this.
Q. How many times have you been deposed?
A. I believe two other times other than this time in this type of a situation.
Q. Let's go through both of those individually, and let's start with the first time that you were deposed. When did that first deposition take place?

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A. The first one would have been prior to COVID, maybe a year or so, or maybe two years prior to COVID, so maybe 2018, 2019. I'm not for sure of the date.
Q. That's okay. What was the nature of that case?
A. It was a case around the opioid epidemic and the suits around drug manufacturers.
Q. I see. What was your role in that case, were you a party in that case?
A. Medicaid was not a party, but they were wanting to know the effects of the drug epidemic and what Medicaid's role was with regards to coverage of opioids and coverage of services for people with substance use disorder.
Q. And let's talk now about the second time you were deposed, when did that occur?
A. That occurred during COVID, so. And it was kind of in the beginning stages of COVID, so I'm -- in summer of 2020 probably.
Q. And what was the nature of that case?
A. That was also a drug opioid epidemic case. I believe that case was more around a different drug manufacturer or perhaps one of the city suits around that, I don't remember which one it was.
Q. And what was your role in that case where you were a party or witness?

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A. Again, we were not a party, it was to find out Medicaid's role with the coverage of opioids and coverage of services for people with substance use disorder.
Q. Now let's turn to the proceedings where you testified in a court hearing of any kind, so these would be proceedings where a judicial officer was present. How many times have you testified in a judicial proceeding?
A. I believe it's been three times.
Q. And starting with the first time, when did you give that testimony?
A. I can't remember exactly. I was working for the Bureau for Medical Services and I had not been here a long time, so maybe 2009, 2010, but I'm not for sure, but it's around that time.
Q. Do you remember what court that case was in?
A. I don't know the name of the court, I know it was Judge Bloom and I know he's over Circuit Court, but I don't know anything beyond that.
Q. Okay. That sounds like a State Court proceeding, does that make sense to you?
A. Yes, it was State Court.
Q. And what was the nature of that case?
A. That was a long-standing court action called

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Hartley, a class action suit that the state was in, I think the state was in that class action for around 30 years.
Q. That's quite long running even for the ordinary case.
A. It was one of the longest in the country I do believe.
Q. That wouldn't surprise me. And what was that case about?
A. It was originally around services for individuals with mental illness, noninstitutional services for those individuals, and then it just kind of grew year after year. What I was specifically testifying about was services for individuals with traumatic brain injury.
Q. Let's talk about the second time that you gave testimony in a judicial proceeding. When did you give testimony in a second judicial proceeding?
A. I believe it was about a year after I first testified with Judge Bloom, and again, it was about the same services, we were starting up newer services for persons with traumatic brain injury.
Q. I see. Also in State Court?
A. Yes.
Q. And what about the third time you testified in a

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judicial proceeding, when was that testimony given?
A. That was later, I don't remember when that would have been, maybe 2015, 2016. This was also State Court and this was, we had a suit around, at the time we were carving in services to our managed care benefit and there was a question as to whether or not the state should be doing competitive bidding for our managed care entities versus at the time we were, any required entity could apply and if they met the requirements they could come into our state and be in managed care. And so, and so it was determined that we did need to be, put those contracts out for bid versus allowing any qualified vendor be a managed care entity in the state of West Virginia.
Q. Thank you. That's helpful. Have you given any other testimony under oath that we have not already discussed?
A. So I've been in mediations before, but I don't recall whether or not they swore us in for those. And I've also testified at the legislature and legislative committee meetings and hearings and they do swear us in now when we testify at the legislature.
Q. Have you ever testified at a legislature relating to the subject of this lawsuit?
A. I have not.

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Q. And have any of the mediations that you've participated in been related to the subject of this lawsuit?
A. No, they have not.
Q. Let me make one clarification. When I say relating to the subject of this lawsuit, what I mean is relating to care for transgender people. Do your answers remain the same with that clarification?
A. My answer would remain the same.
Q. I'd like to turn to some additional questions that will relate to both your individual capacity as a named defendant in this case and as an organizational representative for BMS, is that agreeable?
A. Yes.
Q. What responsibilities fall within your role as commissioner of BMS?
A. So as commissioner of BMS I'm over a large number of state employees that administer the Medicaid program and we have to assure that the budgets are adequate, the policies, the services, access to services, and administer our state plan and administer our waiver programs and assure our policies and procedures are meeting federal guidelines. I also have to be able to communicate all of our services with our stakeholders and be available for legislative requests

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and be the spokesperson for Medicaid services in West Virginia.
Q. Is it fair to say that you administer the Medicaid program?
A. Yes.
Q. Do you recall any other duties or responsibilities in your current role?
A. I believe the answer I gave are a very broad brush of all the things that I do here at Medicaid, you know, all the leadership reports to me and there are several different divisions under that and lots of nuances when it comes to Medicaid, but yes, I make sure we're administering the Medicaid program. Medicaid is a state and federal partnership. West Virginia has a very good rate when it comes to what our federal match is, and so I make sure that we are not putting that federal match at risk.
Q. How do you perform the function of making sure that the federal match is not being put at risk?
A. Pretty much we follow CMS guidelines. If CMS directs us to do something, they mandate us to do something, we make sure that we do it. We update our state plan as needed. If we are to add a service, if the legislature gives us additional monies to add a service, we make sure before we do that that we have

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CMS's permission to do it before we are collecting the match for the services.
Q. Who do you report to?
A. I report to Deputy Secretary Samples and Secretary Crouch.
Q. Are there any others that you report to?
A. Those two gentlemen are it.
Q. Let me make sure that I get the name of the, Secretary Crouch, can you repeat the other, the title and the name of the other individual?
A. Deputy Secretary Jeremiah Samples and Secretary Crouch, Bill Crouch.
Q. Thank you. How often do you report on your work to Secretary Crouch?
A. Secretary Crouch has meetings, they've been a little bit different since COVID just because things just got kind of crazy busy with the pandemic, but he has like weekly leadership meetings where all the commissioners are there. But then of course if I need something from Secretary Crouch, for example, yesterday I needed to make sure he signed something and so I, you know, called him and, you know, made sure that he saw that on his desk and signed it. So the formal meetings, about once a week.
Q. And how often do you report on your work to

Deputy Secretary Samples?
A. Deputy Secretary Samples is also in those leadership commissioner meetings as well and then Deputy Secretary Samples is probably a little bit more in the weeds with regards to some of the day-to-day services just because, you know, that's his role to be more in the weeds than the secretary with regards to some of the day-to-day services. And so I would say I talk to Deputy Secretary Samples at least weekly.
Q. Thank you. How many people work for BMS?
A. So currently we have about 85 positions filled, but we have a number of vacancies right now as well.
Q. Do you have an approximate sense of how many vacancies you have?
A. Probably about 20.
Q. How many BMS employees do you supervise?
A. Five direct supervision.
Q. Okay. And how many BMS employees report directly to you?
A. That's five report directly to me that I have direct supervision over.
Q. And what are the titles and names of those five individuals?
A. Becky Manning, she's my deputy of finance; Sarah Young, she's my deputy of policy; Fred Lewis, he's my

deputy of my managed care units and department of integrity and pharmacy; Riley Romeo is my general counsel; and Kim O'Brien is my assistant to the commissioner, kind of support staff.
Q. And what are the responsibilities of Ms. Manning?
A. She's my deputy of finance, she's the one who's in charge of our six-year budget, anything financial goes through the finance department. Her department is making sure that, you know, claims are getting paid, the systems are working with regards to that and payments are going out accordingly and anything finance related.
Q. And what are the responsibilities of Ms. Young?
A. She is my deputy commissioner of policy, she has all the different policy units, whether it be, you know, inpatient to outpatient to home and community based and also is currently over some of our systems information as well, meaning like our claims systems and different systems. And then, and then she also helps assist with the human resources area, even though we have another manager that reports to her and that helps with that as well.
Q. And what are the responsibilities of Mr. Lewis?
A. He is over our quality units, our department of integrity units, our pharmacy units, and our managed

care units.
Q. Are you aware that you have an online biography on the BMS Website?
A. I'm aware that something is up there, yes.
Q. All right. Give me a moment to get our first exhibit marked.
A. It's been quite a while since I've read it, so.
Q. That tends to happen with biographies.
A. Am I supposed to be pulling up something or doing something?
Q. No.
MS. BORELLI: Actually, let's go off the record briefly.
(A break was taken at 8:46 a.m.)
(Exhibit 1 marked for identification.)
BY MS. BORELLI:
Q. All right. Commissioner Beane, please click on the marked exhibits folder in Exhibit Share and open the document that has been marked as Plaintiff's Exhibit 1. Let me know when you're able to open the document.
A. So after, my apologies, I'm clicking on the folder that says marked exhibits, it doesn't appear that anything is happening. Should I click this downward button?
MS. CYRUS: I'm not seeing anything either,

Tara.
MS. BORELLI: All right. Let's go off the record again.
(A break was taken at 8:48 a.m.)
BY MS. BORELLI:
Q. Commissioner Beane, please take a moment to review this document.
A. Okay.
Q. Is this on the BMS Website?
A. Yes, I believe it is.
Q. I'm going to read from the paragraph at the bottom of the first page. It states that you have, "Led policy implementation or changes under the Affordable Care Act (ACA) which enable approximately 165,000 West Virginians to have healthcare coverage." Did I read that correctly?
A. You did.
Q. Is that an accurate description of your responsibilities?
A. Yes.
Q. And if I refer to the ACA, will you understand that I'm referring to the Affordable Care Act?
A. Yes.
Q. Does the sentence that I read from your biography mean that BMS made policy changes to comply

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with the ACA?
A. Yes.
Q. What changes do you recall being implemented to comply with the ACA?
A. There was a requirement with the ACA around an alternative benefit plan, what your benefit plan was going to be through your expansion calculation. There was also mandated coverage in the ACA around your tobacco cessation program and to assure that you were offering full coverage of tobacco cessation, both the, the pharmacist from a pharmacy benefit of tobacco cessation as well as the counseling.
Q. Apart from the alternative benefits for expansion and the tobacco cessation, were there any other changes that you recall being implemented to comply with the ACA?
A. There were lots of systems changes that we had to make to comply with the ACA so we could enroll individuals with the expanded benefit of enrolling individuals at a different poverty level, up to 165 percent of the poverty level versus where we were prior, that's what has caused the major expansion. Those are the broader brush areas in expanding for the ACA.
Q. And as we discussed, your biography states that you led policy implementation for changes under the

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Affordable Care Act, ACA. What kind of work did you do to lead policy implementation for changes under the ACA?
A. One of the key areas that I was in charge of was getting our alternative benefit plan approved by CMS. So in your alternative benefit plan you had to decide whether your benefit plan was going to mirror your state plan for your expansion adults or look a little bit differently, and still make the requirements that CMS required for the alternative benefit plan. So and then our state did use some co-pays for alternative benefit in our expansion and we added some co-pays as well.
Q. And what was your role in implementing the changes you just described?
A. So I along with consultants that we use, Cole Barry Dunn and myself had weekly calls with CMS and went over our alternative benefit state plan and to assure what we were submitting was meeting all the requirements of the ACA. And then after having several weekly calls around the alternative benefit plan, we did a formal submission and received approval from CMS around our benefits.
Q. And did you have any kind of unique role in the work that you just described?
A. Unique in meaning how, like I'm not sure if I understand your question.

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Q. Let me rephrase. Were you ultimately responsible for the work that you just described, implementing those policy changes under the ACA?
A. Yes.
Q. Your biography also refers to enabling approximately 165,000 West Virginians to have healthcare coverage through Medicaid. Are those West Virginians covered by Medicaid expansion under the ACA?
A. Correct.
Q. Can you explain what Medicaid expansion is?
A. So expansion is what I was talking about and these are the individuals that would have the alternative benefit plan. These are adults 19 through 64 and your financial eligibility is raised prior to that. Adults are, I don't know recall our exact federal poverty level that we had, you know, after expansion. I believe, and I might have this wrong, I think it's 165 percent now the federal poverty level, it's been a long time since I looked at it, but I believe it's 165, we go up to 165 percent of the federal poverty level for expansion adults.
Q. So is it fair to say then that prior to the ACA there were certain poverty level requirements to qualify for Medicaid and after the ACA, the poverty level requirements were raised so that individuals or families

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could have more income and still qualify for Medicaid, is that a fair description?
A. Fair description.
Q. Okay. How many total participants are there in West Virginia Medicaid?
A. Currently our totals are continuing to go up. Because we are under the pandemic requirements we are not able to, during the pandemic you're not allowed to dis-enroll anybody off the Medicaid rolls. And typically on Medicaid you have turn where people turn off yearly, you know, they don't turn in their paperwork or they might, you know, seek employment and no longer meet that federal poverty level guideline or for a number of reasons they might fall off our rolls. During the pandemic you are not allowed to take anybody off your rolls, even if they no longer qualify. So last time I looked our numbers are up to around 615,000. Typically we're around, prior to the pandemic around 520,000, 525,000, there's always some fluctuation.
Q. And the 615,000 figure that you just mentioned, does that include the 165,000 current participants covered through Medicaid expansion under the ACA?
A. That would include our expansion of adults as well. So when you say 165,000, it's always a rolling kind of number, you know, people come on, they come off.

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So when we expanded there were some predictions of how many people we thought were possibly out there in West Virginia that could qualify, but they ended up being around 165,000 individuals that ended up coming onto our rolls. That kind of stabilized afterwards, so.
Q. And so is 165,000 approximately the current number of Medicaid participants who are eligible through Medicaid expansion under the ACA?
A. I don't have a report in front of me that shows my MAGI participants. I would say it's larger than that right now because of the pandemic, I would say our numbers are larger than 165, but I don't have that enrollment report in front of me to tell me for sure.
Q. Understood. For purposes of the 165 figure mentioned in your biography, at the time that was written that referred to Medicaid expansion participants, correct?
A. Correct.
Q. And you referenced an acronym a moment ago, MAGI, is that correct?
A. Yes.
Q. And what does that stand for?
A. It is your gross income modified, I'm not going to remember the MA, but it's like your gross income. So it's like your income that is counted towards your FPL

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in order to qualify for that benefit, and I can't remember what MA is.
Q. And you just used another acronym. I just wanted to help make sure the transcript is clear. I know it's hard not to talk in acronyms because we all do that frequently, but if it's possible to avoid that, that would be great. And what was the second acronym you just mentioned, FPL?
A. The federal poverty level.
Q. Great. Thank you so much. And so the MAGI figure that you referenced, does that refer to Medicaid expansion participants?
A. Yes.
Q. So going back to what's been marked as Plaintiff's Exhibit 1. The same paragraph that we were reviewing previously also states, "Cindy also manages and oversees project development, implementation of health policies, and assures compliance with federal/state regulation while creating innovative healthcare services to address the needs of West Virginians." Did I read that correctly?
A. Yes, you did.
Q. And does Cindy refer to you?
A. Yes.
Q. This states that you manage and oversee

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implementation of health policies. How do you perform those duties?
A. So when we have policy changes I'm informed of what those policy changes are, I will typically read the updated policy manuals before they are published or put online for comment, and I definitely read and sometimes help develop the state plan amendments or waiver applications that we would have to submit to CMS and review before we did the submission.
Q. Does your responsibility to manage and oversee implementation of health policies include the exclusion for gender affirming care?
A. It is in one of our policy manuals, I can't remember which manual it is in, but it is in one of our policy manuals.
Q. And is ensuring compliance with that exclusion part of your responsibilities?
A. What exactly do you mean by ensuring compliance with the exclusion?
Q. Let me phrase this another way. Do you have any duties or responsibilities with respect to making sure that exclusions are complied with?
A. So for items that are excluded, we make sure that our system is set up not to pay for excluded codes. So an example would be, you know, hearing aids, for

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example, we don't cover hearing aids, we make sure that those codes are not covered. And we also, the MCO's know that that is not a covered benefit as well, so they will not cover it. However, the MCO's have the authority to cover additional services that are not in our benefit if they choose to cover them as a value added service.
Q. If Medicaid began covering gender affirming care in the future, would you oversee in any capacity the implementation of that policy?
MS. CYRUS: Object to the extent it calls for speculation. But if you know, you can answer.
A. So we do cover gender affirming care with regards to counseling and hormone therapy, we just don't cover the surgery.
Q. And if the West Virginia Medicaid program were to begin covering gender affirming surgery in the future, would you have any oversight over that policy change?
MS. CYRUS: Same objection. But you can answer if you know.
A. If we would cover in the future then I would review the policy before it went up for public comment and then, and then, you know, approve the policy and then confirm with CMS whether or not it would require a

state plan change before we began the coverage.
Q. Thank you. This paragraph also states that you ensure compliance with federal regulations. Do your responsibilities in that capacity include ensuring compliance with the Affordable Care Act?
A. Yes.
Q. Do your responsibilities also include ensuring compliance with the Medicaid Act?
A. Yes.
Q. Okay. I'm at a potential breaking point, but would be happy to keep going if you would like to continue. Commissioner Beane, would you like a break or would you like to press on for a while?
A. I'm fine for a little while. Probably in about a half hour my coffee will start calling, so I can probably go for a little while longer.
Q. Great, let's do that. I'd now like to turn to your testimony in your capacity as the organizational representative for BMS. At what point were you notified that you would be giving testimony as BMS's organizational representative?
A. I can't remember the day that, I mean, I honestly don't remember the date that we were notified of the suit, whenever the suit came up and I was notified, I don't remember the date.

Q. I'm going to go ahead and mark our next exhibit.
MS. CYRUS: I think she misunderstood the question if you wanted to ask her again. I thought your question was when did she become aware that she would be a 30(b) representative for the deposition, is that what your question was?
MS. BORELLI: Yes. Thank you, Lou Ann, I appreciate that, and I realize I wasn't listening carefully enough.
BY MS. BORELLI:
Q. Commissioner Beane, do you recall when you were notified that you would be testifying at a deposition as the 30(b)(6) representative for BMS?
A. It's been a couple months ago, whenever we turned in, I don't know what those documents were called, we were deciding, you know, who would be the experts in the different areas.
Q. So we're going to go ahead and mark our next exhibit. I'll let you know when it's available in the folder. And it actually should be available now. So, Commissioner Beane, please click on the marked exhibits folder and open the document that's been marked as Plaintiff's Exhibit 2.
(Exhibit 2 marked for identification.)
A. Got it.

Q. Please take a moment to review that document briefly and let me know when you have.
A. I've reviewed it.
Q. Do you see the title in bold lettering on the first page that says, "Plaintiffs' second amended notice of 30(b)(6) deposition"?
A. I do.
Q. Can you walk me through what you've done to prepare as BMS's organizational representative for today's testimony?
A. So I've met with the attorneys on a couple of occasions, I've talked briefly with Dr. Becker around the subject, I have talked with a friend of mine that's in the LGBTQ community around the subject, and I've read some documents in the, mainly the expert testimony document around the subject as well.
Q. You mentioned that you spoke with Dr. Becker, is that correct?
A. Yes.
Q. Were the attorneys present for the conversation with Dr. Becker?
A. No.
Q. Did you speak with him on one occasion or more than one occasion?
A. Just the one occasion and it was about when's

your deposition, when's my deposition and have you read the expert testimony yet, I mean, it was a short conversation.
Q. Do you recall anything else from that conversation?
A. We just discussed, you know, where the line is with regards to the, the transgender surgeries and that it is beyond just what I think a lot of people initially think with regards to the surgery, it can be multiple surgeries including like facial surgeries and different surgeries other than just perhaps some surgeries that people would normally think about it when they think about transgender surgeries.
Q. Can you say a little bit more about what you mean when you say we discussed where the line is with different surgeries?
A. We discussed like where would you be able to say, you know, this is cosmetic versus this is something that is due to your gender dysmorphia diagnosis.
Q. And what do you recall about that specific conversation?
A. Dr. Becker said there were several surgeries and even said that there was a facial surgery that some individuals might want.
Q. Do you recall him saying anything about, I think

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you described a line between surgery for gender dysphoria versus cosmetic surgery, did I capture that correctly?
A. You did.
Q. And what did he say about where the line is for surgery for gender dysphoria versus cosmetic surgery?
A. Neither of us really said like where the line is, we were just saying that it's, that it is, that the request can be beyond what somebody, a layperson would think of when they think of transgender surgery. It could be beyond just like a breast augmentation or the other augmentation, I don't know the, I don't know the scientific word for it.
Q. Does that mean that some surgeries are -- I want to make sure that I use your words to help make this understandable. When you talk about there's a line between surgeries where some of them are for gender dysphoria, did I capture that correctly?
A. I think we were saying all of them could be for gender dysmorphia, but which ones, which ones would somebody consider cosmetic versus for that. And so I don't believe that neither of us have an idea of when is it just for gender dysmorphia or when is it perhaps more cosmetic.
Q. Are some surgeries for gender dysphoria not

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cosmetic?
MS. CYRUS: I'm going to object, it calls for expert opinion. If you know, you can answer.
A. I don't know.
Q. You mentioned that you also spoke with a friend in the LGBTQ community, is that correct?
A. Correct.
Q. What's the name of the individual?
A. Jimmy Dowden.
Q. And did you speak with that friend on one occasion or more than one occasion?
A. Just one.
Q. And what do you remember about that conversation?
A. He said that you would be surprised because of my stance on this issue because I assumed that he would be somebody that would want or be advocating for Medicaid coverage for the surgery and he just told me you would be surprised by my stance, that I know individuals that have had this and have regrets.
Q. And is this friend of yours a medical doctor?
A. No, he is not.
Q. Is he a medical professional of any kind?
A. No, he is not.
Q. Is he transgender?

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A. No, he is not.
Q. Let's see. You said you also reviewed documents to prepare for your testimony as the organizational representative. Do you recall which documents you reviewed?
A. So the expert testimony document, and then I also reviewed some of the emails that was pulled from my, from my email accounts that will probably be used as exhibits. And I can't remember anything else other than things that would have been used already as exhibits, those were the main documents that I looked at.
Q. As the organizational representative did you meet with any transgender Medicaid participants to prepare for today?
A. I have not met with any transgender Medicaid participants.
Q. As the organizational representative did you meet with any mental health providers who specialize in care for transgender people to prepare for today?
A. I have not.
Q. As the organizational representative did you meet with any medical providers who specialize in care for transgender people to prepare for today?
A. I have not.
Q. As the organizational representative did you

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meet with any mental health providers who provide any care to transgender people, even if they do not specialize in that care?
A. Not to prepare for this.
Q. And as the organizational representative did you meet with any medical providers who provide any care to transgender people, even if they don't specialize in providing that care?
A. Not to, I have not met with them to prepare for this.
Q. You also mentioned reviewing expert testimony in connection with preparing to testify as the organizational representative. Do you recall the name of the expert whose report you reviewed?
A. I honestly do not recall the name, but it is, I'm assuming it is an exhibit that you probably already have, but I honestly don't remember the name of the doctor, it's just escaping me.
Q. Was it Dr. Steven Levine, by any chance?
A. Yes.
Q. And did you read any other expert materials from the case to prepare for your testimony as organizational representative today?
A. I did not.
Q. And when was the first time that you reviewed

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the report of Dr. Steven Levine?
A. Last week.
Q. Okay. Have you ever spoken with Dr. Levine?
A. I have not.
Q. Does BMS have one or more medical directors?
A. One.
Q. And who is that medical director?
A. Dr. Becker.
Q. Are there any other medical professionals, for example, nurse practitioners within BMS?
A. Yes, we have several nurses that work for BMS.
Q. And did you speak with any of those nurses in order to prepare to testify as the organizational representative today?
A. I have not spoke to them, but some of them have pulled some of the information that I think is being used as different exhibits in evidence.
Q. And did you review that information that they pulled?
A. Yes, I reviewed some of the exhibits, yes.
Q. All right. I'd like to ask you actually a quick follow-up question. Do you remember which ones you reviewed?
A. Which -- well, I remember we had a pull with regards to how many individuals with gender dysmorphia

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or a diagnosis such as that that we've had ever, like the last five years, I remember, you know, reviewing that document and one of our nurses was the one who helped pull that information together.
Q. Do you remember any other documents that you reviewed?
A. Nothing other than maybe some of the emails and then I think there was some other exhibits around the ACA that we felt might come up.
Q. What was the name of the nurse practitioner who pulled the information that you've been referring to?
A. I believe she's a registered nurse and Jennifer Myers.
Q. Thank you. Also, just for clarity today, I think I have been hearing you refer to gender dysmorphia. When you use that phrase are you intending to refer to gender dysphoria?
A. Yes, I apologize.
Q. That's fine, I just want to make sure the record is clear. Can we have a standing agreement that if you use the term gender dysmorphia, we will know that you mean gender dysphoria for your testimony today?
A. Yes. And again, I apologize.
Q. It's fine. So I'd like to ask you to turn back to Plaintiff's Exhibit 2, which we were just reviewing

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as the 30(b)(6) notice in this case, and turn to Page 4. You've been designated to testify about Topic 18. Let me know as soon as you're at Page 4 and see Topic 18.
A. Okay.
Q. Topic 18 reads, "Your choice to participate in the Medicaid program." Did I read that correctly?
MS. CYRUS: Topic 18?
A. Yeah, it's all interrogatory requests.
MS. CYRUS: I think that was No. 3, Topic No. 3.
MS. BORELLI: Thank you for the clarification, you are correct. All right.
MS. CYRUS: But you're correct, she is designated to testify on that topic.
MS. BORELLI: Give me just a minute. Let's go off the record, give me just a moment, I need to clarify my notes.
MS. CYRUS: Sure. If you want to take a break, maybe this would be a good time to do that.
MS. BORELLI: That sounds like a wonderful idea. Why don't we go off the record and do that.
(A break was taken at 9:23 a.m.)
BY MS. BORELLI:
Q. So turning back to what has been marked as Plaintiff's Exhibit 2, which is the deposition notice in

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this case. I just want to establish quickly your understanding that you've been designated to testify to certain discovery requests in this case, we'll discuss them throughout the day. So if you can scroll with me please to Page 4. You should see a No. 18 at the bottom of that page.
A. Yes.
Q. And that topic reads, "All interrogatory requests, requests for admission, and requests for production of documents directed to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responsive documents, filings or productions by or on behalf of Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau for Medical Services." Did I read that correctly?
A. You are correct.
Q. I will ask you about particular discovery responses throughout the day and I will explain very clearly what they are at the relevant times, but can you confirm that you are prepared to discuss certain discovery responses today as the organizational representative?
A. Yes.

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Q. Great. And we will deal with them again as they come up today. Let's go back to the same exhibit, Plaintiff's Exhibit 2, and please scroll to Page 3 for me, and in particular look for Topic 3 at the top of the page.
A. Yes.
Q. Thank you. Topic 3 is, "Your choice to participate in the Medicaid program." Did I read that correctly?
A. You did.
Q. Are you prepared to testify about this topic?
A. Yes.
Q. With respect to Topic 3 specifically, what did you do to prepare to testify today?
A. I just recognize the history of the Medicaid program and then my work experience and knowledge helps me prepare for Topic 3.
Q. Thank you. When was BMS originally formed as an agency?
A. West Virginia has participated in the Medicaid program since its inception, and that was a little over 50 years ago. So Medicaid has been in West Virginia since Medicaid was offered as a federal/state partnership.
Q. And when was BMS formed as an agency, was it

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formed when West Virginia began participating in Medicaid approximately 50 years ago?
A. I do not know the exact year that the Bureau for Medical Services was called a bureau on its own. My assumption might be that it was soon after they started participating in the Medicaid program.
Q. And you said that West Virginia has been participating since the inception of the Medicaid program. My understanding is that the Social Security Act title authorizing Medicaid was enacted in 1965. Does 1965 sound like the approximate year or time frame that West Virginia began participating in Medicaid?
A. Yes.
Q. Do you know why West Virginia initially decided to participate in the Medicaid program?
A. To serve our most vulnerable citizens and be a part of the federal/state partnership with regards to covering healthcare.
Q. Why does West Virginia currently participate in the Medicaid program?
A. To serve our most vulnerable citizens and to take advantage of the federal/state partnership of assuring healthcare access to the most vulnerable West Virginians.
Q. And do those reasons also apply to transgender

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people?
A. Yes.
Q. I'd like to go ahead and introduce our next exhibit. I'll let you know when to click on the folder to pull it up.
(Exhibit 3 marked for identification.)
Q. All right. Commissioner Beane, if you click on the marked exhibits folder you should be able to open the document that has been marked now as Plaintiff's Exhibit 3. Let me know when you've had an opportunity to open that document.
A. I have it open.
Q. You can see the title on the first page that says, "Medicaid 101"?
A. Yes.
Q. Do you recognize this document?
A. Yes, I do.
Q. Is this a publication of BMS?
A. Yes.
Q. Please turn to Page 3 as indicated in the lower left-hand corner of the document.
A. I'm there.
Q. I'm going to read the first paragraph on that page, please read along with me, "State Medicaid programs are often seen as low-hanging fruit when

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financially strapped states are forced to make budget cuts, however, thanks to the FMAP" --
A. Wait, hold on, I'm sorry, I don't know where you're at. Okay, I'm sorry, I was at a different part of the page. I'm with you now.
Q. Okay. Perfect. I'm going to start again just for clarity, "State Medicaid programs are often seen as low-hanging fruit when financially strapped states are forced to make budget cuts, however, thanks to the FMAP" --
MS. BORELLI: And for the court reporter, that's an abbreviation, an acronym that is F-M-A-P.
Q. "However, thanks to the FMAP, Medicaid spending acts as a tremendous financial boom for the state. The Kaiser Commission on Medicaid and the uninsured recently compiled findings from 20 million different studies examining the economic impact of Medicaid spending and found that in all studies examined Medicaid spending had a positive impact on local economies. These studies also found that Medicaid spending generates economic activity within the state by providing jobs, personal income and state tax revenues. While most state government expenditures reallocate spending from one sector to another, Medicaid is one of the few state government spending opportunities that guarantee to pull

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in money from outside the state and directly benefit the local economy." Did I read that correctly?
A. Yes, you did.
Q. Does that accurately describe the benefits of participating in Medicaid?
A. That is one of the benefits of participating in the Medicaid program.
Q. What are the other benefits of participating in the Medicaid program?
A. It provides access to healthcare to individuals who otherwise would have no healthcare.
Q. Are there any other benefits you can think of?
A. Those are the two big ones.
Q. Does West Virginia decide on an annual basis to continue participating in Medicaid?
A. There is no annual attestation or anything to CMS around participating, we just continue our participation.
Q. Does West Virginia have to take any steps on an annual basis to continue its participation?
A. We have to consistently report and do all the things that CMS requests us to do in order to continue our participation in the Medicaid program, and accounting for funds is one of the big reports that we do.

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Q. Does participating in the Medicaid program entitle West Virginia Medicaid to federal funding through the U.S. Department of Health and Human Services?
A. Yes.
Q. Is West Virginia required to enter a contract with the federal government for its receipt of federal funding?
A. So we are required to have our state plan approved and we are required to report our expenditures in accordance to the state plan and we are required to account for those expenditures on what is called the 64 report and there are --
Q. What is the 64 -- please finish.
A. And then there are other reports that we are required to submit in order to keep different funding streams that are coming from the federal government consistent. So other than the 64 there are also reports called the 372 reports that also have financial implications and then we also have a cost allocation plan for our administrative activities that we are required to update, and then we are also required to report on any advanced planning documents we have and account for those funds as well.
Q. You mentioned a 64 report, what is that?

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A. It's the financial reporting, it's just the name of the financial report that all states do, it's a requirement from CMS.
Q. And what are the 372 reports?
A. They are also financial reporting around your, your 1915(c) waiver services.
Q. And then did I hear you mention advanced planning?
A. Mm-hmm. Those documents are for around some of the technology that it takes to, and the intricacies around technology in order to run the Medicaid program with regards to claims and data solutions and those documents are approved by CMS in order to obtain the match for those different large technology systems that we use.
Q. Is receipt of federal funding through the U.S. Department of Health and Human Services conditioned on any nondiscrimination requirements?
A. Yes, I mean, Medicaid, we are not allowed to discriminate with regards to our services.
Q. Is compliance with Section 1557 of the ACA one of the nondiscrimination requirements that West Virginia Medicaid must adhere to as a condition of receiving federal funding?
A. I don't know the specific section, but we do

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have to comply with the ACA in order to receive our funding because we are an expansion state in order to cover our expansion population.
Q. And does that compliance require adhering to the nondiscrimination requirements of the ACA?
MS. CYRUS: Objection, calls for a legal conclusion. But if you know, you can answer.
A. We do not discriminate.
Q. And is that a, is that a requirement that comes with the federal funding you receive?
MS. CYRUS: Same objection. But you can answer.
A. I don't believe that the federal government would allow for us to discriminate.
Q. So I'd like to turn back now to the deposition notice which has been marked as Plaintiff's Exhibit 2, and we're looking again at Page 3 and Topic No. 4.
A. Okay.
Q. So Topic 4 reads, "The development, creation and/or use of the Medicaid plan." Did I read that correctly?
A. You did.
Q. Are you prepared to testify about this topic today?
A. I am.

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Q. With respect to Topic 4 specifically, what did you do to prepare to testify today?
A. Reviewed the question and determined what the answer would be based on my knowledge and history and experience with the Medicaid program.
Q. What is the Medicaid plan?
A. So with Medicaid because it is a state and federal partnership, we are required to submit state plans with regards to how we're going to cover the services for Medicaid. Medicaid has mandatory services that states in order to be a participant in the Medicaid program you have to cover, and then we have the option to cover some optional services as well. But all of those services require approval from CMS, whether that be in a state plan amendment or in a waiver approval, and those waivers could be 1915(c) waivers, 1915(b) waivers and 1115 waivers.
Q. Let's go through those waivers. I'm afraid I didn't get them down as you were saying them, so I'll need your help remembering what each one was. But I think you just referred to three different waivers, can you describe what each of those three waivers is?
A. So a 1915(c) waiver is a waiver for community based services, so you're waiving some kind of institutional care. Our 1915(b) waiver is a waiver for

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in order for you to have managed care services and it allows you to have managed care companies, which we do here in West Virginia, help you administer your program. 1115 waiver is a demonstration waiver which allows you to go and develop new services to demonstrate that by covering these new services for a particular population you can have a unique set of services that will in turn be cost neutral and provide additional access to healthcare and demonstrate health effectiveness and quality outcomes in healthcare for individuals that you're serving.
Q. Does the Medicaid plan describe the nature and scope of the Medicaid program?
A. Yes, very detailed and long. And there are some state plans that have been there for years and years and years and there are newer state plans that have been updated.
Q. Does the Medicaid plan also outline eligibility standards for participants in Medicaid?
A. I'm sorry, there was some sirens in the background, I think you asked about eligibility, but can you repeat it just so I can make sure.
Q. Yes. Does the Medicaid plan outline eligibility standards for participants in Medicaid?
A. Yes, particularly around financial eligibility.

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Q. And does the Medicaid plan outline policies to ensure the state Medicaid program receives matching federal funds through CMS?
A. Yes. So the state plan not only has the policy pages, but it also has like the financial pages with each state plan as well that kind of outlines what the predicted costs will be and sometimes, sometimes it will have actually the rates or sometimes it will just be a rate methodology.
Q. Just to make sure I clarify one more abbreviation for the record because I can't recall if we have previously, does the abbreviation CMS refer to the United States Centers for Medicare and Medicaid Services?
A. Yes.
Q. Does the Medicaid plan outline how the Medicaid program is implemented in West Virginia?
A. Yes, it gives you a broad outline of implementation, but then we also have policy manuals that give you a more detailed view. If you're a provider, more than likely you're going to look at the policy manual and be able to see versus the state plan just because how it's laid out, the policy being more directed towards what providers need to know with regards to, you know, how to bill, you know, what codes

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are covered and some more of the details are in the policy manuals. The state plan gives you the authority to be able to publish those details.
Q. And are those policy manuals considered to be part of the state plan or are they considered to be separate documents?
A. They're separate, but they have to follow your state plan, meaning I can't have a policy manual for us to cover acupuncture because I don't have a state plan saying that I'm approved to cover acupuncture.
Q. Does BMS prepare the Medicaid plan?
A. Yes, we prepare the state plans.
Q. And did you approve the Medicaid plan?
A. I have not approved every state plan because, as I said, they're historical. So, for example, before I came to BMS, inpatient hospitalization is a state plan that has been there for years and so, but as we update or make changes, those would be the things that I would be approving.
Q. And does Secretary Crouch also approve those updates or changes to the Medicaid plan?
A. Once we do a state plan, which would require a public notice, public comment, we also go through our medical advisory council, they are advisory in nature, but we give the state plans to them and they take a

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vote. To my knowledge we have never submitted a state plan that they have not agreed to as an advisory council. Then it routes for the secretary's signature and then if required it would go to the governor as well. Some state plans are required for a governor's signature and some are not.

Q. When are state plans required to be signed by the governor?

A. I think the majority of state plans have the governor sign off, but during the pandemic the emergency state plans did not require that. And then I believe if there's not a cost, if it's cost neutral I don't believe that we necessarily have had governor's signature if it's a state plan that has no cost to it.

Q. How was the West Virginia Medicaid plan initially created?

A. State plans are kind of, it's almost like a piecemeal puzzle, and so every state is a little bit different. People will say if you've seen one Medicaid state plan, you've seen one Medicaid state plan.

So as the Medicaid agency started, very nuance with, you know, these are the services you have to cover, states, you know, started covering more and more services. As states get institutionalized they added additional services.

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

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

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

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

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A. Yes.

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

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

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

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

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something like that.

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

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

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

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

A. That would be my office.

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

A. Yes, yes.

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Q. When the Medicaid program began covering hormone therapy for gender confirming care, did that require a change to the Medicaid plan?
A. That did not require a change because we already covered those drugs. This removed the gender edit.
Q. I see. So because hormone therapy was already covered for non-transgender people, allowing coverage for gender confirming care didn't require a change to the Medicaid plan, is that correct?
MS. CYRUS: Object to the form of the question. But you can answer, go ahead.
A. We have a pharmacy benefit and so we already cover, you know, all those medications in our pharmacy benefit, it was just a simple removing an edit based on gender, and the pharmacy benefit is already approved by CMS.
Q. And when the gender edit was removed so that, so that hormone therapy could be received for gender affirming care, did that require approval from CMS?
A. No, because we were already approving, we already had approval to cover that medication, we just removed the gender edit.
Q. And a follow-up question to our discussion a little bit earlier. What happens when West Virginia Medicaid wants to initiate a plan, a change to the

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Medicaid plan on its own, separate and apart from a directive like a State Health Officer letter?
A. First we see the cost is always something that we, we have a flat neutral budget and so cost is the big thing that we look at, how much is it going to cost or is it going to be cost savings, sometimes your state plan can actually save money. And so if it's a cost we need to make sure we have an allocation or have the funds in the budget to cover the cost. And so that's kind of like the first step.
Usually if we're deciding to cover something new it's usually something that has been advocated for or a lot of times a bill will be run in the legislature to direct us to apply to CMS for this coverage. The most recent of those I believe is adult dental, we had no adult dental benefit. A couple years ago the legislature basically directed us to do a limited adult dental benefit of $1,000 dental benefit for our adults a year annually. Before the only dental benefit we had for adults is if you needed an extraction we would do that for health reasons, but beyond that there would be like no, no cleaning or fills or anything like that.
Q. Tell me a little bit about how the Medicaid plan is maintained. Is the Medicaid plan reviewed regularly?
A. I wouldn't say like all pages of the Medicaid

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plan are reviewed regularly. We review things as they come up, meaning as waivers, you know, those have to be renewed every five years. As there's different directives or changes in healthcare or things that we have to cover that we had not covered previously, you know, we'll make changes to the state plan.
As things change in healthcare we'll review to see if it requires a state plan. So right now we're in the process of reviewing if it will be required for us to add pages for us to continue telehealth post pandemic because during the pandemic we brought in our use of telehealth in order for individuals to have access to care when everybody was kind of like sheltered in. And it's, you know, proven to be positive, so we would want to cover that post pandemic and so we're discussing with CMS whether or not that will require additional state plan changes or if it can just be a policy change because the services are the same, it's just how they're delivered.
Q. Could the Medicaid plan remain operative until there are changes or does it need to be readopted on a regular basis to remain in effect?
A. So the Medicaid plan like stays in effect until there's a change to that plan or that plan's page. When you submit a SPA to CMS, so say, for example, in your

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behavioral health pages this happened to us, we added, years ago we added a service called ACT, it was called assertive community treatment for individuals with severe mental illness. There were other services on that page or on the attaching pages that once you open your state plan CMS has the authority to review anything that's on that page or anything on the attaching pages.
So even though they might have approved a service in 1970 on an attaching page, if now they have a problem with that approval or how you're doing it, then they have the authority to question and ask you to update how you're doing those types of services perhaps, or question whether or not that would be still be approved because as different administrations come in to CMS, different regulations are interpreted differently as well.
Q. I want to go back and clarify one quick thing about the scope of coverage for gender confirming care which you described at the beginning of the day. So I believe you testified that coverage for gender affirming hormone therapy is provided and coverage for counseling is provided, am I capturing your testimony correctly?
A. You are.
Q. And so to clarify, if a request for coverage of hormone therapy was submitted and the only diagnosis

code on that claim was gender dysphoria, would that request still be covered?
A. Yes. For pharmacy? I'm sorry, I just want to make sure I heard your question.
Q. Sorry. Did you hear what I asked before you answered?
A. I'm not sure. If you could ask it again just to make sure I'm answering it right.
Q. Of course. So if a request for coverage of hormone therapy were submitted and the only diagnosis attached to that request was gender dysphoria, would that request still be approved?
A. Yes.
Q. And if a request for coverage of counseling were submitted and the only diagnosis attached to that request was gender dysphoria, would that request be approved?
A. Yes.
Q. Thank you for the clarification. So I'd now like to move us to another topic in the notice. So I'm going to ask you to please turn back to Plaintiff's Exhibit 2, which is our deposition notice, and let me know when you've turned to Page 4.
A. Okay.
Q. And Topic 15 reads, "As to healthcare coverage

for West Virginia Medicaid participants, your organizational structure, including its units, divisions and departments." Did I read that correctly?
A. Yes.
Q. Are you prepared to testify about this topic?
A. Yes.
Q. With respect to Topic 15 specifically, what did you do to prepare to testify today?
A. I just went over in my head the organizational chart.
Q. And you testified that Medicaid is a joint federal and state program, correct?
A. Correct.
Q. Can you explain what that means?
A. Meaning that all of our dollars are matched by the federal match. And so right now our match due to the pandemic is around 81 percent, so, you know, you can look at it for every $0.19 that the state of West Virginia puts in, the federal government puts in $0.81. Typically our match is around this, you know, 74, 75, so it's like a 3 to 1 match.
Q. That's helpful. Is BMS a single state agency authorized to administer the Medicaid program in West Virginia?
A. Yes.

Q. What does that mean?
A. It means we're the agency designated to operate and be in partnership with Medicaid with regards to administering of the Medicaid program. We are like the Medicaid program, even though some states will like delegate out certain pieces of their Medicaid program, meaning in some states they will like if you have an IDD waiver, some states let their behavioral health bureau manage that waiver that the single state agencies are ultimately responsible if something goes wrong or it's mismanaged, however, we manage our program in-house, we don't necessarily farm out pieses of the program, except for eligibility. And in that case our Bureau for Financial Management in our county offices assist members to come in and do their application for financial eligibility for the Medicaid program.
Q. Is BMS's role as a single state agency authorized to administer the Medicaid program in West Virginia reflected in the state code?
A. I do not believe it is in state code, I don't think it's in state code.
Q. Is that role reflected in the Medicaid plan?
A. Yes, I'm sure it is, yes.
Q. Do you have anything else to add to your answer?
A. No.

Q. Does BMS serve any other purpose?
A. Other than to enact the Medicaid program, no.
Q. And would you describe BMS as having a mission?
A. Yes.
Q. And how would you describe the mission of BMS?
A. The mission of BMS, and this is probably not going to totally match the mission statement that's online if you're going to pull it up later, but the mission of BMS is to assure quality healthcare and access to healthcare to West Virginians and to be good stewards of the state dollar and be good stake, and be a good partner with all our stakeholders.
Q. Does West Virginia Medicaid offer coverage on a fee for service basis?
A. We do.
Q. What does that mean?
A. So the Medicaid program right now, about 85 percent of all of our members are with a managed care organization, meaning that managed care organization that they sign up for and they get to choose which one they want will help them with their benefits, will help assist them, will pay their claims and will make sure that they have access to all the Medicaid services and help them with access if they have problems like finding a doctor or something like that.

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And then our long-term care services and some of our other services, our pharmacy services, is carved out in a fee for service environment. A fee for service environment is an environment of Medicaid where you go to the doctor and Medicaid simply pays that claim on a fee for service basis. If you're in managed care what a Medicaid agency does is we have actuarially sound rates that we pay the managed care companies, like a per member per month rate in order to manage all your care and then they have to pay the claim on more of the fee for service basis or whatever arrangement they have made with that provider.

Q. Is it fair to say then that fee for service care results in the medical provider being paid directly by the state?

A. Yes. The fee for service care, your contract is directly with the Medicaid agency and your claim is being paid through our fiscal agent right now is Gainwell.

Q. Whereas for members who are enrolled in an MCO, their medical providers get paid through the MCO, is that correct?

A. Correct.

Q. And does the state enter contracts with those MCO's to provide Medicaid benefits to participants

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enrolled through the MCO?

A. We do.

Q. And are those contracts entered annually?

A. Yes.

Q. Is Mountain Health Trust the name of West Virginia's, a West Virginia Medicaid's managed care program?

A. Yes.

Q. So Mountain Health Trust is distinct from fee for service, correct?

A. Yes.

Q. And the MCO's within the managed care program include UniCare, The Health Plan of West Virginia, and Aetna Better Health of West Virginia, correct?

A. Yes.

Q. Are there any other MCO's besides the three that I've just named?

A. We only have the three MCO's currently.

Q. You testified that BMS enters into contracts with the MCO's to provide care to Medicaid participants, correct?

A. Correct.

Q. Do those contracts require the MCO's to exclude gender affirming care?

MS. CYRUS: Object to the form of the

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question. But you can answer.

A. I do not believe that it requires them to exclude it, however, it would not be considered in their rate. And so one of the things with managed care is a managed care company can choose to cover things that are not necessarily in the Medicaid benefit, meaning managed care companies can cover things that we don't cover.

So, for example, at one time one of the managed care companies, and they might still be doing this, I honestly can't remember, was covering eyeglasses. We currently don't cover eyeglasses for people with like farsighted, nearsighted, we refer them to, you know, other areas like a Lions Club or something like that for coverage. And so one of the MCO's at one time was advertising that that was like one of their value added services, so, you know, choose us as your managed care company and here's an additional service that we might be able to provide you.

Q. Are you aware of any MCO's offering as additional services outside of their Medicaid reimbursable care gender affirming surgery?

A. I do not believe so.

Q. I'm going to have us take a moment now to look at our next exhibit. So if you can click on the marked exhibits folder and open the document that has been

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marked as Plaintiff's Exhibit 4.

(Exhibit 4 marked for identification.)

A. I have it pulled up.

Q. Great. Please take a moment to briefly familiarize yourself with the document and let me know when you're finished.

A. It appears to be one of the MCO's contracts.

Q. Do you see a Bates stamp in the lower right-hand corner of the first page numbered DHHRBMS001121?

A. Yes.

Q. And do you see a date towards the top of the page of May 6, 2021?

A. Yes.

Q. Does this appear to be a letter from the chief executive officer of Aetna Better Health of West Virginia to BMS?

A. Yes.

Q. And does the first paragraph state Aetna's acceptance of the term in the 2021 model purchase of service provider agreement for Mountain Health Trust?

A. Yes.

Q. Please scroll to the next page Bates stamped DHHRBMS001122.

A. Okay.

Q. Do you see that Bates stamp?

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

"No. 6, sex transformation procedures and hormone therapy associated with sex transformation procedures"?
A. Yes.
Q. Does this indicate that BMS's contract with Aetna requires Aetna to exclude gender affirming care?
A. It is excluded as far as a service that is considered in your rates.
Q. Can you explain what that means?
A. So, for example, No. 1 says, "All nonmedically necessary services." We know that MCO's sometimes provide services that are not medically necessary, but it might be an incentive. So they might give you a $20 gift card if you went to all of your well checks or you had your baby do all of your well checks. That's not, that's not a medically necessary service, but we allow the MCO's to do those value added services.
Q. And so does that indicate that if the MCO's cover this care, gender affirming care, they will not receive any reimbursement from the Medicaid program?
A. It means that that service was not in their rates. So when we do the rates for the MCO's we have our benefits and what we cover. This is a service we don't cover. So when the actuaries look at all the history and everything in their rates and they come up with an adult member gets a $400 a month PMPM, that

surgery would not be considered in that rate, but once I give that money over to the MCO and they have that $400 a month, they have to cover all the benefits that are required, but if they want to cover additional benefits that we don't cover here, they wouldn't be penalized other than it's not in their current rate, they would have to say they're going to do it based on their management of the program.
Q. So in other words, BMS will not cover what this document refers to as sex transformation procedures, correct?
MS. CYRUS: Object to the question. But go ahead.
A. Correct.
Q. And if the MCO's did want to cover that care, specifically gender affirming surgery, they would have to come up with their own money to do so, is that correct?
A. Yes. It would, it would be within the rates that we give them, but it would not constitute what, what the actuaries use to bill their rate.
Q. Let me make sure I'm understanding what you're saying. So let me go back to first principles. I think I heard you say gender affirming surgery is a noncovered service for BMS, correct?

A. Correct.
Q. And so when BMS negotiates with the MCO's for the amount of money that they will receive from BMS to cover all of the required care, that calculation does not include any money to cover gender affirming surgeries, correct?
A. Correct.
Q. And if the MCO's wanted to cover gender affirming surgeries, they would need to come up with their own money, correct?
A. Yes, they would use their own money. So can I give like an example --
Q. Sure.
A. -- what this would be? So I'm going to use like two examples. So we don't cover acupuncture, it's not a benefit in our state plan that we cover, it would not be in the rates. But let's say the MCO saw a benefit and covered acupuncture, that if we cover acupuncture we're not going to have to do as many back surgeries and in the long run it's going to be a cost-saving to us, which in the end a managed care company is going to look at that financial obligation in their businesses, so they're going to try to make as much money as they can with regards to still providing the services they have to provide, but also any cost savings that they have up

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

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

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

A. Correct.

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

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

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

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contracts with the other two MCO's. We just reviewed the contract for Aetna. Does BMS also have a contract with UniCare providing its provision of services to Medicaid participants?

A. Yes.

Q. And does BMS have a contract with The Health Plan providing its provision of services to Medicaid participants?

A. Yes.

Q. Do you know if the contracts with UniCare and The Health Plan have a similar provision to the one that we reviewed in the Aetna contract providing that BMS will not cover gender affirming surgery?

A. I'm sure they do, I'm sure they're identical.

Q. Okay. What I'd like to do is really quickly have you take a look at those contracts just to confirm that we are looking at the correct document. So we will go ahead and mark the next exhibit, this will be the contract with UniCare. This will take a little longer because the files are rather large.

A. Okay.

(Exhibit 5 marked for identification.)

Q. Okay. If you click on the exhibits folder you should see what's been marked now as Plaintiff's Exhibit 5.

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A. I found it. Do you want me to go to 65 again?

Q. No, I think that won't be necessary. Can you just confirm for me that you see a Bates stamp in the lower right-hand corner of the first page that reads DHHRBMS001682?

A. I do.

Q. And does this appear to be the 2021 BMS contract with UniCare?

A. It does.

Q. Can you just quickly look at the document and confirm that the document is what you believe it to be?

A. It does appear to be the contract.

Q. With UniCare, correct?

A. With UniCare.

Q. Thank you. And we'll go ahead now and mark the next exhibit. And I will let you know when it's loaded.

(Exhibit 6 marked for identification.)

Q. Go ahead and click on that exhibits folder and you should now see what's been marked as Plaintiff's Exhibit 6.

A. I have it up.

Q. And do you see a Bates stamp in the lower right-hand corner that reads DHHRBMS002212?

A. I do.

Q. And can you review this document and let me know

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once you've familiarized yourself with what it is?

A. It appears to be the contract with The Health Plan.

Q. So this is the 2021 BMS contract with The Health Plan, correct?

A. Correct.

Q. Sorry, was that a yes?

A. Yes. I'm sorry, I said correct. Can you all hear me again, am I mumbling?

Q. Every once in a while the volume gets lower, which I do as well, so we'll both try and speak up. But thank you, Commissioner Beane. So we just reviewed three contracts I believe all dated 2021. Are there contracts in place right now for the year 2022 with Aetna, UniCare and The Health Plan?

A. I'm sure there are. There's usually a delay in signatures, so, but of course we have contracts.

Q. And would those contracts contain the same provisions that we reviewed in the 2021 Aetna contract providing that BMS will not cover gender affirming surgery?

A. I believe so.

Q. Apart from the fee for service option, the managed care option, those are two -- let me say that again more clearly. Apart from the fee for service

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option and the managed care option, are there any other options for managed care participants to receive care?
A. No, those are our two delivery systems to pay claims.
Q. And can you remind me, I think you may have said this earlier, but the current percentage to your best approximation of Medicaid participants that are enrolled in a managed care program versus a fee for service program?
A. It's approximately 85 percent of managed care. Our fee for services are our long-term care population that would be in some of those 1915(c) waivers, our nursing home population, and then our dual population which would be individuals who have Medicare and Medicaid.
Q. Thank you. Are you familiar with the abbreviation EPSDT?
A. I am.
Q. What does that stand for?
A. Early periodic screening diagnostic and treatment I believe.
Q. Well done. It's a lot of acronyms, I don't always remember what all of your acronyms stand for. What population does the EPSDT program apply to?
A. Children.

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Q. And is there a specific age range for the children covered by that program?
A. 21 and under, under 21.
Q. Are the coverage standards different under the EPSDT program?
A. EPSDT, that coverage standard is different. Under EPSDT the law is anything that can, I'm probably going to butcher it, not only care, but can ameliorate the condition. So an example would be, you know, a child might require extensive physical therapy just so not to lose movement maybe in their legs or something like that, even though they might never have full movement in their legs, they might be, they need continued physical therapy just to maintain what they do have would be an example.
Q. You referred to a standard of anything that can ameliorate a condition as a standard for coverage under EPSDT. Is that a broader standard than the one that applies to Medicaid participants in fee for service or MCO plans?
A. So EPSDT would be, it's still delivered through your fee for service or your managed care vehicle, it's just that the, usually it's the pediatrician, it's usually the pediatrician has recommended through their EPSDT check that the child needs the special service

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that's not covered. For example, a child might need a modified car seat that has special padding or something, that would be something that typically the Medicaid program would not cover, but this child needs it in order to maintain the, their health the best they can when they're being transported would be an example of something from EPSDT.
Q. So the coverage standards under EPSDT can be more generous than for adults, is that correct?
A. That is correct.
Q. How does the exclusion apply to services covered through the EPSDT program?
A. To my knowledge we've never had an EPSDT request for gender surgery.
Q. Is gender affirming hormone therapy approved under the EPSDT program?
A. It could be if somebody requested it through EPSDT.
Q. What about puberty delaying treatment for gender affirming care?
A. If it was requested through EPSDT, we could cover it.
Q. Thank you. Let's turn now to the Rational Drug Therapy Program. What is the Rational Drug Therapy Program?

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A. Rational Drug Therapy is the vendor that we use to do our utilization management for our pharmacy benefit. So if your doctor prescribes you something and he's asking for like 90 milligrams in a painkiller that is way over what we would normally use then it would flag and then they would have to have your doctor submit additional information as to why you would need that, you know, off label use before they would approve something like that.
Q. How does the Rational Drug Therapy Program fit within the Medicaid program?
A. It's a vendor that we use to help us manage our pharmacy benefits. So I believe they're based out of Morgantown. They have the call center and they, like they're the ones that are talking to the pharmacists, because if you recall, like I have 85 staff. So West Virginia Medicaid is highly reliant on our various vendors. Some Medicaid programs in the other states have, for example, Virginia, which Virginia population wise is larger, but they have 400 state staff, so they do some of their work in-house where we vend a lot of our work out to various vendors to perform the services for us.
So Rational Drug Therapy is one of those vendors who have pharmacies, not pharmacies, pharmacists that

will talk to the other pharmacists about why this was flagged or if the pharmacist is trying to fill a prescription and it's not going through, they can call Rational Drug Therapy, why is this not going through, what's the problem, and they'll let them know this is what's going on with that prescription or what's going on with that member's medical card.

Q. And does the vendor Rational Drug Therapy Program provide those services for fee for service and MCO and EPSDT participants?

A. Yes. So I just want to correct you on the EPSDT. Like an EPSDT participant isn't separate from Medicaid, managed care or fee for service. EPSDT is just that, that screening, and then a doctor has done that assessment and based on that assessment they're asking to do that. So you can be an EPSDT, you can have an EPSDT request in a fee for service and a managed care, it's not a separate program for say any child. In fact, we want all of our children to get the EPSDT screening and checks.

Q. Thank you. That's helpful. And as soon as it came out of my mouth, I thought that doesn't sound right. I really appreciate the clarification. Okay. So it sounds like then in terms of the two pathways to delivery of services being fee for service and MCO, the

Rational Drug Therapy Program provides pharmacy services for both pathways, correct?

A. Correct.

Q. And I assume there's an annual contract that BMS enters with the Rational Drug Therapy to provide those services, correct?

A. Correct.

Q. What is the West Virginia Children's Health Insurance Program?

A. That's CHIP. CHIP is another program for children that historically has not been under the purview of Medicaid in West Virginia. Legislation was run this session that, actually I don't believe the governor has signed it unless he signed it today while we've been in here, that would move CHIP under the Medicaid program with regards to administration.

Q. That's helpful. So until and unless the bill is approved, the CHIP program is not a Medicaid program currently?

A. Not in West Virginia.

Q. Okay. And do you know if the bill that you just described were to be signed, when would the effective date be in terms of moving CHIP to be within the Medicaid program?

A. I believe it is 90 days from passage of the bill

after the governor signs it. And so we are working on the assumption that the governor is going to sign the bill and we're targeting a July 1st.

Q. What is Mountain Health Promise?

A. That is our managed care contract for our children who are in either our foster care environment, they have an open Bureau for Social Services case or post adoptive care, meaning that they were previously in Social Services and now they've been adopted. So it's a, a lot of people will say it's like the foster care managed care program.

Q. Does the exclusion apply to Mountain Health Promise?

A. I am sure that it is probably in their contract, but I would have to look to make sure.

Q. And if a child through adolescence covered through Mountain Health Promise received a recommendation through an EPSDT screening for a particular form of care, that care might still be, that gender affirming care might still be approved even if it were otherwise excluded, is that correct?

A. Yes. To my knowledge I don't think we've had that for any type of surgery, but yes, they would have to look at the EPSDT request.

Q. Okay. And it's conceivable it could be covered

through the EPSDT request?

A. Correct.

Q. We talked I think earlier about FMAP, and let's just review that again briefly to make sure that we understand what it is. What is the Federal Medical Assistance Percentage?

A. It is the match rate, meaning the percentage of federal dollar that we get with regards to what the state rate is. So when we talked earlier, and I'm rounding, but we're usually around this percentage, it's usually like a 3 to 1. But it does vary, you know, sometimes it's 74.19 one year, sometimes it might be 75.20, you know, so it's around that usually for West Virginia Medicaid.

There are times when the FMAP is different. The FMAP for the expansion population is a 90/10 FMAP according to -- and that was in the ACA. So when we first expanded that was actually at 100 percent and it went down at 30 years and it levels out at a 90/10 match for your expansion population. But right now because of the pandemic in general I'm around an 81 percent of FMAP because there's an enhanced FMAP right now due to the pandemic and the inability, it's to help pay for all the extra people that are on the Medicaid rolls that are not screened off.

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Q. Did your description just now, does that fully describe how FMAP is calculated or are there other things that go into how FMAP is calculated?
A. So on the federal side the FMAP is calculated based on how well your state is doing financially. So unfortunately our FMAP is high because financially West Virginia is considered kind of a poor state economically, but even states that are doing very well financially, the lowest your FMAP can go is a 50/50.
Q. I want to talk briefly about Medicaid expansion just to round out our discussion earlier. Does Medicaid expansion under the Affordable Care Act affect the benefits that the participants receive or does that simply refer to expanding the eligibility for coverage?
A. So it's, it's both. You expand eligibility, but then CMS has to approve your alternative benefit plan if your plan is not exactly mirrored to your state plan, where our plan has some little nuances, they had to approve our alternative benefit plan.
Q. And is the alternative benefit plan separate from fee for service and MCO care or are the expansion participants covered through either fee for service or MCO's?
A. So our expansion members are in our MCO's, however, when you first come on with Medicaid you have a

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choice period. I can't remember, it's escaping me if it's 30 or 60 days, my apologies, but for that short period you're in fee for service, then you choose your MCO. And let's say I chose Aetna, and then for the next month one I would be in Aetna. Depending on when I choose is when I roll over into Aetna. If I choose after the 15th of the month I'm going to be in fee for service an extra month, if I choose before the 15th of the month, then my next month will be in Aetna.
Q. I see. And is there any plan for Medicaid expansion participants that is not subject to the exclusion?
A. No.
Q. Are there any units or divisions or departments within BMS that we have not yet discussed?
A. I don't believe so. I mean, I think we talked about, honestly I can't remember if I went over, I think I listed all of the different units of BMS at one time was one of the questions, but I can't remember.
Q. Would you mind doing that again because I similarly can't remember and I want to make sure we have it. Would you please go ahead and list them. Did you say all the units or divisions or what are they called, is BMS organized into units or divisions or departments, how do you describe that?

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A. So we have the different deputies cover kind of all the different, I guess I can't remember what we call them, divisions or units, divisions. And so, you know, we have a legal division, I think I did do this, we have department of integrity, we have quality, we have MCO, we have pharmacy, policy, waiver, institutional facility, finance and systems. So I think I probably did cover it now that I'm saying it again.
Q. Okay. And are those all considered departments or divisions?
A. They're like units or divisions. I mean, some people, I mean, I don't, I can't remember what we say in the organizational chart but, you know, there's a director of their unit or division, I can't remember if we call them units or divisions.
Q. Thank you. And let me make sure that we've got a complete list on the record. So those, I'll call them units, include program integrity, quality, pharmacy, policy, waiver, finance and institutional facility. Did we get that correct?
A. Yeah. Behavioral health is in there, my apologies.
Q. Okay.
A. And I didn't say it.
Q. No problem. So we add behavioral health to the

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list and then that list would be complete, right?
A. Yes. And you said finance and legal?
Q. And legal should go on that list as well, okay, we'll add legal to the list. Great. Anything else that we've missed or is that it?
A. I think that's it.
Q. Okay. And are there any other significant aspects of the West Virginia Medicaid program structure that we have not discussed?
A. I feel like we've hit all of it.
Q. Great. All right. Let's do a time check. I'd be happy to keep going if you would like to continue or if you would like a break we can break now.
A. A break would be fine.
MS. CYRUS: I don't know what, I'm not sure how long you plan to go today, Tara, and as long as you need to go, of course is fine, but if you think we're going late into the afternoon, I would suggest we might consider a short lunch break, like 30 minutes.
MS. BORELLI: Yes. In fact, why don't we go off the record.
(Lunch break taken from 10:57 a.m. to 11:34 a.m.)
AFTERNOON SESSION
BY MS. BORELLI:

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Q. Commissioner Beane, I'd like to refer you back to Plaintiff's Exhibit 2, this is our deposition notice. And please let me know when you've pulled that up and reached Page 4.
A. Okay.
Q. And I'm going to refer you to Topic 16 which reads, "The number of Medicaid participants who are transgender and/or have sought any form of care for the treatment of gender dysphoria." Did I read that correctly?
A. You did.
Q. And are you prepared to testify about this topic?
A. I am.
Q. With respect to Topic 16 specifically, what did you do to prepare to testify today?
A. We ran reports for the discovery to kind of show through the years the number of people with a diagnosis of gender dysphoria. And then we also I believe ran a pharmacy report to see how many individuals we had on hormone therapy for the reasons of transgender.
Q. Thank you. Now before we talk further about the number of transgender participants who sought care, I'd like to revisit a number we discussed earlier relating to the total number of West Virginia Medicaid

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participants. So you provided the approximation I think of 615,000 currently, is that correct?
A. That is correct.
Q. Thank you. I will remember to let you respond. And what I'd like to do is look at a couple of specific documents that were provided to us, these may be the ones that you were referring to earlier. So we're going to go ahead and mark our next exhibit and I will let you know as soon as it's loaded.
(Exhibit 7 marked for identification.)
Q. All right. Commissioner Beane, this document should be available now if you click the exhibits folder and you should see what has been marked as Plaintiff's Exhibit 7. Let me know when you open that document.
A. I have it opened.
Q. Great. Have you seen this document before?
A. I have.
Q. Did you review it in connection with your testimony as BMS's organizational representative today?
A. I did.
Q. You've been designated to testify about the response to request for production No. 1. On the first page you'll see text that reads, "No. 1, documents sufficient to show the total annual number of West Virginia Medicaid participants." Did I read that

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correctly?
A. Correct.
Q. And the response reads, "Supplemental response. The managed care and fee for service monthly enrollment report 2021, attached as Exhibit 126, Bates number DHHRBMS020684, and managed care and fee for service monthly enrollment 2022 through March, attached as Exhibit 127, Bates numbered DHHRBMS020685." Did I read that correctly?
A. Yes.
Q. Okay. Are you prepared to testify about this request?
A. Yes.
Q. All right. And we're going to go ahead and mark another exhibit now.
(Exhibit 8 marked for identification.)
Q. All right. Click on the exhibit that has Plaintiff's Exhibit 8.
A. Yes.
Q. On the lower right-hand corner of the first page the document has a Bates stamp DHHRBMS020684. Do you see that?
A. Yes.
Q. Do you recognize this document?
A. Yes.

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Q. What is this document?
A. It shows our enrollment.
Q. So does it appear to be a table from 2021 showing the number of Medicaid members by month?
A. Yes.
Q. And the table shows the number of members in each of the MCO's, in the Mountain Health Promise, and in the fee for service program, correct?
A. Correct.
Q. And the column at the bottom of the table shows the total number of members enrolled in all Medicaid plans by month, correct?
A. Correct.
Q. So in December 2021 there were a total of 618,691 members, is that right?
A. Correct.
Q. We're now going to mark another exhibit and we'll tell you when it's loaded.
(Exhibit 9 marked for identification.)
Q. All right. The exhibit should be loaded now. Please open what's been marked as Plaintiff's Exhibit 9 and let me know when you've been able to open the document.
A. I have it.
Q. In the lower right-hand corner of the first page

the document has the Bates stamp DHHRBMS020685. Do you see that?
A. Yes.
Q. And do you recognize this document?
A. Yes.
Q. Does it appear to be a table showing the monthly number of Medicaid members for 2022?
A. Yes.
Q. And does this appear to be formatted in a similar table to the one that we just reviewed?
A. Yes.
Q. And does this table indicate that in March of 2022 there were a total number of 628,825 Medicaid members?
A. Yes.
Q. And based on the numbers that you just reviewed, your best estimate of the current number of Medicaid participants is still 615,000 approximately, is that correct?
A. It looks like I was a little off, it's 628.
Q. So 628. And I recognize we're still in the month of March, I'm not sure if there's much fluctuation within a month or not, but is the number in this chart for March of 2022, to your knowledge does that remain accurate for the approximate number of total Medicaid

members?
A. Right. So if you look at those charts, you're trending up each month. And so until the PHE hits, you know, is taken off, we'll continue to trend up. Once the PHE is taken off, we estimate there's probably 90 to 100,000 individuals that will eventually roll off of the Medicaid rolls.
Q. And what is PHE?
A. The public health emergency.
Q. And is that the rule that provides that members cannot be rolled off of Medicaid during the pandemic?
A. Correct. That's why our numbers are going up and up and up.
Q. Understood. Let's turn back to Topic 16 which we reviewed in the deposition notice which is Plaintiff's Exhibit 2. That topic as a reminder is, "The number of Medicaid participants who are transgender and/or have sought any form of care for the treatment of gender dysphoria." To help us discuss this topic I would like to refer to a discovery response that we received from BMS. We're going to mark our next exhibit and I will tell you when it's loaded.
(Exhibit 10 marked for identification.)
Q. All right. The exhibit is loaded. Go ahead and let me know when you've been able to open and review

Plaintiff's Exhibit 10.
A. I've opened it.
Q. Okay. Do you see a title on the first page that reads, "Defendants' response to plaintiffs' second set of interrogatories to Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, Bureau of Medical Services interrogatories"?
A. Correct.
Q. Please scroll down to Page 3 where you will see a request No. 11.
A. Yes.
Q. The first sentence reads, "Taking necessary steps to comply with applicable privacy laws for each year since 2016 to the present, identify the number of health plan participants who have submitted one or more claims with a diagnosis code for gender dysphoria or gender incongruence." Did I read that correctly?
A. Yes.
Q. And the response on the second page is a series of numbers by year, do you see that?
A. Yes.
Q. For example, it lists 602 members for 2020, correct?
A. Yes.
Q. And 686 members for September 30th of 2021,

correct?
A. Correct.
Q. Does that mean, for example, that a total of 602 separate members that have claimed the treatment of gender dysphoria in 2020?
A. Correct.
Q. Do you have any information about how many of these members sought coverage for counseling?
A. I do not have that information.
Q. Similarly, do you have any information about how many of those members sought coverage for hormone therapy or surgery?
A. I do not have that information. I don't recall. We might have pulled a pharmacy report on the hormone therapy, I just can't remember.
MS. CYRUS: Tara, just let me note an objection to the extent, and maybe you're asking her this as a fact witness as opposed to a 30(b), but that particular response was not one that we identified Commissioner Beane to testify to, just to be clear, I don't believe.
MS. BORELLI: Okay.
MS. CYRUS: That's for production 11 is not on -- let's see, let me get back.
MS. BORELLI: This is interrogatory 11, you

might have to go back.
MS. CYRUS: Yeah, we have interrogatory No. 2 was her only interrogatory.
MS. BORELLI: I see, okay. I think in order to help aid some of the organizational testimony, we've pulled relevant discovery responses to see if it would help get us through a fairly technical discussion here. But let's note for the record that she was not designated as the organizational representative to talk about this discovery response. And thank you for the information to help us understand what, how to read that response.
MS. CYRUS: Sure.
BY MS. BORELLI:
Q. So let's go ahead and take a look at another exhibit. So we're going to go ahead and mark that now and I will let you know when it's loaded.
(Exhibit 11 marked for identification.)
Q. All right. Go ahead and click on the marked exhibits folder, you should see something marked as Plaintiff's Exhibit 11. Let me know when you've had a chance to open that document.
A. I have it open.
Q. Do you see a Bates stamp in the lower right-hand corner numbered DHHRBMS021563?

A. I do.
Q. Have you seen this document before?
A. I have.
Q. And what is this document?
A. It shows the number of members that are receiving hormones for gender care.
Q. And just to clarify, does this document refer to transgender people?
A. I would assume that they would be receiving the hormones due to the transgender, the gender dysphoria condition.
Q. And so to clarify, the reference at the top left to males on estrogen, does that refer to transgender women?
A. Yes. I had to think about it for a minute, I'm sorry.
Q. And so the reference to female testosterone, that refers to transgender men?
A. Yes.
Q. Am I understanding this document correctly if in the final column is showing that in 2021 --
A. I'm sorry, I'm having a hard time hearing you.
Q. I will try to speak up. Thank you. Am I understanding this document correctly if I read the final column that showing that in 2021 there were 114

transgender women receiving estrogen?
A. Yes.
Q. And there were 139 transgender men receiving --
A. I'm sorry, did you cut out?
Q. I must have.
MS. CYRUS: You froze for just a second.
Q. Oh, I'm sure it's my Internet. Let me give that another try. I'll start over just to make sure this is clear. So final column shows that in 2021 there were 114 transgender women receiving estrogen, correct?
A. Correct.
Q. And there were 139 transgender men receiving testosterone in 2021, correct?
A. It's, the 139 also includes, I'm going to butcher it, the Oxandrolone, I don't know how to say that.
Q. Let me review the document with you. The Oxandrolone, I don't know how to pronounce it either, do you know what that drug is?
A. I'm assuming it's a drug like a testosterone, I'm assuming it's a hormone like testosterone, but I don't know exactly the difference.
Q. I see. Okay. And so 139 refers to transgender men receiving testosterone including Oxandrolone, and 121 refers to the number of transgender men receiving

testosterone excluding Oxandrolone, is that correct?
A. Correct.
Q. Okay. Thank you. Does West Virginia Medicaid know which of its participants are transgender?
A. Meaning that have had the surgery?
Q. Not necessarily that have had surgery. Does West Virginia Medicaid track in any way whether a member is transgender?
A. We do not. We didn't even like have all these numbers pulled until the request from the state.
Q. Okay. So West Virginia Medicaid doesn't collect as a demographic matter information about a participant's transgender status?
A. No.
Q. Does West Virginia use any kind of code or modifier in its system to identify transgender members?
A. We don't, but we do. So I know that sounds weird. So I think we don't have anything in the system, but I do know that there was a case where we had someone who was identifying as male and was male in our system that was pregnant. So we had to put a modifier on that to get those, because we of course wanted to cover the pregnancy, in order to get those pregnancy codes covered we put a modifier on that person so we could provide their healthcare.

Q. So the modifier facilitates access to the pregnancy related care, correct?
A. Correct. I believe that's how we got those claims to pay, to go through in order to, you know, of course we didn't not want to cover their healthcare, but it was flagging as noncovered because it looked like a male pregnancy versus, you know, a transgender pregnancy.
Q. And is a modifier used to facilitate access to any other forms of care?
A. I mean, we use modifiers all the time for various reasons in the West Virginia Medicaid program. So we have modifiers to show the services at a facility versus maybe in the home, we have modifiers that have rate differentials. And so there's numerous reasons that you would put a modifier on a code or in order to make sure that the individuals are accessing the care, we're paying the claim.
Q. Does BMS use a modifier for transgender members to facilitate access to any care besides pregnancy related care?
A. No.
Q. And then to confirm, the modifier facilitates access to pregnancy related care only, correct?
A. I believe we've only had one case that that has

occurred in West Virginia and we put a modifier on so we can get those claims paid.
Q. Does BMS track a gender marker for its members?
A. Meaning male, female?
Q. Correct, including male and female. Does BMS have a gender marker of male or female or any other kind of gender marker on each member?
A. Yes, when you apply for Medicaid you say whether you're male or female, that's in the system.
Q. And just to go back to our questions a moment ago about that modifier. So the modifier doesn't, there's no modifier that's attached to transgender members generally, it sounds like that modifier that we were discussing uses one kind to refer access to pregnancy care of a transgender man, is that correct?
A. You are correct.
Q. So back to gender markers. You testified that each Medicaid member has to designate a marker of male or female when they apply for Medicaid, is that correct?
A. Correct.
Q. And can members change that gender marker at any time after they have originally designated it?
A. I would assume so. I don't think we have anything stopping that, but I would, I honestly don't know if that's occurring or if that's happening. I

think you can go back and modify your application, but I honestly am not 100 percent sure.
Q. And so would you have any sense of what would be required of the member to modify their gender marker in the BMS system?
A. I do not know, but I do know we had the one case of the male pregnancy, so it was marked as male in the system, but was pregnant, so that would be somebody who had obviously either had applied for Medicaid while he was already male or had changed his designation in the system.
Q. And then going back to the modifier we discussed before. Do you happen to know what that modifier is?
A. I have no idea what modifier code they used. Sometimes it's like a U1, U2, I mean, it's just a code, you know. Sometimes it's like, you know, an AW, I mean, and I don't know what modifier they used.
Q. Thank you. We're now going to look at another exhibit and I will let you know when it's loaded.
(Exhibit 12 marked for identification.)
Q. Okay. Go ahead and click on that exhibits folder and you should see a document that's been introduced as Plaintiff's Exhibit 12. This document is an Excel spreadsheet. And in order to be able to interact with the document you will need to download it

and the way to download it is to right click over the document and you should see an option to download. Do you see that?
A. I must be doing something wrong. The document is open though, but I still need to download it?
Q. Well, I'd like to see if we can get through the questions without the need for you to click through it. I think the only issue is that when Excel documents are opened in the system without being downloaded a person can't interact with the elements of the Excel document.
A. Right clicking it's saying copy and sort, it's not -- maybe I'm right clicking over the wrong area.
Q. Let's see if you can answer based on the view of the document, and if we need to make another arrangement we can take a quick break and get a copy over to you.
A. There is a download button up here at the top right-hand of the screen, it looks like a little cloud. Do you want me to click that?
Q. Yes, go ahead and select the box next to Exhibit 12 and download it. Thank you. We must have slightly different, I must have different permissions with the right click.
A. Okay, it downloaded.
Q. Thank you. I will represent to you that this document was produced to us as DHHRBMS016178. Do you

recognize this document?
A. I don't believe I previously reviewed this document in detail but, I mean, I can tell what the document is by reviewing it now that it's an Excel sheet of claims that have been paid or denied and with diagnosis.
Q. So you would know generally how to interpret this spreadsheet?
A. Yes.
Q. All right. I'd like you to hold onto that document and we're going to take a look at another exhibit now in conjunction with this document. So I'm going to go ahead and have the next exhibit introduced.
(Exhibit 13 marked for identification.)
Q. All right. And if you click on the exhibits folder you should see Plaintiff's Exhibit 13. Let me know when you've opened that document.
A. I have it open.
Q. Have you seen this document before?
A. I have.
Q. And what we're going to do is look at a portion of this document that I believe explains the spreadsheet that we just opened. So do you see the title on the first page of Plaintiff's Exhibit 13 that says, "Defendants William Crouch, Cynthia Beane and West

Virginia Department of Health and Human Resources, Bureau of Medical Services' third supplemental responses to plaintiffs' second set of production of documents and things." Did I read that correctly?
A. You did.
Q. And please scroll down to Page 2 and I'm going to read what is labeled, "Supplemental response." It reads, "Please see the spreadsheet attached that is Exhibit 950, Bates No. DHHRBMS016178 containing claims for diagnosis codes F64.0, F64.2, F64.8 and F64.9. Please note that for all MCO claims as reflected in column A, an entry of denied in column X simply means that such claim was presented to MCO and BMS does not have information about the outcome of that claim and it would need to be obtained from the particular MCO. BMS only has for outcomes for claims that are fee for service as indicated as FFS in column A." Did I read that correctly?
A. You did.
Q. Do the codes referenced in that answer, specifically F64.0, F64.2, F64.8, F64.9, refer to treatment for gender dysphoria?
A. Yes, I think those are diagnosis codes related to that diagnosis.
Q. Thank you. Let's turn back to the spreadsheet,

I believe that's Plaintiff's Exhibit 12.
A. Okay.
Q. Does each row in that spreadsheet refer to a separate claim?
A. Yes, it appears that each row is referring to a separate claim.
Q. And if you click on the 2021 tab and scroll to column W, you'll see the words paid, denied and reversed, do you see that?
A. Yes.
Q. What does reversed mean?
A. So --
MS. CYRUS: Excuse me. Let me place an objection on the record to the extent it hasn't been established that Commissioner Beane prepared this. And we do have someone else designated to testify about this. But at any rate, you can ask, she can answer what she knows about it.
MS. BORELLI: Thank you, Lou Ann.
MS. CYRUS: Sorry. Thank you.
BY MS. BORELLI:
Q. What does reverse mean?
A. Reverse means usually the provider comes in and they've done a duplicate claim or they'll reverse the claim and then resubmit the claim at a later date with

maybe additional codes or additional services. Those are the main reasons people reverse a claim.
Q. And where a row indicates the claim has been denied, is that on the basis of the exclusion?
MS. CYRUS: I'm going to object to the form of the question. If you know, you can answer.
A. No. So there are a lot of reasons claims deny. So it could be that it's a duplicate claim, it could be that the member doesn't have eligibility that day, it could be NCCI edit which means like some of those edits if you get this service from your doctor, then this service isn't paid because it should all be encompassed in the medical visit. So there are a lot of reasons claims deny other than being denied because of a diagnosis code.
Q. We reviewed earlier Plaintiff's Exhibit 10 which indicated the number of Medicaid participants who have submitted one or more claims with the diagnosis code for gender dysphoria or gender incongruence. You may recall that, for example, 686 members were identified through September 30th, 2021 having submitted one or more claims for treatment of gender dysphoria.
My question for you is, in light of the numbers you reviewed earlier, do you know why this spreadsheet has more than 10,000 rows in it for 2021? If you hit

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the control and end button simultaneously it will take you to the end of Tab 2021 and you will see that there are more than 10,000 rows with data.

MS. CYRUS: Object to the form of the question. But if you know, you can answer.

A. I don't believe, you know, I didn't pull this sheet, but I don't believe it's based on this, you know, individual. So like it looks like all claims. So I might, and like I said, I didn't pull it, but this edit, I don't see where it's by individual. So I might have, you know, 200 claims, but I'm only one person.

Q. All right. Thank you for that. What I'd like to do now is turn back to Plaintiff's Exhibit 2 which is the deposition notice in this case. Let me know when you have that pulled up and scroll to Page 4 of Plaintiff's Exhibit 2.

A. I'm on Page 4.

Q. And you should see a No. 17. Do you see that?

A. I do.

Q. No. 17 reads, "All lawsuits, counterclaims, arbitrations, complaints or judicial, quasi-judicial actions brought or threatened against you related to the denial of gender confirming care." Did I read that correctly?

A. You did.

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Q. Are you prepared to testify about this topic?

A. I am.

Q. And with respect to Topic 17 specifically, what did you do to prepare to testify today?

A. I just have knowledge of what lawsuits have been brought against me pertaining to this topic.

Q. Thank you. We'll go through these categories one by one. Let's start with lawsuits. Aside from this case, have any other lawsuits been brought against BMS relating to gender confirming care?

A. Not to my knowledge.

Q. Have any other lawsuits been threatened against BMS relating to gender confirming care?

A. Not to my knowledge.

Q. Let's move to counterclaims. Have any counterclaims been brought against BMS relating to gender confirming care?

A. I'm sorry, can you define like counterclaims.

Q. Sure. So counterclaim might be raised in a lawsuit where one party sues another party and then the party that got sued brings a counterclaim against the original party. So a claim in a lawsuit is another way you can think about it. Were you aware of any such claims or lawsuits against BMS or threatened against BMS related to gender confirming care?

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A. Not to my knowledge.

Q. Turning to arbitrations. Has BMS participated in any arbitrations related to gender confirming care?

A. No, not to my knowledge.

Q. Has anyone threatened to seek an arbitration against BMS relating to gender confirming care?

A. I don't believe so.

Q. I'm going to turn now to complaints. Apart from the complaint in this case, have any complaints been filed against BMS relating to gender confirming care?

A. Not that I'm aware of.

Q. And has anyone threatened to bring a complaint against BMS related to gender confirming care?

A. Not that I'm aware of.

Q. Aside from this case, have any other judicial actions been brought against BMS related to gender confirming care?

A. Not that I'm aware of.

Q. And have any other judicial actions been threatened against BMS related to gender confirming care?

A. Not that I'm aware of.

Q. Are those answers the same for quasi-judicial actions?

A. What is a quasi-judicial?

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Q. So I'm trying to think of a good example. Sometimes it's an administrative complaint would be an example, a complaint perhaps brought through an agency?

A. Not that I'm aware of.

Q. Okay. So you're not aware of any quasi-judicial actions brought against BMS relating to gender confirming care?

A. I'm not aware of any.

Q. And no quasi-judicial actions threatened against BMS?

A. Not that I'm aware of.

Q. Is there anything we haven't discussed that relates to somebody having any form of complaint against BMS, formal or informal, related to gender confirming care?

MS. CYRUS: Object to the form of the question. You can answer.

A. We've had requests that we've denied, but I don't know if that's necessarily what I would call a complaint, but we have had a request that I can recall that was denied.

Q. And was there an appeal of that request?

A. Not that I'm aware of.

Q. Okay. All right. We're going to go ahead and mark our next exhibit and I will tell you when it's

loaded.
(Exhibit 14 marked for identification.)
Q. Okay. Go ahead and click on the exhibit folder and you should see what's been introduced as Plaintiff's Exhibit 14.
A. I have it up.
Q. All right. Please take a moment to familiarize yourself with this document and tell me if you're familiar with it?
A. I have.
Q. All right. Have you seen this document before?
A. I have.
Q. And did you review this document in connection with your preparation to provide organizational representative testimony today?
A. Yes, I've reviewed this document.
Q. Do you see a title in the first page that reads, "Defendants' second supplemental response to plaintiffs' first set of interrogatories to Defendants William Crouch, Cynthia Beane and West Virginia Department of Heath and Human Services, Bureau for Medical Services"?
A. Yes.
Q. And do you see the word interrogatories below it?
A. Yes.

Q. Okay. Let me pause just a moment. Okay. And do you see below that a request No. 1 that reads, "Identify all persons with involvement in or knowledge of the creation, review and maintenance of the exclusion of coverage for gender confirming care in the health plans offered through West Virginia's Medicaid program"?
MS. CYRUS: Let me state an objection on the record to the extent that she has not been designated to testify to that interrogatory as a 30(b) witness, but of course you can ask her as a fact witness.
MS. BORELLI: Thank you, Lou Ann.
Q. Did I read that correctly?
A. Yes.
Q. And if you scroll to Page 2, do you see that you've been identified as somebody knowledgeable on that topic?
A. Yes.
Q. When was the exclusion first created?
A. I do not know when it was first created. I know that it has been here ever since I've been at Medicaid and I believe in researching all this I think the earliest we found it was maybe in a policy back in 2004.
Q. Okay. Do you know why the exclusion was created?

A. I do not know, I wasn't here. I think it's, I think it's in a policy manual listed with a bunch of different exclusions.
Q. Are you aware of anyone who would know why the exclusion was created?
A. There is no one here that would know. Our turnover in staff does not allow for people to have been here that long pretty much, but no, I don't know anybody that would know.
Q. So you aren't familiar with the process that led to the creation of the exclusion?
A. I'm not.
Q. And are you familiar with what might have been considered at the time the exclusion was created?
A. I don't know. It would just be speculation that they were just going down a list of services that were not covered at the time.
Q. And has BMS reviewed whether to maintain the exclusion since it was created?
A. I'm sorry, I can't hear your question.
Q. Has BMS reviewed whether to maintain the exclusion since it was created?
A. We have not reviewed that particular policy.
Q. So can you then tell me a little bit about how exclusions work. Do exclusions remain in the Medicaid

plan unless and until a review or affirmative step is taken to change them?
A. So they're in our policy manual, so that's different than the Medicaid plan. And so if we decided to cover something and that was an exclusion, so I'm guessing acupuncture is on that list as well, without looking at it I'm not sure if we listed it, but I'm sure it is, but in order to cover that our first step would be to do a state plan to get CMS's approval and then we would change it in the policy manual once we got CMS's approval.
Q. And BMS has not undertaken that process with respect to the exclusion for gender affirming care since 2004, correct?
A. Yeah, we have not taken that step of the process of covering that surgery since 2004, it has not been looked at.
Q. Okay. I'm going to ask you to go ahead and turn back to, we're very familiar with the document by this point, Plaintiff's Exhibit 2, the deposition notice in this case.
A. Okay.
Q. And please scroll to Page 4 and let me know when you can see Topic 11.
A. I see it.

Q. Topic 11 reads, "Any governmental interest that you contend supports the exclusion and their factual bases." Did I read that correctly?
A. You did.
Q. Are you prepared to testify about this topic?
A. I am.
Q. And with respect to Topic 11 specifically, what did you do to prepare to testify today?
A. Made sure we didn't have any directive from CMS directing us to cover the service.
Q. And when you did that review did you find anything from CMS directing BMS not to cover gender affirming surgery?
A. I didn't find anything telling us that it was a mandatory service.
Q. And did you find anything telling BMS to exclude the care?
A. No.
Q. My understanding from your counsel is that you would be addressing Topic 11 as it relates to CMS, while your colleague Becky Manning will address the request as it relates to the budget. Is that your understanding as well?
A. That I'm going to address it as it relates to CMS, yeah, sure, yes.

Q. And you also have been designated to give testimony as the organizational representative for the discovery request on the same topic. So I want to turn to that next, and for the sake of efficiency I'll ask you questions about these related topics at the same time. Is that agreeable?
A. Yes.
Q. All right. Give us a moment to load the next exhibit and I will tell you when it's available.
(Exhibit 15 marked for identification.)
Q. All right. Go ahead and click on the exhibit folder and you should see what has been marked as Plaintiff's Exhibit 15. Let me know once you've had a chance to open and review the document.
A. Is this in a pdf? The computer is like asking me what to open it in, or is it Word?
MS. CYRUS: Yeah, I got the same message. Is it Adobe?
MS. BORELLI: You know what, I'm having the same issue myself. Given that we've been going not quite an hour, why don't we go ahead and take a break and we'll resolve the exhibit issue on our end and then we can come back and talk about it further, how does that sound?
MS. CYRUS: Sure. By the way, so while I

said that, I did click on Adobe and it did open it, if it's plaintiffs' response to first set of interrogatories, if that's what it is, Exhibit 15, it did open it, just FYI.
MS. BORELLI: Okay.
BY MS. BORELLI:
Q. Commissioner Beane, are you able to do the same thing?
A. Okay. Mine opened down here on my laptop for some reason, I can't get my mouse down there. Hold on.
MS. CYRUS: That's weird.
A. Why did it not open up there.
Q. It downloaded directly on my laptop as well. I'm not sure what about the file format caused it to do that, but are you able to view it as a downloaded file on your laptop?
A. Let me see if it will let me. Hold on. I can't get the mouse to go over here to the laptop screen, why can't I do that.
Q. All right.
MS. BORELLI: How about this, let's go off the record and go ahead and take that break.
(A break was taken at 12:27 p.m.)
(Exhibit 16 marked for identification.)
BY MS. BORELLI:

Q. So just before a break we were having a technical issue with the document that was introduced as Plaintiff's Exhibit 15. We think we have resolved the issue by uploading a duplicate of the same document, which should now be in your exhibits folder as Plaintiff's 16. So the record will reflect that the documents are the same and that exhibit appears twice as 15 and 16 because of this technical issue.
Commissioner Beane, are you now able to open up what's marked as Plaintiff's Exhibit 16?
A. I have opened it.
Q. Please take a moment to review the document and let me know when you are done.
A. I've looked at it.
Q. Have you seen this document before?
A. I have.
Q. Did you review it in connection with your testimony as BMS's organizational representative today?
A. I did.
Q. You've been designated to testify about the response to interrogatory No. 2. Please turn to Page 2 of the document. In approximately the middle of the page you'll see text that reads, "No. 2, describe in detail the factual basis for each governmental interest that defendants contend supports the exclusion." Did I

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read that correctly?
A. You did.
Q. And the response reads, "These defendants state that they provide coverage that is mandated for coverage by the Centers of Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations." Did I read that correctly?
A. You did.
Q. And are you prepared to testify about this interrogatory as the organizational representative for BMS?
A. I am.
Q. With respect to interrogatory 2 specifically, what did you do to prepare to testify today?
A. I went back and made sure we didn't have a SHO letter, a State Health Officer letter, mandating us to cover the service and, and reviewed our budget to make sure that, well, to make sure that I was aware of when we were going into our budget deficient.
Q. So referring to the response to interrogatory 2 that I read a moment ago, is that an accurate description of the governmental interest in the exclusion?
A. I'm sorry, what?
Q. Were you having trouble hearing me or is it that

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you would --
A. Can you say the question again, I was having trouble hearing you.
Q. No problem. I'll repeat. Referring again to the response to interrogatory 2 that I read a moment ago, is that an accurate description of the governmental interest in the exclusion?
A. Yes, we have no mandate from CMS to provide the coverage.
Q. And does that response to interrogatory 2 constitute a complete description of all of the governmental interest being claimed in the exclusion, it does, correct?
A. Correct.
Q. What is the factual basis for the statement in response to interrogatory 2 that defendants, "Provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services"? Let me repeat, what is the factual basis for that assertion?
A. So Medicaid has mandated coverages that CMS assured that we have state plans for and that we are covering those services. And so if there's a service that they are mandating all 50 states and territories to cover that not all 50 states and territories are covering, they will send out what's called the State

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Health Officer letter and it will direct us to add that coverage.
Q. I think you said a moment ago that you looked to see if there was a SHO letter, I assume that's the abbreviation S-H-O, correct?
A. Correct.
Q. And that abbreviation refers to State Health Officer letter?
A. Correct.
Q. And a SHO letter is a letter that's sent by CMS, is that correct?
A. Correct.
Q. And you said a SHO letter might be sent if there's a mandated service that a state Medicaid program is not covering, correct?
A. Correct. So the most recent example that we have of that, which is fairly recent because sometimes you can go quite a while without having it, is the medication assisted treatment services. Every state is mandated to cover all forms of MAT services, and so if your state was not previously covering all those services, you had to do a state plan. Or if you were covering these services but they were not outlined correctly in your state plan, you had to revise your state plan to assure CMS that you were covering those

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services without any kind of restrictions that would not allow individuals to receive those MAT services.
Q. And did you just use the abbreviation MAT?
A. Yeah, that's medication assisted treatment services, it's services for persons who are with substance use disorder.
Q. Understood. So you said in connection with preparing to testify as the organizational representative today you looked to see if CMS had sent a SHO letter to BMS about gender affirming surgery, is that correct?
A. Correct.
Q. And did you find any such letter?
A. I did not.
Q. Are there any other facts that you're aware of that support the governmental interest, which is again, to quote, "Defendants state that they provide coverage that's mandated for coverage by CMS," are there any other facts that support that governmental interest?
A. I cannot find any directive from CMS telling me I have to cover this service. If there was, we would have to cover the service or lose billions of dollars, and we would not be able to put that at risk.
Q. Understood. And are there any other facts that you're aware of that are related to that interest?

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A. Not that I'm aware of.
Q. So I think you testified earlier that counseling is covered for treatment of gender dysphoria through the Medicaid program, is that right?
A. Correct.
Q. Do you have knowledge of why counseling is covered for gender dysphoria?
A. We do not have a restriction on the diagnosis code of why you might seek counseling, it might be for situational depression, it might be for schizophrenia, it could be for gender dysphoria, it could be for a variety of reasons.
Q. And who made the decision to allow coverage for counseling even if the only diagnosis code for the counseling is gender dysphoria, was it BMS that decided to do that?
A. BMS has decided not to edit based on diagnosis for counseling, meaning if your doctor, your therapist thinks you need some counseling because of whatever reason, we don't have an edit that says you can only get counseling for these five diagnoses. You can receive counseling initially for any diagnosis.
What will come into play is if you're going to counseling and you've been going for a few months and there's no progress and you want to continue to go to

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counseling every week, then utilization management might look and see, you know, why are you going, you know, why does this person need to continue to go to counseling, because you usually go to counseling and then come back off of it. We don't edit for diagnosis, but just edit for progress, making sure that the counseling is helping you.
Q. And so when you refer to an edit and say you don't edit for diagnosis, does that mean that BMS does not currently place any restriction on access to counseling based on the diagnosis?
A. Correct.
Q. Edit means we don't limit access to that care, when you say we don't have an edit, that's what that means?
A. Right. So when I say edit, I'm thinking about like my system, and there's edits in the system. And so, for example, an example that has come up from my testimony is we had an edit for not paying pregnancy codes if the individual in the system was male, and so that was an edit that we had to work around in order to pay those codes.
Q. Thank you. Has BMS ever had to give approval of the coverage for counseling even when it's only indicated by a gender dysphoria diagnosis code?

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A. No, because our state plan is written for counseling. I'd have to go back to review it, but I think it's any kind of behavioral health diagnosis. We don't have it specified out with regard to what kind of behavioral health diagnosis you might have.
Q. And are there any restrictions ongoing using the federal funding that West Virginia Medicaid receives to pay for counseling received for a diagnosis of gender dysphoria?
A. No, we receive FMAP for that.
Q. So you can use those matching federal dollars to provide counseling for gender dysphoria, correct?
A. Yes. All of our counseling is a behavioral health service that is matched by the federal government.
Q. And as we discussed earlier, hormone therapy for the treatment of gender dysphoria is covered through the Medicaid program, correct?
A. Correct.
Q. BMS previously excluded coverage of hormone therapy for gender dysphoria, is that right?
A. You are correct.
Q. And when did BMS first exclude coverage for hormone therapy?
A. I do not know when we first did it. I believe

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we took the edit off in 2017.
Q. Does it ring a bell if I ask whether BMS would have first started excluding coverage in 2011?
A. Is that when the MCO's had the pharmacy benefit?
Q. I'm not sure of the answer to that, and it sounds like that doesn't ring a bell. So I think your testimony is you are unsure when the edit first, or when hormone therapy was first excluded for gender dysphoria, but a decision was made in 2017 to allow coverage for hormone therapy for gender dysphoria, correct?
A. Correct.
Q. And do you have knowledge of why hormone therapy is covered for gender dysphoria?
A. I believe the pharmacy director at the time, I think then it was Vicki Cunningham, recognized some of the denial of the claims and, and worked with the team to remove the edit.
Q. And who was the decision-maker about providing that coverage?
A. She would have asked me like is it okay if I do this.
Q. And did you approve when she asked that question?
A. I did.
Q. Did BMS have to approve the change to begin

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covering hormone therapy for gender dysphoria?
A. We did not have to do a state plan for that.
Q. And why did you not have to get BMS approval to do a state plan for coverage of hormone therapy for gender dysphoria?
MS. CYRUS: Objection, asked and answered. But you can answer again.
A. We were already covering hormones, so it was just resubmitting the edit.
Q. And are there any restrictions on using the federal funding that West Virginia Medicaid receives to pay for hormone therapy for gender dysphoria?
A. No.
Q. So BMS can use the federal funding it receives to help pay for hormone therapy for gender dysphoria, correct?
A. Yes.
Q. We're going to go ahead and introduce our next exhibit and I will tell you when it's loaded.
(Exhibit 17 marked for identification.)
Q. Okay. Go ahead and click on that folder and I believe you should see what's been marked as Plaintiff's Exhibit 17.
A. I see it.
Q. Great. Please take a moment to review this

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document and let me know when you have.
A. I've reviewed it.
Q. In the lower right-hand corner of the document do you see the Bates stamp DHHRBMS012594?
A. Yes.
Q. And do you recognize this document?
A. It looks like an email that I've been copied on.
Q. And please scroll to the email at the bottom of this chain dated October 24, 2016 from Vicki Cunningham.
A. Yes.
Q. And who is she?
A. She was my pharmacy director at the time.
Q. Okay. So Vicki writes, and I'm going to read her text out loud, "All, we have had many questions from other states about covering estrogen for gender dysphoria plan members. At this time we are not covering it, but CMS has made it clear that we can and get match on the drug." Did I read that correctly?
A. You did.
Q. Do you have any knowledge about the communications with CMS that she's describing in that email?
A. I don't have direct knowledge, but I do know as the pharmacy director she had contacts with CMS particularly around our pharmacy benefit that she would

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call, you know, and bounce things off of much like CMS the way they're structured, they have different individuals that have expertise in different things, so she's talking to somebody at CMS who is knowledgeable around the pharmacy benefit and that would have been her main contact at CMS.
Q. So if the Medicaid program were to approve coverage for gender confirming surgery, would CMS have to approve that coverage?
A. Yes.
Q. So, for example, let's say if the Medicaid program began covering hysterectomies for gender confirming care, would CMS have to approve performing a hysterectomy for gender dysphoria?
MS. CYRUS: Objection, calls for speculation. If you know, you can answer.
A. I don't know if they would have to for the hysterectomy because we already cover hysterectomy much like we already cover the hormones, so that would just be a technical assistance question just to ask to make sure, kind of like Vicki asked here to make sure. And we might be able to cover a hysterectomy without the state plan because that's a surgery that's already covered in our state plan.
Q. Thank you. And then is it generally true, I

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think as you described with counseling and hormone therapy and hysterectomies, that if a service is one already offered by BMS, that allowing that service for an additional diagnosis doesn't necessarily require any approval from CMS?
MS. CYRUS: Object to the form of the question. But if you know, you can answer.
A. Yeah, I think what we would do in those cases, we would always, because much like Vicki did here, we always double check with CMS and then CMS would tell us whether or not it would require a state change.
Q. You were saying for a hysterectomy, however, just to stick with that particular example, the Medicaid plan currently provides hysterectomy procedures for other diagnoses, correct?
A. Correct.
Q. And ordinarily if BMS were to approve a surgery that's already providing for any additional diagnosis, that ordinarily wouldn't require a change to the Medicaid plan, correct?
A. Honestly, we might have covered a hysterectomy out there for this reason and I would not know for sure if we did or not.
Q. And do you have a sense of how that might come to pass?

MS. CYRUS: Object, calls for speculation. If you know, you can answer.
A. I mean, people get hysterectomies all the time and so, you know, if it's a female requesting a hysterectomy, depending on what the doctor put on the prior authorization, there could be a number of reasons, and that might be one of the reasons in addition to other reasons that they are getting a hysterectomy.
Q. And has BMS ever had any communication with CMS about gender affirming surgeries?
A. Not that I'm aware of.
Q. So BMS has never inquired whether expanding access to surgeries that are already covered for other diagnoses would be approved for purposes of treating gender dysphoria?
MS. CYRUS: Object to the form of the question. But you can answer.
A. Not that I'm aware of.
Q. Is puberty delaying treatment for gender dysphoria ever covered through the Medicaid program?
A. I don't believe we've ever covered it, but I can't tell you 100 percent. I mean, I do not think we've covered it.
Q. But it might be covered through the EPSDT process, correct?

A. Maybe.
Q. And just to clarify, so have you ever covered puberty delaying treatment or the treatment for precocious puberty?
A. I'm sorry, what?
Q. Have you ever covered puberty delaying treatment for precocious puberty?
MS. CYRUS: Object to the form of the question. If you know, you can answer.
A. I don't know if I know that answer, I don't know if I know what that even means.
Q. Okay. Give me just one moment to look over my notes. All right. We're going to introduce our next exhibit. I will let you know when it's loaded.
(Exhibit 18 marked for identification.)
Q. All right. Go ahead and click on the exhibits folder and you should see a document marked as Plaintiff's Exhibit 18. Let me know when you've had a moment to open the document and familiarize yourself with it.
A. I have familiarized myself with it.
Q. In the lower right-hand corner the first page of the document has a Bates stamp DHHRBMS012319. Do you see that?
A. It's 319, did you say 311?

Q. If I did, I misspoke, it should be DHHRBMS012319, is that correct?
A. Yes.
Q. Do you recognize this document?
A. Yes.
Q. And what is it?
A. It's an email trail around a specific case of a request for I believe it was an 11-year-old who wanted to delay puberty.
Q. Okay. Please go to Page 2 of the pdf, and that should be Bates stamped DHHRBMS012320. Do you see that?
A. Yes.
Q. And do you see an email from Dr. James Becker dated October 7, 2020?
A. Yes.
Q. He states, "Cindy, I'm still considering the appeal that is on my desk today. I was able to review the recommendations of the American Academy of Pediatrics in regard to treatment of TGD. They do support the use of medication to delay pubertal development. The guidelines is filled with precautions about side effects and possible future consequences. They make the point that the effect of these medications is reversible if the medication is stopped. They argue that this approach may give providers and counselors a

chance to ensure that the patient is fully committed to this change and understands what they are choosing. I think on the basis of that information, I am inclined to approve the treatment with a host of warnings about provider responsibility for monitoring safety and efficacy." Did I read that correctly?
A. Yes.
Q. Referring again to that page, did you respond the same day to say, "Please hold on the approval and let me discuss with leadership"?
A. Correct.
Q. Who were you referring to when you referenced leadership in that email?
A. My guess is I probably ran this by Deputy Secretary Samples.
Q. Do you think you might have conferred with anyone else or likely just Deputy Secretary Samples?
A. I remember this case being discussed with Deputy Secretary Samples and then we also had a call on this case with Dr. Becker and internal individuals here at BMS, I believe Jennifer Myers was on the call, and then I also think we discussed it in our leadership team which consisted of the people on this email along with Brad is not on the email, but he would have been on the leadership team when Dr. Becker brought it up.

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Q. So it sounds like one of the consultations that you would have done was with Deputy Secretary Samples, is that correct?
A. Correct.
Q. And do you recall what he said when you consulted with him?
A. I don't recall. I'm pretty sure I outreached and just asked him his thoughts and I don't recall that he gave an answer either way. He probably pushed it back in our court as to make the decision.
Q. And then it sounds like it was also discussed with what you described as the leadership team, is that correct?
A. Correct.
Q. And that included the people that are on this email chain.
A. So Dr. Becker would bring issues like this to the leadership team, and so it would be the three deputies, Dr. Becker and Riley Romeo who is my general counsel who makes up the BMS leadership team, and myself.
Q. And who are the three deputies?
A. Fred Lewis, Sarah Young and Becky Manning.
Q. And do you recall what the discussion was with the leadership team about this particular case?

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MS. CYRUS: I'm going to object to the extent that if Riley Romeo was involved, and he's general counsel for BMS and if he gave legal advice, I'm going to object to attorney-client privilege. But beyond that, you can answer.
A. Honestly, I don't recall what was all discussed other than Dr. Becker probably brought it up as an issue that we need to be figuring out what we're going to do with this individual case that was laid on his desk.
Q. And was a decision eventually made about this individual case?
A. Yes.
Q. And do you recall who made the decision about this case?
A. I did.
Q. And what was the, what was your decision about this case?
A. We did not cover -- I believe it ended up not being a pharmaceutical, but a device perhaps, and we did not cover, we did not cover the request to delay puberty.
Q. And when you made that decision, what was the basis for your decision?
A. Just the discussions with Dr. Becker and the nurses and the concern about the age of the individual

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being 11 years old and whether or not they were able to make such a decision for themselves.
Q. And what do you recall substantively being shared with you that led you to that decision?
A. Dr. Becker basically, you know, told me both sides of the situation. Initially concerns that, well, maybe it's okay, and then concerns. And so if Dr. Becker is not 100 percent sure and has, you know, some concerns, then I didn't think it was a good path for us to follow to cover something.
Q. And did you do any research of your own before making a decision?
A. I rely on Dr. Becker and the nurses to do that.
Q. So the information that you considered in making the decision would have come from Dr. Becker and the nurses and that would have been the information you considered, correct?
MS. CYRUS: Object to the form of the question.
A. Correct.
Q. And what were the names of the nurses that you consulted with?
A. I believe on the call was Jennifer Myers. I do not recall if Carrie Mallory was on the call or not, but she would typically be another nurse that Dr. Becker

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works with that does research for Dr. Becker, and I know that Dr. Becker was on the call.
Q. So on a slightly different topic, are you familiar with what social transition refers to?
A. I'm sorry, did you say -- I can't hear you.
Q. Are you familiar with what social transition refers to?
A. I am not.
Q. So that would mean BMS does not have a position on whether transgender children should be prevented from socially transitioning, correct?
A. I don't believe we have a position. I'm not even sure what it is.
Q. And are you familiar with what is sometimes referred to as conversion therapy?
A. For someone who is gay, like pray the gay away?
Q. Yes, it can be referred to that. And for purposes of this question, assume that it's applying that principle to be transgender, so assume --
A. Yes, I have heard of that.
Q. Does BMS have a position on whether transgender children should be subjected to conversion therapy?
A. No one should be subjected to that therapy.
Q. Thank you. All right. If you are good to keep going for a little while, then I think I'll turn to our

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next topic.
A. Okay.
Q. Great. We will go ahead and introduce our next exhibit and I will tell you when it's loaded.
(Exhibit 19 marked for identification.)
Q. All right. Go ahead and click on the exhibit folder and you should see what's been marked as Plaintiff's Exhibit 19.
A. I have it up.
Q. Have you familiarized yourself with the document?
A. Yes.
Q. Have you seen this document before?
A. I believe so.
Q. Did you review this document in connection with the testimony as BMS's organizational representative?
A. Yes, I believe so.
Q. You've been designated to testify about the response to request for production No. 7. Please turn to Page 3 and we'll review it together.
A. Okay.
Q. Towards the bottom of the page you'll see text that reads, "No. 7. If defendants contend that the exclusion of gender confirming care is supported by any governmental interest not encompassed in the requests

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above, all documents supporting that contention." Did I read that correctly?
A. Yes.
Q. And the response reads, "Supplemental response. Please see information and communications from CMS regarding mandatory coverage which does not include gender confirming care marked as Exhibit 96, Bates No. DHHRBMS016179 through 016223." Did I read that correctly?
A. You did.
Q. Similar to before, my understanding from your counsel is that you will address request for production No. 7 as it relates to communications from CMS while your colleague Becky Manning will address this request as it refers to budget documents, is that your understanding as well?
A. Yes.
Q. Are you prepared to testify about this request?
A. Yes.
Q. With respect to request for production 7 specifically, what did you do to testify today?
A. Made sure that we didn't have any communications from CMS telling us that this was a required coverage.
Q. And apart from the discovery response I just read which identifies certain documents, are you aware

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of any other responsive documents to this request?
A. I don't believe so.
Q. We'll go ahead and pull up our next exhibit then. I'll tell you when it's ready.
(Exhibit 20 marked for identification.)
Q. All right. Go ahead and click on the exhibit folder and you should see the exhibit marked as Plaintiff's Exhibit 20. Let me know when you've had a chance to review the document.
A. I have the document pulled up.
Q. And in the lower right-hand corner the first page of the document has the Bates stamp DHHRBMS016179. Do you see that?
A. Yes.
Q. Do you recognize this document?
A. I do.
Q. And what is this document?
A. Answer to our question from earlier, this document is a State Health Official letter, a SHO letter, and it's telling us about how we do the MAGI based or the expansion based income methodology for qualifying for Medicaid.
Q. And if you take a moment to scroll through the document, does it appear to be a collection of more than one memo from CMS state Medicaid health officials?

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A. It's all about how we, how we do the eligibility based on MAGI income, but different components of MAGI income of what you can exclude and include in order for individuals to be eligible for the expansion.
Q. Thank you. That's helpful. Please scroll down to Page 42 out of 45 of the pdf.
A. My apologies, I didn't scroll down enough on the first one, and so this is another, it starts another letter here. What page am I on here? Sorry. It's on Page 19 started another letter.
Q. That's helpful. Thank you for the clarification. And scroll with me, if you will, to Page 42 of the pdf. And in case the system doesn't tell you what page you're on as you scroll, you'll be looking for a page that has a Bates ending with the numbers 220.
A. Okay, I'm there.
Q. And do you see a title at the -- actually, for clarity, let me make sure I've got the complete Bates stamp. The complete Bates stamp on this page is DHHRBMS016220. Do you see a title at the top of the page that says, "Mandatory and optional Medicaid benefits"?
A. I do.
Q. Is that followed by a listing of mandatory benefits?

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A. It is.
Q. And can you describe again what mandatory benefits are?
A. Those are benefits that CMS says you have to cover this benefit in order to participate in the Medicaid program.
Q. And does this look to you like an accurate and complete list of the mandatory benefits required by CMS?
MS. CYRUS: Object to the form of the question. If you know, you can answer.
A. It does, it looks like what's probably on CMS's Website.
Q. And then below that list do you see a list of optional benefits?
A. I do.
Q. And these are optional benefits provided by BMS, correct?
A. By BMS?
Q. Yes.
A. No. These are just optional benefits that the state can choose to provide, these are not necessarily West Virginia BMS optional benefits.
Q. And you testified that BMS does provide a number of optional benefits, correct?
A. We do.

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Q. Which benefits on this list do you recognize as optional benefits that BMS provides?
A. Well, we definitely provide prescription drugs. The clinic services, I would have to look at how they're defining that because we have a number of clinics, but I would like to make sure that it's not a clinic that we wouldn't cover, I'm not sure what the definition of that is on this particular Website.
We do physical therapy, occupational therapy, speech and hearing. We do have respiratory care, we do have a number of screening and preventative services, we do cover podiatry. We have a limited optometry benefit, we have a limited adult dental benefit, we do not cover eyeglasses, we do have a chiropractic service, we do have private duty nursing, we do have personal care, we do have hospice.
I would have to see the definition of this case management, but we do have a targeted case management service. We do have ID services, we do have ICF, IMD services. We do not have 1915(i) services, we do not have 1915(j) services, we do not have 1915(k) services. I do not believe we have TB related services, I'm not sure what those, I mean, I know what it is, but I'm not sure of what services they're talking about there. We do cover inpatient psychiatric care for individuals that

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are 21, and we do have health home services.
Q. And are you aware of any other optional services that BMS provides that you haven't just listed?
A. They do not have -- we have 1915(c) home and community based waivers and I don't believe they have the 1915(c) services on this list, and we also have a 1115 demonstration waiver for SUD, substance use disorder services as well, and neither of those are on this list.
Q. Is counseling including counseling for gender dysphoria, would that follow one of the services under the mandatory list or under the optional list of benefits?
A. It would be both. So our, under your mandatory list you'll see federally qualified health centers. Our FQHC's also provide behavioral health and they receive a separate encounter for behavioral health, so they could be receiving those services under, the counseling under the mandatory there.
And then under optional benefits, let's see, where was that. They would receive it mainly through our diagnostic screening, preventative and rehab services. And so rehab services, a lot of your behavioral health services are considered rehabilitative in nature and they're under the rehab part of your state

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plan, so that would be another area that they could receive them.
And let me see if there was any other. And then we have other practitioner services, and so they can definitely probably receive them there as we like enroll psychologists, counselors, an ICSW to provide counseling.
Q. That's helpful. Are the optional services also known as waiver services?
A. Not all the optional services are waiver services, a lot of these are state plan services. So our pharmacy benefit is a state plan service, physical therapy, occupational therapy, speech are state plan services. But we do have those waivers, the 1915(c) waivers and the 1115 that are also waiver services. But a lot of these services that you'll see here, private duty nurse is a state plan, personal care is a state plan, hospice is a state plan. Do you want me to go down the entire list?
Q. No, that's sufficient. Thank you. So we talked earlier about the example of hysterectomy. Is that ever considered part of the mandatory services required by CMS?
A. I don't think the specific procedure perhaps but, you know, it is -- actually, maybe because it's, I

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don't know how they would do hysterectomy as a mandatory. Of course we cover -- I'm thinking it through in my head. I don't think CMS takes it down to the procedure code of level of different procedures with regard to that. I would have to honestly ask CMS if that would be considered a part of your diagnostic that in treating it, you know, that you're in the hospital, can you get it. Honestly, I think I would have to ask CMS if hysterectomy is mandatory because they don't, they don't go down to that level.

Q. And you said they don't go down to that level. Is another way of describing that that when we look at this list of the mandatory benefits it includes broad categories without specifying specific kinds of surgical procedures, for example, is that right?

A. It does, but I do know like when we, the last noncovered surgical procedure that we had to cover did require a state plan and it was something, it was years ago and this was a suit, we were sued, and after we were sued we started covering the service and it required a state plan for us to do it, from what I recall, and that was a specific surgical procedure.

Q. What kind of surgical procedure was that?

A. It was a bariatric surgery. We were not covering bariatric surgeries, and then it's been many,

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many years ago, and we were sued and then after that we did a state plan. I don't recall, I wasn't in the position I'm in now and so when that happened I don't recall if it was a settlement or if we lost or, but I do know we did a state plan to cover those surgeries.

Q. And that meant that state plan had to be approved by CMS, correct?

A. Correct.

Q. All right. So just to clarify one more thing. You said in preparing for your testimony today you were looking at various documents by CMS and that were transmitted to BMS, and you didn't see any documents prohibiting or requiring coverage for gender confirming care, correct?

A. I do not believe there are any documents that prohibit it, but I do not believe there are any documents that mandate it either.

Q. Okay. So the decision to not cover the care resides with BMS, correct?

MS. CYRUS: Object to the form of the question.

A. Yes.

Q. Was that correct?

A. Correct.

Q. All right. I think we're going to turn now to

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

(Exhibit 21 marked for identification.)

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

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

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

Q. You've seen this document before?

A. Yes.

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

A. Yes.

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

A. Okay.

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

A. Correct.

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

A. You are correct.

Q. Are you prepared to testify about this request?

A. Yes.

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

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

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

A. Yes, we cover medically necessary services.

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

A. Correct.

Q. And if the care is not medically necessary it would not qualify for coverage under Medicaid, correct?
A. Correct. The one exception to that would be an EPSDT 4-4 plus over on ameliorating the condition, that's a little bit broader term of medically necessary. But in the end it's still medically necessary to ameliorate the condition, it's just a little bit broader.
Q. That's helpful. Based on the exclusion for gender affirming surgery from the Medicaid plan, is gender affirming surgery excluded regardless of whether it's medically necessary for a specific member?
MS. CYRUS: Object to the form of the question. If you know, you can answer.
A. We do not cover that surgery regardless of whether or not there's a physician or a review team saying it's medically necessary.
Q. We can move on now to another exhibit. So we'll go ahead and look at it when it's ready.
(Exhibit 22 marked for identification.)
Q. Okay. Go ahead and click on the exhibit folder and you should be able to open what's been marked as Plaintiff's Exhibit 22.
A. I have it open.
Q. Please take a moment to review the document and

let me know when you have.
A. I've looked at the document.
Q. Have you seen this document before?
A. I believe so.
Q. Did you review it in connection with your testimony as BMS's organizational representative today?
A. I believe so.
Q. You've been designated to testify about the response to request for production 16. Please turn to Page 9 of the document and let me know when you see No. 16.
A. I'm there.
Q. And that reads, "No. 16, all statements of witnesses or potential witnesses or persons interviewed in connection with this lawsuit." Did I read that correctly?
A. You did.
Q. The response reads, "Response. Please see affidavits of Brian Thompson, Angela," how do I pronounce that last name?
A. Wowczuk, I don't know.
Q. Okay. Let me start this response again.
MS. BORELLI: Before I do, for the benefit of the court reporter I will spell the last name, W-O-W-C-Z-U-K. And then there's a first name that I

will read after that, Tadd, it's spelled T-A-D-D.
Q. So I'll read this response again in its entirety, "Response. Please see affidavits of Brian Thompson, Angela Wowczuk."
MS. CYRUS: I think it's Wowczuk, by the way. Excuse me.
MS. BORELLI: Thank you, Lou Ann.
Q. Okay. Let me read that again, "Response. Please see affidavits of Brian Thompson, Angela Wowczuk and Tadd Haynes, Exhibit 2, Bates No. DHHRBMS000006-12." Did I read that correctly?
A. Yes.
Q. Okay. Are you prepared to testify about this topic?
A. Yes.
Q. With respect to your request for production 16 specifically, what did you do to testify today?
A. I believe that I quickly reviewed the affidavits of Tadd and Brian and Angela.
Q. Are you aware of any other statements of witnesses upon which defendants intend to rely in this lawsuit?
A. Not that I'm aware of.
Q. Are you aware of any other statements of potential witnesses upon which defendants intend to rely

in this lawsuit?
A. Not that I'm aware of.
Q. Are you aware of any other persons interviewed in connection with this lawsuit apart from Brian, Angela and Tadd?
A. Not that I'm aware of.
Q. We're going to move on to our next exhibit then. I will tell you when it's available to review.
(Exhibit 23 marked for identification.)
Q. Okay. Go ahead and click on the exhibits folder and let me know when you've been able to open and review the document marked as Plaintiff's Exhibit 23.
A. Got it.
Q. Have you seen this document before?
A. Yes.
Q. Did you review it in connection with your testimony as BMS's organizational representative today?
A. I believe so.
Q. You've been designated to testify about the response to request for production 17. Please turn to Page 3.
A. Okay.
Q. And you'll see there text that reads, "No. 17, documents obtained from third parties as a result of authorizations, releases and/or subpoenas relating to

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the subject matter of this lawsuit." Did I read that correctly?
A. You did.
Q. And the response reads, "Supplemental response. See Exhibit 125 which consists of documents provided by Aetna regarding Plaintiff Anderson. See also documents provided by UniCare regarding Plaintiff Fain previously produced and marked as Exhibits 93 and 94." Did I read that correctly?
A. You did.
Q. Are you prepared to testify about this topic?
A. Yes.
Q. With respect to request for production 17 specifically, what did you do to prepare to testify today?
A. Just reviewed this with the attorneys.
Q. And apart from the documents identified in the response to request for production 17 that I just read, are you aware of other documents obtained by defendants from third parties related to this suit?
A. Not that I'm aware of.
Q. Are you aware of other documents obtained through a subpoena related to this suit?
A. Not that I'm aware of.
Q. Okay. If you'll give me just a couple of

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moments to confer with my co-counsel, I will be right back and I can give you a sense of how much more we might have for today.
A. Okay.
(A break was taken at 1:44 p.m.)
BY MS. BORELLI:
Q. Commissioner Beane, we do not have any further questions for you today. Thank you for your time.
A. Thank you for no more questions.
EXAMINATION
BY MS. CYRUS:
Q. Well, wait a minute, not so fast. Commissioner Beane, I just have a couple follow-up I wanted to ask you before we finish up.
A. Okay, Lou Ann.
Q. Well, I just wanted to follow up on a couple of areas, I just wanted to make sure your testimony was clear. You were asked about the emails with Dr. Becker about the 11-year-old child who was seeking something that would delay puberty, do you recall that?
A. I do.
Q. Okay. And I wanted to ask you, was it your understanding that what was being sought turned out to be a device and not a pharmaceutical?
A. Yes.

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Q. Okay. And was that the reason it was not covered was because it was not a pharmaceutical?
A. We did not cover the device.
Q. Okay. Was it going to have to be implanted as far as you understood?
A. That's my understanding.
Q. Okay.
A. And I have a very limited understanding of it, but yes.
Q. Was it your understanding that that was considered a surgery implanting the device?
A. I'm assuming that is a surgery to implant the device, yes.
Q. Okay. But are you, but you are aware it was not a pharmaceutical?
A. It was not a pharmaceutical.
Q. Okay. Then regardless of the questions on whether it was appropriate to delay puberty in a 11-year-old, if I understand your testimony correctly, that wasn't the deciding factor as to whether or not it was covered, it was not covered because it was not a pharmaceutical, is that correct?
MS. BORELLI: Objection, object to form.
A. What am I supposed to do, I'm sorry?
Q. You can answer. She's objecting for the record,

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just like I objected.
A. Oh, okay. I'm sorry, Lou Ann, can you say it again.
Q. Yes. You talked about, you had questions about whether it was appropriate or safe to delay puberty in an 11-year-old. I'm just asking you, regardless of those questions, was a deciding factor whether it was not covered the fact that it was not a pharmaceutical?
MS. BORELLI: Object to form.
A. I think it was both, it was not a pharmaceutical and there was a concern about the age.
Q. Okay. And you also were asked about whether BMS prohibited, I'm sorry, whether CMS prohibited BMS from covering transgender surgery or gender affirming surgery. And one reason you testified about was that that surgery is not mandated by CMS. And we have another witness who's going to testify about the budget, but is the other reason that it's not covered is due to budgetary constrictions, the constraints on the Medicaid budget, if you know?
MS. BORELLI: Object to form.
A. Yes. So anything that grows my budget, I really have to have, you know, approval or have extra money in the chaffers to cover it.
So a perfect example, because I think people can

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

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

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

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

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

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

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

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

A. We will have a budget deficit.

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

MS. BORELLI: Object to form.

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

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

MS. BORELLI: Object to form.

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

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

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

MS. BORELLI: Object to form.

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

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

MS. BORELLI: Object to form.

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

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

MS. BORELLI: Object to form.

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

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

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I have.

MS. BORELLI: And we will now take another break and confer and just see if we have any follow-up questions based on those lines of questioning.

MS. CYRUS: Okay.

MS. BORELLI: Let's take ten minutes, be back in ten.

MS. CYRUS: Sure thing.

MS. BORELLI: Thank you.

(A break was taken at 2:03 p.m.)

FURTHER EXAMINATION

BY MS. BORELLI:

Q. Commissioner Beane, I have just a few additional questions for you based on the last line of questions that you were asked. You've testified today that there was litigation over bariatric surgery, the coverage under the Medicaid program, correct?

A. Correct.

Q. And did you testify that as a result of that litigation coverage was provided for bariatric surgery through Medicaid?

A. Yes. I believe that there was a state plan submitted and approved and we started covering bariatric surgery procedures.

Q. Do you know how that coverage for bariatric

surgery was funded?
MS. CYRUS: Object to the form of the question. If you know, you can answer.
A. I'm sure once the SPA was approved, then it's funded like our other medical services with the state and federal match.
Q. Have you ever performed research about the cost of gender affirming surgery?
A. I have not.
Q. Have you ever reviewed research about the cost of gender affirming surgery?
A. I at one time asked Dr. Becker if he could look into like how much the states that are covering this, how much their spend was, but I don't recall ever receiving anything from him with regards to it.
Q. Are you aware of anyone else within BMS who has researched the cost of gender affirming surgery?
A. Not that I'm aware of.
Q. And is there anything you considered related to the cost of gender affirming surgery that we haven't discussed?
A. I don't believe so.
Q. All right. I think those are all the questions we have for the moment, preserving our right to ask further questions if Lou Ann has additional questions

for you now.
MS. CYRUS: I don't have any further questions and we will have her read.
(Proceedings concluded for the day at 2:21 p.m., 03-29-2022)

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF WASHINGTON)

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

That the testimony was transcribed by me and is a true record of the testimony of the witness;
That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

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

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;
That the right to read and sign the deposition by the witness was reserved.

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

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

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

April 11, 2022

To: Ms. Cyrus

Case Name: Fain, Christopher Et Al. v. Crouch, William Et Al.

Veritext Reference Number: 5096149

Witness: Commissioner Cynthia Beane Deposition Date: 3/29/2022

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096149
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/29/2022
WITNESS' NAME: Commissioner Cynthia Beane
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

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

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

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 5096149
CASE NAME: Fain, Christopher Et Al. v. Crouch, William Et Al.
DATE OF DEPOSITION: 3/29/2022
WITNESS' NAME: Commissioner Cynthia Beane
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).
I request that these changes be entered as part of the record of my testimony.

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

_____ _____
Date Commissioner Cynthia Beane

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:
They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.
I have affixed my name and official seal
this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 5096149
PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Commissioner Cynthia Beane
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20_____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

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

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

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

05/04/2022 _____
Date Commissioner Cynthia Beane

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

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

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

Kimberley M. O'Brien
Notary Public

July 28, 2026
Commission Expiration Date

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

d

West Virginia Rules of Civil Procedure

Part V. Depositions and Discovery

Rule 30

(e) Review by Witness; Changes; Signing. If requested by the deponent or a party before completion of the deposition, the deponent shall have 30 days after being notified by the officer that the transcript or recording is available in which to review the transcript or recording and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by subdivision (f)(1) whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

Veritext Legal Solutions complies with all federal and State regulations with respect to the provision of court reporting services, and maintains its neutrality and independence regardless of relationship or the financial outcome of any litigation. Veritext requires adherence to the foregoing professional and ethical standards from all of its subcontractors in their independent contractor agreements.

Inquiries about Veritext Legal Solutions' confidentiality and security policies and practices should be directed to Veritext's Client Services Associates indicated on the cover of this document or at www.veritext.com.

Meet the Commissioner

Exhibit
01

Cindy Beane, MSW, LCSW, is the Commissioner for the West Virginia Bureau for Medical Services. Ms. Beane has over 20 years of experience working with health care in both the public and private sectors. Commissioner Beane was competitively selected to be a Medicaid Fellow for the National Medicaid Leadership Institute Class of 2018. Ms. Beane, along with five additional Medicaid directors (Florida, Indiana, Minnesota, Tennessee and Texas) participated in a 10-month leadership program to develop additional skills and expertise necessary to lead and improve their programs in an ever-changing financing environment.

Commissioner Beane has extensive experience in Mental Health program policy development and development of Home and Community-Based programs. She led policy implementation for changes under the Affordable Care Act (ACA), which enable approximately 165,000 West Virginians to have healthcare coverage. Cindy also manages and oversees project development, implementation of health policies and assures compliance with federal and state regulations, while creating innovative health care services to address the needs of West Virginians.

Under Commissioner Beane, West Virginia was the first state in the nation to obtain approval for coverage of the Neonatal Abstinence Centers. In addition, her team developed and is administering a Continuum of Care waiver designed to treat substance use disorders (SUD) among the Medicaid population. Additionally, Cindy has implemented the Health Homes initiatives to improve quality outcomes for members with chronic conditions, including diabetes and bi-polar disorder, expanded managed care to include behavioral health, and worked with dedicated staff to develop an oversight plan to detect and eliminate fraud, waste and abuse.

Commissioner Beane and her team are currently undertaking efforts to enhance children services for our most vulnerable at-risk children and continues to be committed to administering, promoting, and assuring appropriate, cost conscience strategies to strengthen health care services for the people of West Virginia to improve their quality of life.

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

Exhibit
02

CHRISTOPHER FAIN,
individually and on behalf of all others
similarly situated, *et al.*,

Plaintiffs,

v.

WILLIAM CROUCH, *et al.*,

Defendants.

CIVIL ACTION NO. 3:20-cv-00740
HON. ROBERT C. CHAMBERS

PLAINTIFFS' SECOND AMENDED NOTICE OF 30(b)(6) DEPOSITION

PLEASE TAKE NOTICE THAT pursuant to Rule 30(b)(6) of the Federal Rules of Civil Procedure, Plaintiffs, individually and on behalf of the proposed classes, will take the deposition of Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services through its corporate representatives most knowledgeable about the topics listed herein at the following dates and times, and continuing thereafter until completed:

1. **Sarah Young**, March 11, 2022, beginning at 9 a.m. E.T.
2. **Secretary Crouch**, March 17, 2022, beginning at 11:30 a.m. E.T. to 4 p.m. E.T.
3. **Secretary Crouch**, March 18, 2022, beginning 12:30 p.m. E.T. until completion
4. **Commissioner Beane**, as a Rule 30(b)(6) designee and in her individual capacity, March 29, 2022, beginning at 9:00 a.m. E.T.
5. **Dr. Becker**, March 30, 2022, beginning at 8:00 a.m. E.T. to 4:00 p.m. E.T.
6. **Frederick Lewis**, April 4, 2022, beginning at 9:00 a.m. E.T.

7. **Brandon Lewis**, April 5, 2022, beginning at 10:00 a.m. E.T.

8. **Jennifer Myers**, April 8, 2022, beginning at 9:00 a.m. E.T.

9. **Becky Manning**, April 12, 2022, beginning at 10:00 a.m. E.T.

10. **Brian Thompson,** April 13, 2022, beginning at 9:00 a.m. E.T.

If needed, and to the extent any of the designees above are not able to provide the seven hours of testimony on the record provided for under Federal Rules on the dates specified above, Plaintiffs reserve their right to continue the deposition on another date until it is completed.

The depositions will be taken remotely via video teleconference offered by Veritext. The depositions of each designee will continue from day to day until concluded. The depositions will be taken under oath before a certified shorthand reporter or other officer authorized to administer oaths. The deposition will be recorded by stenographic means, and on videotape. The deposition shall be used for discovery purposes and may be used as evidence in this action, including at trial.

The definitions contained in Plaintiffs' First Set of Requests for the Production of Documents apply to this deposition notice. The relevant time period is January 1, 2016 to the present unless otherwise noted below.

Pursuant to Rule 30(b)(6), Deponents provided by Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services shall be knowledgeable officers, directors, managing agents, or other persons who consent to testify on their behalf concerning the above-captioned matter regarding the following:

1. Your authority to and/or role in establishing eligibility standards for Medicaid providers, determining benefits, and reimbursing providers.

2. Your receipt of federal and/or state funds, including funds from the U.S.

Department of Health and Human Services, and all representations made to the federal and/or state government in the course of securing such funds.

3. Your choice to participate in the Medicaid program.

4. The development, creation, and/or use of the Medicaid Plan.

5. Your efforts to administer the Medicaid Program in West Virginia and/or affirm Your compliance with the Medicaid Act and the Patient Protection and Affordable Care Act.

6. Your relationship with each of the following, including any written or unwritten agreements, policies, practices, and/or procedures, and/or communications as they relate to the provision of healthcare coverage to West Virginia Medicaid participants: Mountain Health Trust, UniCare Health Plan of West Virginia, Inc., The Health Plan, Aetna Better Health of West Virginia, and the Rational Drug Therapy Program.

7. Your role in determining and/or offering healthcare coverage to West Virginia Medicaid participants, including Your authority, responsibility, and duties as they relate to determining and/or offering healthcare coverage to West Virginia Medicaid participants.

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

9. The decision to stop excluding hormone therapy from coverage in 2017 and/or Your experience covering and/or denying coverage for hormone therapy before and after 2017.

10. Your policies, practices, and procedures related to the Exclusion, including

but not limited to how the Exclusion is developed, approved, and maintained.

11. Any government interests that you contend support the Exclusion, and their factual bases.

12. Any research, consideration, and/or analysis by or on behalf of You regarding providing access to gender-confirming care for West Virginia Medicaid participants.

13. Any research, consideration, and/or analysis by or on behalf of You regarding the legality of the Exclusion.

14. As to healthcare coverage for West Virginia Medicaid participants, Your data and documents systems, including but not limited to hardware configuration, software configuration, network configuration, internet structure, and document and data retention systems.

15. As to healthcare coverage for West Virginia Medicaid participants, Your organizational structure including its units, divisions, and departments.

16. The number of Medicaid participants who are transgender and/or have sought any form of care for the treatment of gender dysphoria.

17. All lawsuits, counterclaims, arbitrations, complaints, or judicial or quasi-judicial actions brought or threatened against You related to the denial of gender-confirming care.

18. All interrogatory requests, requests for admission, and requests for production of documents directed to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services, and any discovery responses, responsive documents, filings, or productions by or on behalf of Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Dated: March 1, 2022

/s/ Walt Auvil
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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document on March 1, 2022 with the Clerk of the Court using the CM/ECF system, which will send notification of filing, and a copy of the same, to the following CM/ECF participants:

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Dated: March 1, 2022

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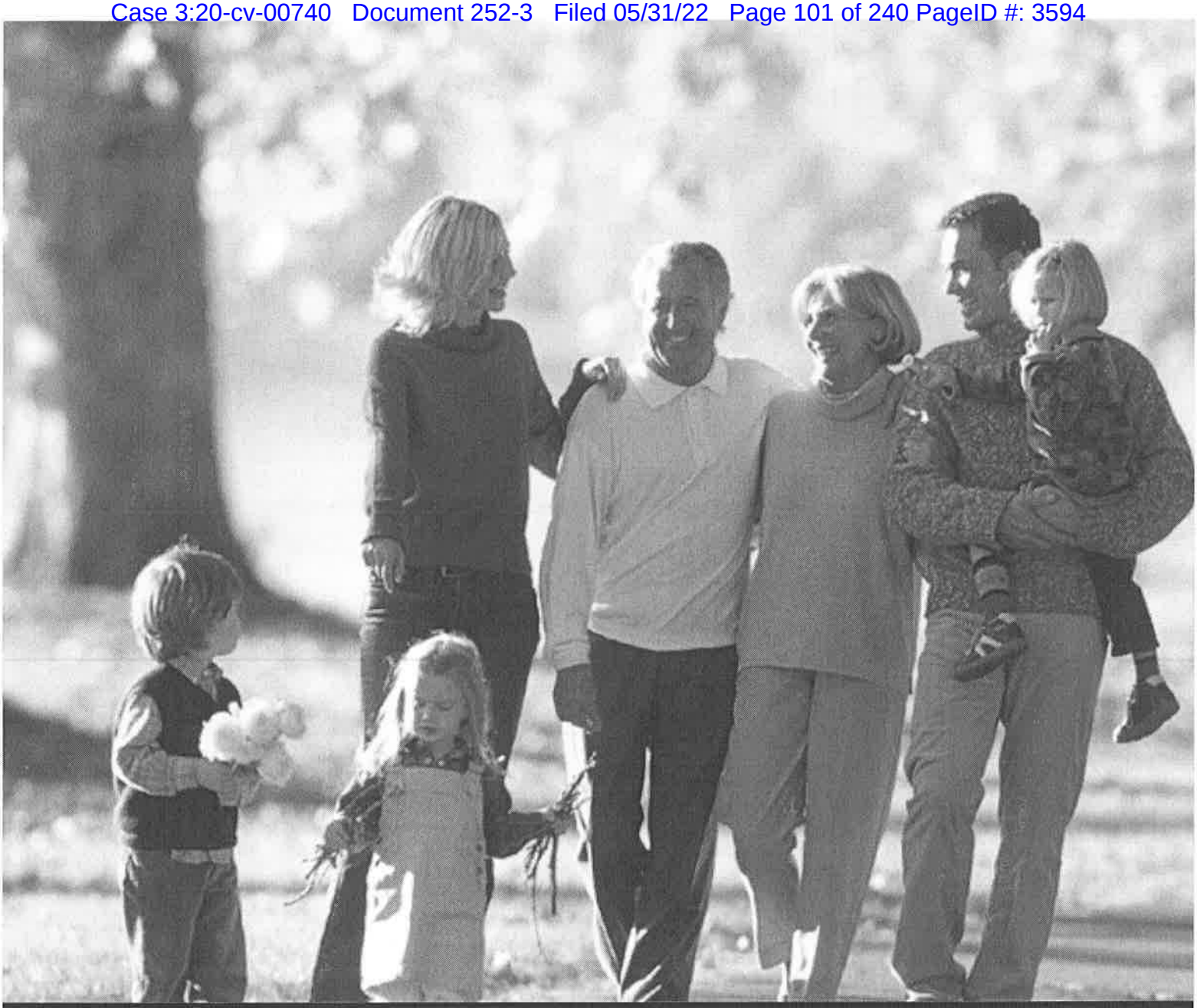


MEDICAID 101

An Overview of West Virginia's Medicaid Program

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES

Exhibit
03

Medicaid: The Basics

Medicaid is a public benefit program that provides health insurance and medical services to eligible individuals. Medicaid is financed by state and federal governments and is administered by states. In West Virginia, the Bureau for Medical Services (BMS) within the West Virginia Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the West Virginia Medicaid program.

Across the country, Medicaid is the nation's single largest health insurer, covering more than 73 million individuals in May 2018, or about 22% of the US population.[1] Medicaid contributes substantially to the financing of the US health care system, supporting local public health infrastructure, hospitals, mental health centers, at-home-care, community clinics, nursing homes, physicians, and many other health professionals and administrators.

The Medicaid program is critical to the health and well-being of hundreds of thousands of West Virginians. This manual is intended to provide you with a brief overview of the West Virginia Medicaid program, including how the Medicaid program is financed, Medicaid care delivery models, covered services, and trends in Medicaid enrollment and spending. The information in this manual should not be considered Medicaid policy. Rather, this manual is intended to serve as an accessible resource to answer frequently asked questions related to the Medicaid program. Every effort was taken to document data sources used in the creation of this book. If you have additional questions related to Medicaid program, or any of the information in this manual, please see the contact information in the Appendix.

MEDICAID VS. MEDICARE

Medicaid: A public assistance program that serves low-income people of all ages. Medicaid is jointly funded by states and the federal government but is administered by states. Patients with Medicaid usually do not have out-of-pocket costs related to covered medical expenses.

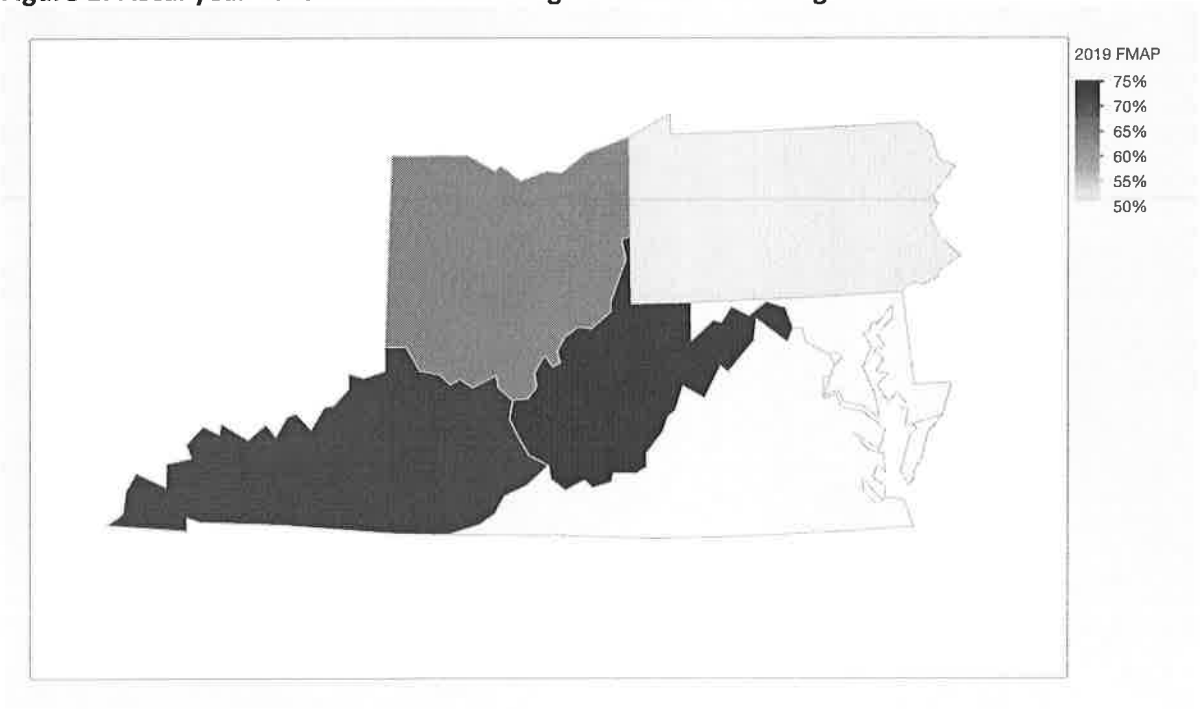
Medicare: An insurance program funded and administered by the federal government. Medicare provides health insurance for hospital and medical care to seniors age 65 and older and some individuals under age 65 with disabilities. Medicare beneficiaries typically have some out-of-pocket costs.

Who pays for Medicaid?

A state-federal partnership

Medicaid is jointly funded by state and federal governments. The majority of Medicaid funding is provided by the federal government. The federal government shares financial responsibility for the Medicaid program by matching state spending with federal dollars. The federal share of those costs is determined by the Federal Medical Assistance Percentages (FMAP). The FMAP is calculated annually using a formula set forth in federal statute and is inversely proportional to a states per capita income relative to the US average. States with lower per capita incomes have higher FMAPs. As seen in Figure 1, West Virginia has the highest FMAP in the region.

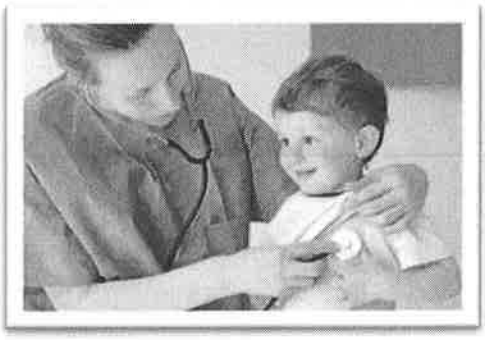
Figure 1: Fiscal year 2019 FMAP in West Virginia and surrounding states



In fiscal year 2019, West Virginia's FMAP is 74.3%.[2] This means that the federal government pays for 74.3% of the costs for eligible Medicaid services, while BMS is only responsible for 25.7% of the costs. In practice, if a Medicaid member has a hospital stay that results in $1,000 in costs, the federal government will pay $743, while BMS will pay only $257. In this sense, the FMAP acts as a multiplier for state spending. For example, in West Virginia, every $100 in state spending on Medicaid services will bring in $290 in matching federal funds. States may also receive an enhanced FMAP for covering certain services or populations. Perhaps most notably, states currently receive a 94% FMAP for the Medicaid expansion population.[3] These matching funds directly benefit patients receiving medical care while also helping to finance the healthcare infrastructure in areas with large Medicaid populations.

State Medicaid programs are often seen as low-hanging fruit when financially strapped states are forced to make budget cuts. However, thanks to the FMAP, Medicaid spending acts as a tremendous financial boon for the state. The Kaiser Commission on Medicaid and the Uninsured recently compiled findings from 29 different studies examining the economic impact of Medicaid spending and found that in all studies examined Medicaid spending had a positive impact on local economies.[3] These studies also found that Medicaid spending generates economic activity within the state by providing jobs, personal income, and state tax revenues. While most state government expenditures reallocate spending from one sector to another, Medicaid is one of the few state government spending opportunities that is guaranteed to pull in money from outside the state and directly benefit the local economy.

Medicaid care delivery systems



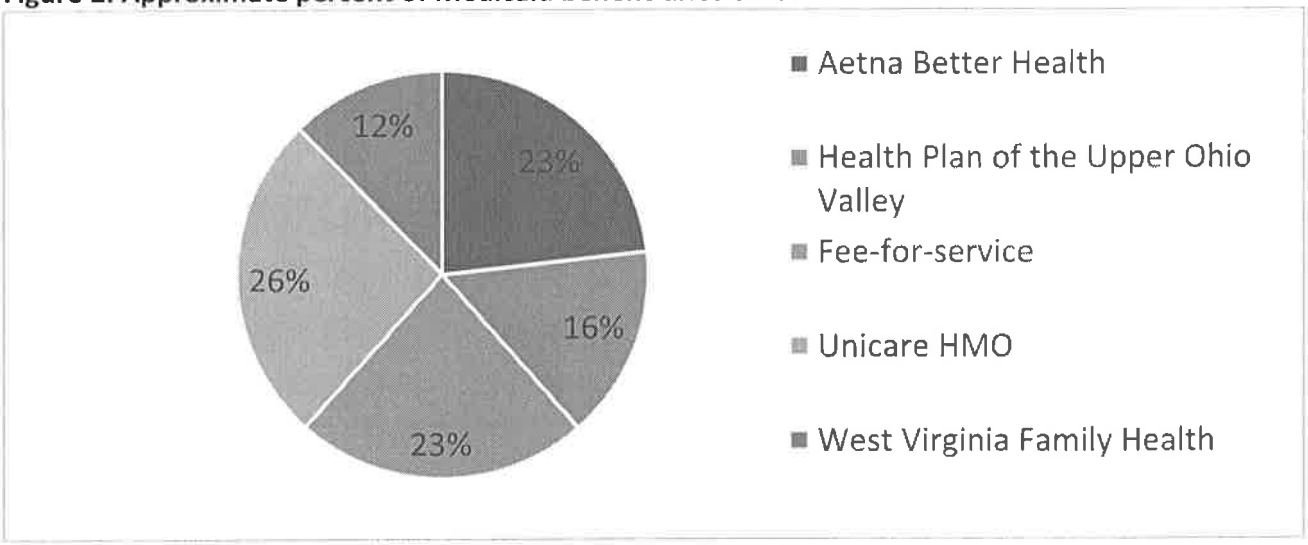
States are generally given leeway to set standards and policies for how they deliver medical and pharmacy services to Medicaid enrollees. States are also able to choose how services are purchased and payments distributed to Medicaid providers. The two most common care delivery systems are fee-for-service and managed care.

Fee-for-service: States directly pay providers a flat fee for each service delivered.

Managed care: States contract with health plans or managed care organizations (MCOs) and pay these groups a monthly per member capitation payment to provide all covered Medicaid services.

More than 75% of West Virginia Medicaid beneficiaries receive their benefits via the managed care delivery system through the Mountain Health Trust program. The Mountain Health Trust program contracts with four Managed Care Organizations (MCOs) for the provision of medical benefits. The four MCOs contracted through the program include Aetna Better Health of West Virginia (formerly Coventry Health Care of West Virginia), Health Plan of the Upper Ohio Valley, Unicare, and West Virginia Family Health. Individuals who are not covered by an MCO receive all benefits via the fee-for-service delivery system and are typically eligible for Medicaid through a waiver program such as the Intellectual/Developmental Disabilities Waiver or the Traumatic Brain Injury Waiver. Importantly, some Medicaid benefits, including pharmacy benefits, long-term care services, and non-emergency medical transportation are still paid via the fee-for-service delivery system for all Medicaid beneficiaries.

Figure 2: Approximate percent of Medicaid beneficiaries enrolled in each MCO



Covered benefits and services

The federal government requires every state Medicaid program to cover a specific set of benefits and services. The services that programs are required to cover have changed greatly since the Medicaid program's inception in 1965, given advancements in medical technologies and changes in the makeup of the Medicaid population. In addition to the required covered services, states are allowed some flexibility in terms of offering additional benefits so long as services are equitable in terms of availability and scope for all Medicaid beneficiaries.

Medicaid programs are required to cover the following services:

- Inpatient and outpatient hospital services
- Physician services
- Nursing facility services
- Early periodic screening, diagnostic and treatment services for children, including dental services
- Laboratory and x-ray services
- Home health services including nursing services, home health aides, and medical supplies and equipment
- Rural health clinic services
- Federally qualified health center services
- Transportation to medical care
- Certified pediatric and family nurse practitioner services
- Emergency medical services for certain noncitizens, also known as emergency medical assistance
- Family planning services, including nurse midwife services
- Tobacco cessation counseling for pregnant women

West Virginia's Medicaid program also covers the following optional services:

- Alcohol and drug treatment
- Chiropractic services
- Emergency dental care for adults
- Orthodontics for children
- Emergency hospital services
- Post-cataract eyeglasses for adults
- Hearing aids for children
- Home care including personal care assistant services
- Hospice care
- Medical equipment and supplies
- Prescriptions and medication therapy management
- Both physical and mental rehabilitative services
- Inpatient and outpatient substance use disorder treatment
- Case management
- Care coordination
- Autism spectrum disorder services

Who is eligible for Medicaid in West Virginia?

West Virginia Medicaid provides health insurance to a diverse population of individuals. All individuals who meet federally established income eligibility requirements are guaranteed Medicaid coverage. However, states are also allowed some flexibility in terms of eligibility requirements and can extend coverage to certain optional populations. The vast majority of Medicaid beneficiaries in West Virginia fall into one of the following categories:

Pregnant women and children

It is extremely important that women receive adequate medical care while they are pregnant. Fortunately, Medicaid provides prenatal care to many pregnant women without other forms of insurance. More than half of all births in West Virginia are paid for by Medicaid. Medicaid is also the primary health insurance program for low-income children from birth to age 18. Nearly half of all West Virginia children receive health care and important developmental services through Medicaid. Ensuring the health and developmental success of pregnant women and children is a sound investment in West Virginia's future.

Aged and disabled population

Medicaid is the primary insurer for many individuals with mental or physical disabilities. Individuals who are aged, blind, or disabled, and who have limited assets to support themselves may be eligible for supplemental security income (SSI) from the federal government. In West Virginia, all individuals who receive SSI automatically become eligible for Medicaid. Once enrolled, these individuals may receive health care, therapy, and long-term care services with few or no out-of-pocket costs. Medicaid also supports seniors in West Virginia by paying for some low-income Medicare beneficiaries' co-pays, deductibles, and premiums as well as certain medical services. For example, Medicaid pays for the majority of all nursing home care for West Virginia seniors.

Expansion adults

Historically, adults aged 19-64 without dependent children were not eligible for Medicaid coverage. However, with the passage of the Patient Protection and Affordable Care Act, states were given the option of expanding Medicaid eligibility to adults with incomes up to 133% of the federal poverty level. West Virginia is one of 36 states to expand Medicaid eligibility to this population. Importantly, the federal government pays an enhanced FMAP for Medicaid services provided to this population.

MEDICAID VS. CHIP

While Medicaid insures many children in West Virginia, some children receive benefits through the Children's Health Insurance Program (CHIP). Medicaid is intended to provide health benefits to the poorest children in the state. CHIP expands health insurance coverage to children in families who have incomes above the Medicaid eligibility threshold who do not have commercial insurance. Services provided through CHIP are generally comparable to those offered under the Medicaid program, however states have more flexibility in determining the breadth of coverage for CHIP services.

How is Medicaid eligibility determined?

Medicaid eligibility is dependent on a host of factors including household income, family size, age, disability, and citizenship status. The specifications for these criteria vary by eligibility category. For example, pregnant women may make up to 158% of the federal poverty level (FPL) and qualify for Medicaid eligibility, while adults in the expansion population may only

make up to 133% of the FPL. West Virginia Medicaid's income eligibility thresholds, as a percentage of the FPL, for various groups are displayed in Figure 3. Figure 4 displays the 2018 FPL designations for different family sizes; families that make less than this amount are deemed in poverty. Regardless of eligibility group, individuals must pass an annual asset test to become eligible for Medicaid benefits. Assets include items such as a car above a certain value, personal savings, and life insurance policies. Notably, a family home is not considered an asset for Medicaid eligibility.

Figure 3: Eligibility thresholds as a percent of the FPL for various Medicaid groups[5]

Population	**Eligibility threshold as a percent of FPL**
Children	
Ages 0 – 1	158%
Ages 1 – 5	141%
Ages 6 – 18	133%
CHIP	300%
Adults	
Aged and Disabled*	Up to 300% of SSI Limit
Expansion population	133%
Pregnant Women	158%

*Eligibility for the aged and disabled population is based on social security income (SSI) limits. Certain individuals can make up to 300% of the SSI limit and qualify for Medicaid benefits

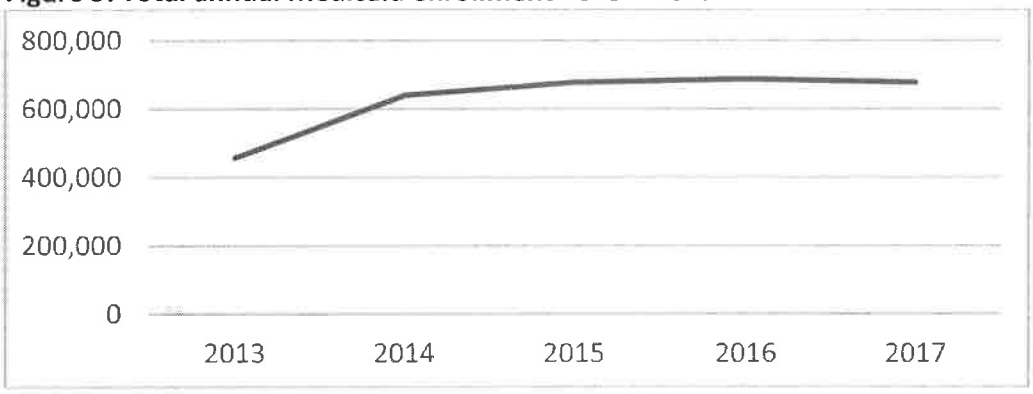
Figure 4: 2018 FPL by family size[6]

Family Size	**FPL Threshold**
Individuals	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8+	$42,380

Medicaid enrollment by the numbers

Figure 5 displays the number of individuals enrolled with West Virginia Medicaid at any point in a calendar year from 2013 – 2017. Please note that the number of individuals enrolled with Medicaid on any given day will be significantly less than the number enrolled at any point in the calendar year. For example, there are about 530,000 individuals enrolled in Medicaid on any particular day of the month, while there are generally more than 650,000 individuals enrolled at some point over the course of an entire year.

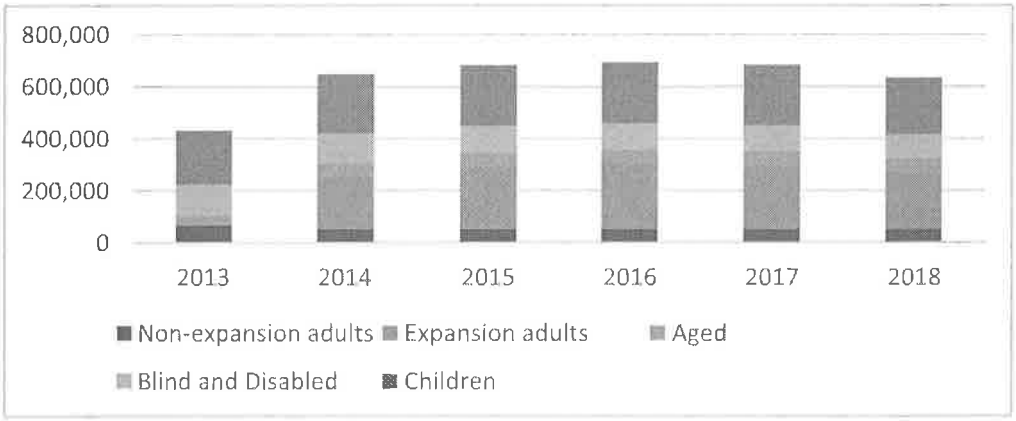
Figure 5: Total annual Medicaid enrollment 2013 – 2017



In 2017, more than 675,000 West Virginians were enrolled in Medicaid at some point during the year. This represents approximately one third of the state's total population in 2017. West Virginia chose to expand Medicaid eligibility under the Affordable Care Act in 2014. From 2013 to 2014, Medicaid enrollment increased by more than 50%, and has remained relatively stable since then.

Figure 6 displays trends in Medicaid enrollment from 2013 – 2017 by Medicaid eligibility category. Changes in Medicaid enrollment from 2013 – 2017 have been driven almost entirely by the adult expansion population. The number of blind and disabled individuals enrolled in Medicaid has decreased slightly over this time period.

Figure 6: Annual Medicaid enrollment by eligibility group 2013 – 2017



Given the dramatic increases in Medicaid enrollment over the last five years, West Virginia now has one of the lowest uninsured rates in the country. Figure 7 displays trends in the percentage of West Virginians with Medicaid coverage relative to the percent of uninsured West Virginians. While more than one-third of the state's population was enrolled with Medicaid at some point in 2017, only about 6% of the state's population was uninsured for the majority of the year.

Figure 7: Percent of West Virginians with Medicaid relative to percent uninsured 2013 – 2017[7,8]

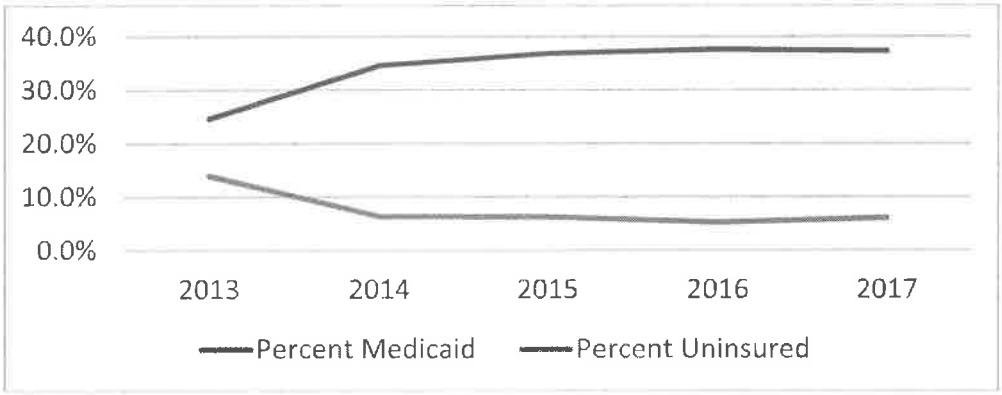
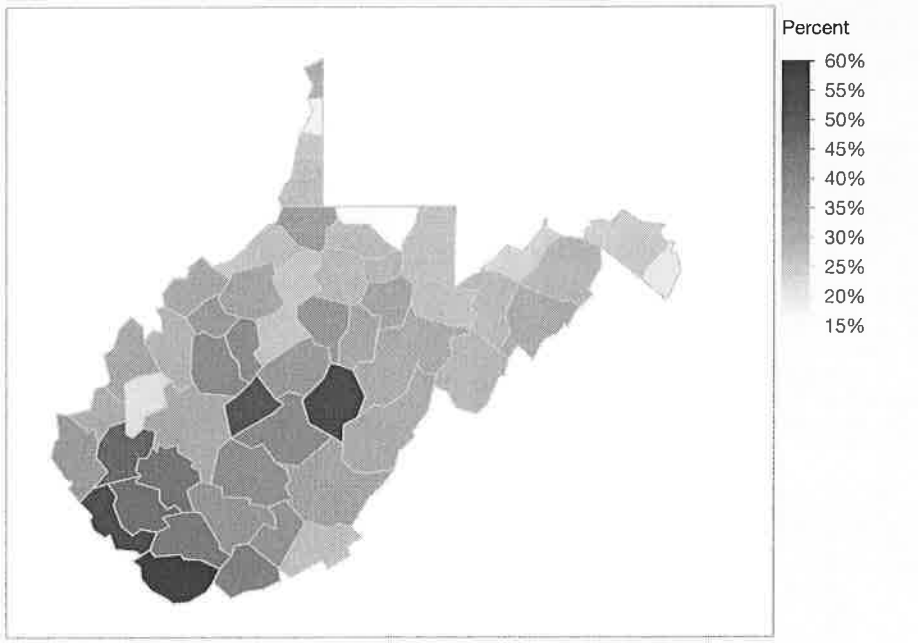


Figure 8 displays the percent of individuals enrolled in Medicaid in each county in West Virginia during calendar year 2017. Generally speaking, counties in the southern region of the state had higher rates of Medicaid coverage relative to counties in the Northern region or Eastern Panhandle.

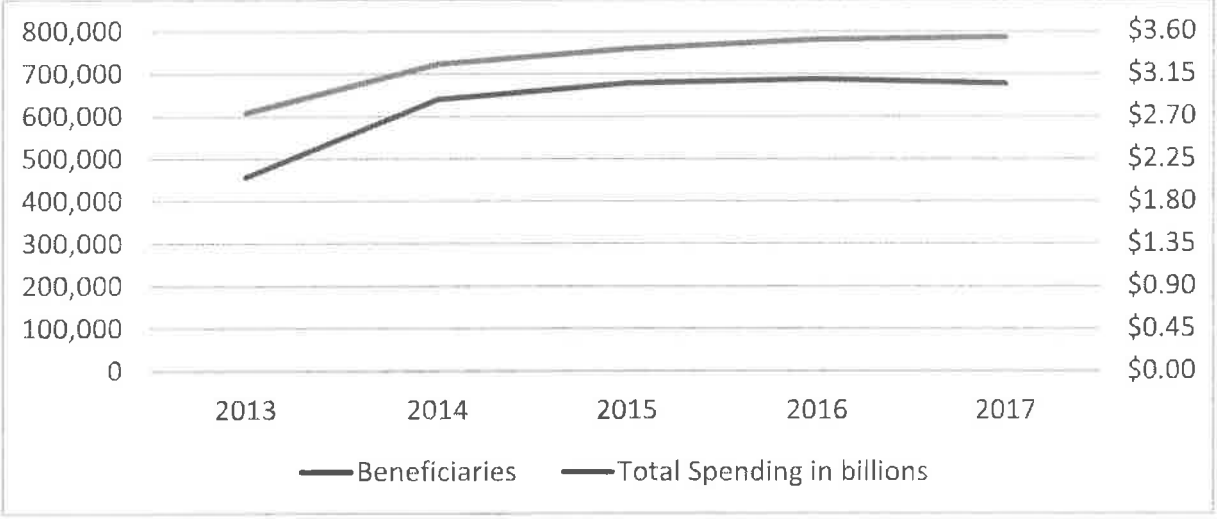
Figure 8: Percent of individuals with Medicaid in each county in calendar year 2017



Medicaid spending by the numbers

Annual Medicaid enrollment increased substantially following implementation of Medicaid expansion under the Affordable Care Act. Understandably, Medicaid spending also increased over this time period, however it was outpaced by increases in Medicaid enrollment. Figure 9 displays trends in annual Medicaid enrollment and spending from 2013 – 2017.

Figure 9: Annual Medicaid enrollment and spending 2013 – 2017



Medicaid enrollment increased by more than 50% from 2013 to 2014, but total Medicaid spending increased by less than 20% over the same time period. While the adult expansion population has largely driven increases in Medicaid enrollment, this population accounts for a relatively small proportion of total Medicaid spending. Figure 10A displays the percent of Medicaid beneficiaries by eligibility category in calendar year 2017, while Figure 10B displays the percent of spending attributable to each eligibility category in the same year.

Figure 10A: Percent of Medicaid beneficiaries by eligibility group in calendar year 2017

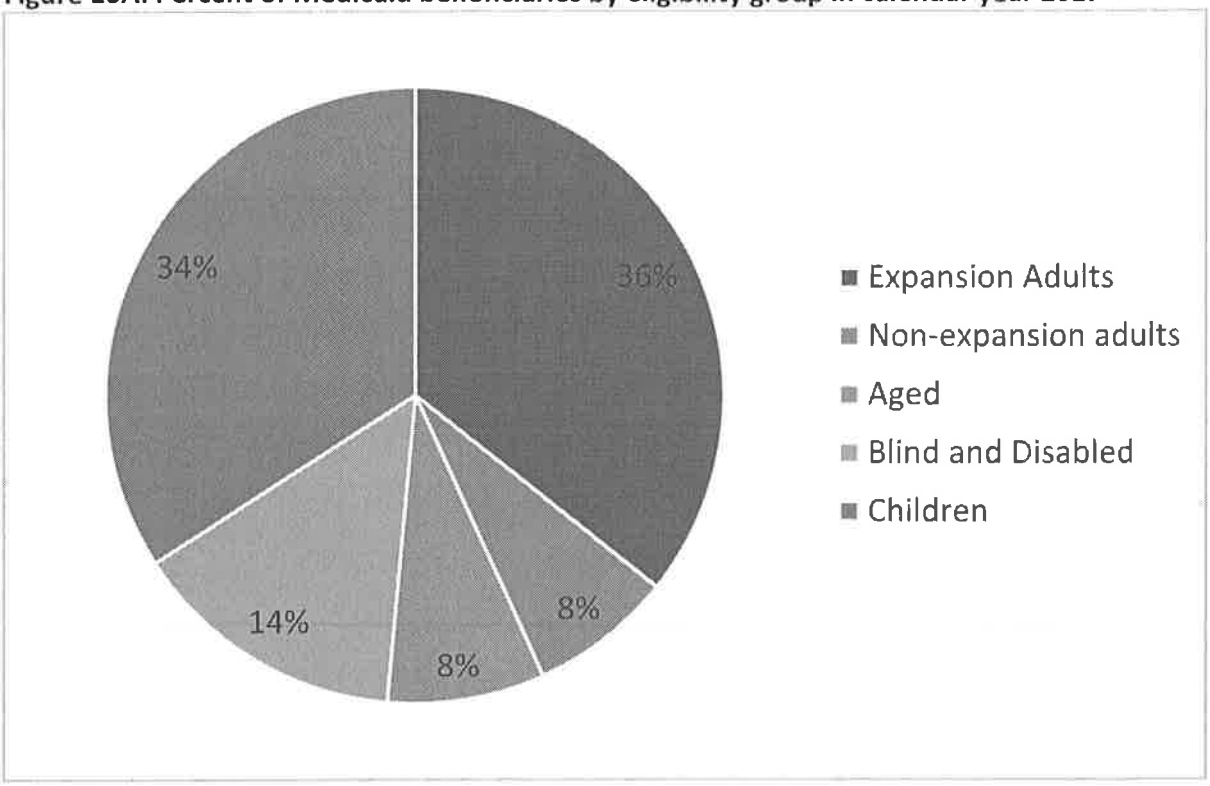
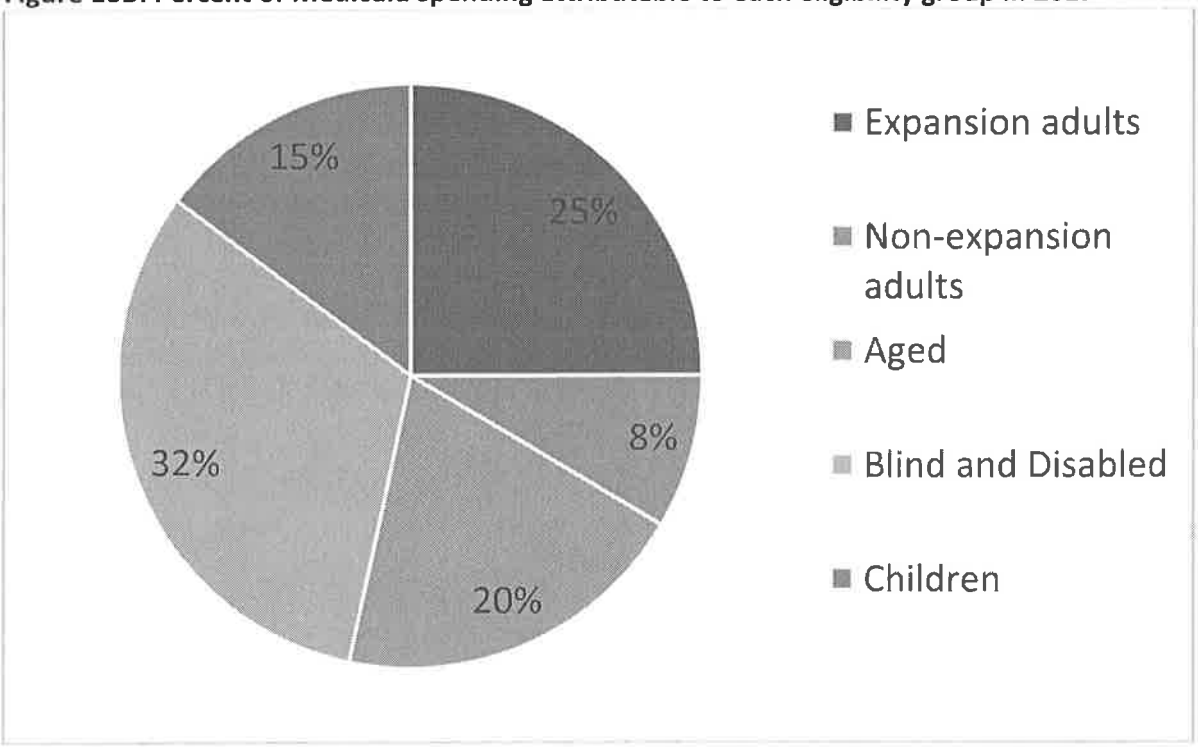


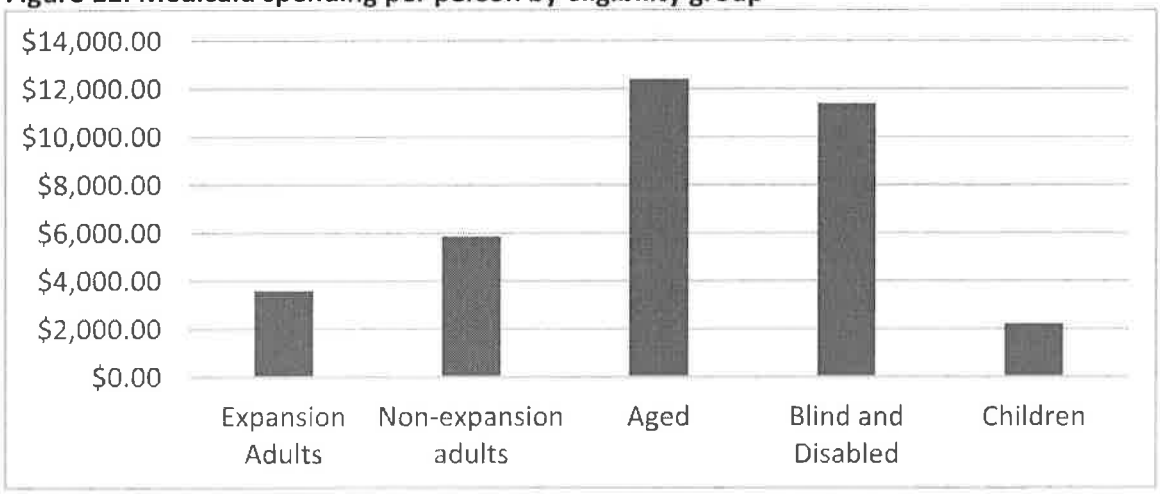
Figure 10B: Percent of Medicaid spending attributable to each eligibility group in 2017



In 2017, more than one-third of Medicaid beneficiaries were part of the adult expansion population, however, these individuals accounted for only about 25% of total Medicaid spending during the calendar year. On the other hand, the aged population and the blind and disabled populations together comprised only about 22% of the Medicaid population in 2017, however they accounted for more than 50% of all Medicaid spending. The aged population and the blind and disabled Medicaid populations tend to have special healthcare needs and require more frequent Medicaid services than other groups. It is understandable that the expansion population accounts for a smaller proportion of Medicaid spending relative to populations with greater healthcare needs.

Figure 11 displays average Medicaid spending per person by eligibility group. Individuals in the aged population and the blind and disabled Medicaid populations account for a much greater share of Medicaid spending than individuals in other eligibility groups. Beneficiaries in the aged population and blind and disabled population accounted for two to four times greater average spending per person relative to beneficiaries in any of the other eligibility groups.

Figure 11: Medicaid spending per person by eligibility group



Medicaid innovations and successes

Innovative approaches to treating Substance Use Disorder

West Virginia has been at the epicenter of the nation's drug crisis. In 2017, West Virginia had the highest drug overdose death rate in the country, with a rate that was greater than double the national average.[9] This crisis has dramatically impacted our Medicaid program, which insures many individuals suffering from Substance Use Disorder (SUD). In the last year, BMS has implemented several innovative policies to improve the quality and availability of SUD treatment for Medicaid beneficiaries. Ultimately, these policies will bolster the SUD care delivery network in the state and improve the health and well-being of West Virginians.

BMS was recently awarded a Medicaid 1115 waiver by the Centers for Medicare and Medicaid Services (CMS) to enhance the continuum of care for beneficiaries with SUD. This waiver is

intended to improve the availability, quality, and coverage of SUD treatment services for Medicaid beneficiaries. The waiver allows Medicaid beneficiaries with SUD to receive the full continuum of care for SUD treatment as defined by the American Society of Addiction Medicine. Medicaid enrollees with SUD are now eligible to receive additional behavioral therapies including peer recovery support and withdrawal management services, as well as short-term residential treatment. The 1115 waiver also expands access to medication assisted treatment (MAT) including methadone treatment services from opioid treatment programs. Additionally, emergency medical service providers can now be reimbursed for administration of naloxone to Medicaid beneficiaries suffering an overdose. Importantly, the new services provided under the 1115 waiver are consistent with the industry standard best practices set forth by the American Society of Addiction Medicine.

In addition to the 1115 waiver, BMS is also taking an innovative approach to treating babies born with neonatal abstinence syndrome (NAS). NAS is a disorder caused by prenatal exposure to opioids or other drugs. Babies with NAS experience a host of symptoms including tremors, vomiting, seizures, excessive crying and sensitivity to stimuli, and these infants require around-the-clock care during the first few weeks of life. BMS is the first Medicaid program in the country to have an approved state plan amendment (SPA) specifically to bolster NAS treatment services. The SPA allows health facilities to be recognized as NAS Treatment Centers, and allows them to receive Medicaid reimbursement for providing NAS treatment. Services that can now be reimbursed under the SPA include comprehensive assessment and care plan development; housing in a low or reduced stimuli environment; pharmaceutical withdrawal management; therapeutic swaddling; rocking; newborn massage; and other services.

Home and Community-Based Services for person-centered care

The Medicaid Home and Community-Based Services (HCBS) waiver program allows state Medicaid agencies to provide services to members in their homes or communities to avoid institutionalization. HCBS programs work to create sustainable, person-centered, long-term support systems for people with disabilities, chronic conditions, and the elderly. The goal of HCBS waiver programs is to improve members' independence, health, and quality of life. Within broad federal guidelines, states can develop HCBS programs tailored to the needs of Medicaid beneficiaries who prefer to receive treatment in their home or communities rather than an institutional setting. West Virginia has three HCBS waiver programs:

1. Aged and Disabled Waiver—This program is a long-term care alternative that provides services that enable an individual to remain at or return home rather than receiving nursing home care. The goals and objectives of this program are focused on providing services that are person-centered, promote choice, independence, respect, and community integration.
2. Intellectual/Developmental Disabilities (I/DD) Waiver—This program provides services that instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The I/DD waiver program provides services in natural settings where the member resides rather than in intermediate care facilities.
3. Traumatic Brain Injury (TBI) Waiver—This program provides services to individuals with a documented traumatic brain injury, defined as a non-degenerative, non-congenital injury to the brain resulting in the need for a nursing facility level of care. The purpose of the program is to prevent unnecessary institutionalization by providing services and supports that are person-centered and promote independence and community integration.

Health Homes for at risk populations

The Affordable Care Act gave state Medicaid programs the option of creating the Health Homes program to provide a comprehensive system of care coordination for Medicaid beneficiaries with multiple chronic conditions. The Health Homes program does not act as a place where patients live, but as a system for holistically providing medical, behavioral, and social support services for individuals with complex healthcare needs. Individuals enrolled in Health Homes are assigned a multidisciplinary team of healthcare providers who collaboratively provide services and supports in a coordinated manner. Health Homes services include comprehensive care management, care coordination, health promotion, and community and social support services. Each patient enrolled in the program is also assigned a personal care manager who is required to contact the patient at least bi-weekly to ensure the patient's needs are being addressed. West Virginia currently has two Health Homes. The first Health Home began in July 2014 for members with bipolar disorder who have, or are at risk of having, hepatitis B or C. The second Health Home

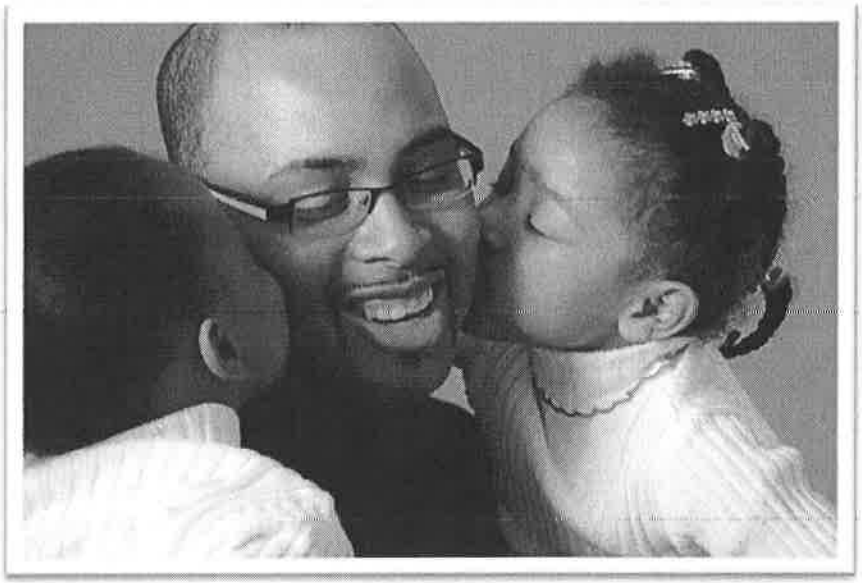
began in April 2017 and is designed for Medicaid beneficiaries with pre-diabetes, diabetes or obesity, who are at risk of also having anxiety or depression.

Reducing pharmacy spending and investing in the state

On July 1, 2017, BMS carved out pharmacy services from the managed care program and began delivering these services as part of the fee-for-service delivery model. With this model, pharmacy benefits are managed by the State Pharmacy Services program, which serves as its own Pharmacy Benefits Manager (PBM). This model unbundles incurred costs and creates a more transparent method of payment for pharmacy services. Claims processing is handled by DXC, the fee-for-service medical/dental claims processor, and processing fees are transparent. Supplemental rebates on preferred drugs are negotiated through a multi-state consortium of Medicaid programs. The collection of federal and supplemental rebates is overseen in-house and the entire amount collected is retained by the Medicaid program. So far, this initiative has paid dividends, with significant cost-savings in the first year alone. In addition to savings on administrative costs and increased rebates, BMS increased the dispensing fee to $10.49 per prescription, providing a significant re-investment back into the pharmacy business community.

Looking to the future

BMS is committed to providing innovative, high quality, and accessible healthcare to the citizens of West Virginia. As part of this commitment, BMS recently completed a strategic planning initiative to more formally establish the Bureau's mission, core values, and major strategic initiatives. This plan will be used to guide the overall direction that BMS will take over the next five years. Development of this strategic plan is only the first step in continuing efforts to improve transparency and better serve the citizens of West Virginia. A copy of the BMS strategic plan can be found on the website: dhhr.wv.gov/bms.



Notes

Notes

Appendix

For additional information about the West Virginia Medicaid program, please contact BMS at: 304-558-1700

For additional information pertaining to preparation of this manual, please contact Nathan Pauly at Nathan.J.Pauly@wv.gov.

References

1- https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
2- https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
3- https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/
4- https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7075_02_es.pdf
5- https://www.medicaid.gov/state-overviews/stateprofile.html?state=West-Virginia
6- https://www.healthcare.gov/glossary/federal-poverty-level-fpl/
7- https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf
8- https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=uninsured&selectedRows=%7B%22states%22:%7B%22west-virginia%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
9- https://www.cdc.gov/nchs/products/databriefs/db329.htm

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

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

Plaintiffs,

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

v.

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

Exhibit
07

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

DOCUMENT REQUESTS

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

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

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

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

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

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

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

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

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CONFIDENTIAL

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

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

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

Exhibit
08

EXHIBIT
126

CONFIDENTIAL

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

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

Exhibit
09

EXHIBIT
127

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

Exhibit 10

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

Plaintiffs,

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

v.

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

Defendants.

DEFENDANTS' RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

INTERROGATORIES

8. Identify all conditions, diagnostic codes, or instances where coverage for hysterectomy and/or oophorectomy surgical procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

a. Diagnostic code(s);

b. Procedure code(s);

c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis. In addition, we have requested documents which are used as part of the review process and these will be supplemented upon receipt.

9. Identify all conditions, diagnostic codes, or instances where coverage for vaginoplasty procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

a. Diagnostic code(s);

b. Procedure code(s);

c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis.

10. Identify all conditions, diagnostic codes, or instances where coverage for orchiectomy, penectomy, and/or phalloplasty procedures is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:

    a. Diagnostic code(s);

    b. Procedure code(s);

    c. Medical necessity criteria.

RESPONSE: Objection, this Interrogatory seeks information regarding procedures for which Plaintiff Fain is not seeking relief. Therefore, this request is not relevant, is not proportional to the matters in issue, and is outside the scope of permissible discovery. Without waiving this objection, multiple factors go into the review of any particular request, including past medical history, surgical history, and diagnosis.

11. Taking necessary steps to comply with applicable privacy laws, for each year since 2016 through the present identify the number of Health Plan participants who have submitted one or more claims with a diagnosis code for Gender Dysphoria or Gender Incongruence. This includes, but is not limited to, the following diagnosis: F64.0, Transsexualism (ICD-10-CM); F64.2, Gender identity disorder of childhood (ICD-10-CM); F64.8, Other gender identity disorders (ICD-10-CM); F64.9, Gender identity disorder, unspecified(ICD-10-CM); HA60, Gender incongruence of adolescence or adulthood (ICD-11); and HA61, Gender incongruence of childhood (ICD-11).

RESPONSE: Upon information and belief:

2016 30 members
2017 50 members
2018 243 members
2019 439 members
2020 602 members
2021 (through 9/30) 686 members.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,
BUREAU FOR MEDICAL SERVICES,
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 25th day of October, 2021, a true and exact copy of **DEFENDANTS' RESPONSE TO PLAINTIFF'S SECOND SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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Exhibit
11

	Males on estrogen	Females on Testosterone (Including Oxandrolone)	Females on testosterone (Excluding Oxandrolone)
2012	1	4	0
2013	2	5	0
2014	2	2	0
2015	2	6	0
2016	0	4	1
2017	19	20	14
2018	39	48	41
2019	44	65	56
2020	61	79	71
2021	114	139	121

EXHIBIT
173

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

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

Exhibit 13

Plaintiffs,

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

v.

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

Defendants.

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

DOCUMENT REQUESTS

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

SUPPLEMENTAL RESPONSE:

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

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 3rd day of February, 2022, a true and exact copy of **DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES' THIRD SUPPLEMENTAL RESPONSES TO PLAINTIFFS' SECOND SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS** was served on counsel via electronic means as follows:

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Caleb B. David, Esquire (WVSB #12732)
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson,
individually and on behalf of all others
similarly situated,

Plaintiffs,

Exhibit
14

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

v.

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

Defendants.

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

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

SUPPLEMENTAL RESPONSE: Without waiving prior objections, and in addition to the individuals previously disclosed, these defendants state as follows:

Cynthia Beane, Commissioner for the Bureau for Medical Services;

Sarah Young, Deputy Commissioner for Policy Coordination and Operations; and

Brian Thompson, Director of Pharmacy Services

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

By counsel

/s/Kimberly M. Bandy
Lou Ann S. Cyrus, Esq. (WVSB #6558)
Roberta F. Green, Esq. (WVSB #6598)
Caleb B. David, Esq. (WVSB #12732)
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN,
SHAWN ANDERSON,
a/k/a Shauntae Anderson,
individually and on behalf of all others
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Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 25th day of March, 2022, a true and exact copy of ***Defendants' Second Supplemental Response To Plaintiff's First Set Of Interrogatories To Defendants William Crouch, Cynthia Beane, And West Virginia Department Of Health And Human Resources, Bureau For Medical Services*** was served on counsel via electronic means as follows:

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

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

Plaintiffs,

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

v.

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

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

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

   RESPONSE: Objection. All persons having "knowledge of" any exclusion is overly broad and burdensome and could entail countless people inside and outside of the Defendant WVDHHR. Knowledge of the creation of any exclusion by the individual Managed Care Organizations, as well as review and maintenance of any such exclusion, would be with the individual MCOs.

Without waiving these objections, the following individuals have been involved in the process of determining whether coverage is excluded:

Dr. James Becker, Medical Director, West Virginia Bureau for Medical Services

Jennifer J. Myers, Director of Professional Services, Bureau for Medical Services

Tanya Cyrus, Chief Quality and Integrity Officer, Bureau for Medical Services

Carrie Mallory, Program Manager, Bureau for Medical Services

Karen Burgess, Certified Coder, Office of Program Integrity

Cynthia Shelton, former Director of Operations, Bureau for Medical Services.

2. Describe in detail the factual basis for each governmental interest that Defendants contend supports the Exclusion.

RESPONSE: These Defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations.

3. Identify and describe in detail every instance in which a Health Plan offered through West Virginia's Medicaid Program provides partial or full coverage for Gender-Confirming Care of any kind, including but not limited to counseling and/or therapy, hormone therapy, or surgery. Include in you answer the coverage criteria for such care and the date such coverage began.

RESPONSE: Objection. This question seeking "every instance" is overly broad and burdensome. Without waiving the objection, with respect to any gender-confirming care that it is requested through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs regarding any care requested through them.

Upon information and belief, counseling is a covered service. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason.

To the extent that this Request includes hormone therapy, these defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed.

Further, without waiving the objection, with regard to hormone therapy, these Defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender-confirming care.

With respect to pharmacy services, please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

4. Identify all conditions, diagnostic codes, or instances where coverage for hormone therapy is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    a. Diagnostic code(s);
    b. Procedure code(s);
    c. Medical necessity criteria.

RESPONSE: These defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed. Without waiving this objection please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

5. Identify all conditions, diagnostic codes, or instances where coverage for mastectomy, breast reduction surgery, and chest reconstruction surgery is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    d. Diagnostic code(s);
    e. Procedure code(s);
    f. Medical necessity criteria.

RESPONSE: With respect to any such care requested or provided through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs.

Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

6. Describe in detail the factual basis for the decision to no longer exclude coverage for hormone therapy as treatment for gender dysphoria in the Health Plans offered through West Virginia's Medicaid Program.

RESPONSE: Upon information and belief, in or around 2017 it came to the attention of then-Pharmacy Director that claims were being denied based on gender edits that were in place for estrogen and testosterone containing products. After consulting with the Medical Director, a decision was made to remove the gender edits so that the hormone therapy would not be denied on the basis of gender.

7. Identify all persons, including but not limited to persons affiliated with the Rational Drug Therapy Program, who have been involved in the decision to provide coverage for hormone therapy as treatment for gender dysphoria.

RESPONSE: Upon information and belief, former Pharmacy Director Vicki Cunningham and Medical Director Dr. James Becker were involved in removal of the gender edit.

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

By counsel

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'SFIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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

Exhibit 16

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

Plaintiffs,

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

v.

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

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

INTERROGATORIES

1. Identify all persons with involvement in, or knowledge of, the creation, review, and maintenance of the Exclusion of coverage for Gender-Confirming Care in the Health Plans offered through West Virginia's Medicaid Program.

   RESPONSE: Objection. All persons having "knowledge of" any exclusion is overly broad and burdensome and could entail countless people inside and outside of the Defendant WVDHHR. Knowledge of the creation of any exclusion by the individual Managed Care Organizations, as well as review and maintenance of any such exclusion, would be with the individual MCOs.

Without waiving these objections, the following individuals have been involved in the process of determining whether coverage is excluded:

Dr. James Becker, Medical Director, West Virginia Bureau for Medical Services

Jennifer J. Myers, Director of Professional Services, Bureau for Medical Services

Tanya Cyrus, Chief Quality and Integrity Officer, Bureau for Medical Services

Carrie Mallory, Program Manager, Bureau for Medical Services

Karen Burgess, Certified Coder, Office of Program Integrity

Cynthia Shelton, former Director of Operations, Bureau for Medical Services.

2. Describe in detail the factual basis for each governmental interest that Defendants contend supports the Exclusion.

RESPONSE: These Defendants state that they provide coverage that is mandated for coverage by the Centers for Medicare and Medicaid Services (CMS). These defendants are constrained by budgetary/cost considerations.

3. Identify and describe in detail every instance in which a Health Plan offered through West Virginia's Medicaid Program provides partial or full coverage for Gender-Confirming Care of any kind, including but not limited to counseling and/or therapy, hormone therapy, or surgery. Include in you answer the coverage criteria for such care and the date such coverage began.

RESPONSE: Objection. This question seeking "every instance" is overly broad and burdensome. Without waiving the objection, with respect to any gender-confirming care that it is requested through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs regarding any care requested through them.

Upon information and belief, counseling is a covered service. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason.

To the extent that this Request includes hormone therapy, these defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed.

Further, without waiving the objection, with regard to hormone therapy, these Defendants do not have a database where they keep track of the information in the manner requested. The data is not kept in a manner which would allow them to identify which patients have requested hormone therapy for gender confirming care. Information is tracked by the medication or drug requested, not the diagnosis or reason for the request. Upon information and belief, there are no gender edits for most estrogen and testosterone containing products, so coverage would not be denied on the basis that the hormone therapy was sought as part of gender-confirming care.

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https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

4. Identify all conditions, diagnostic codes, or instances where coverage for hormone therapy is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    a. Diagnostic code(s);
    b. Procedure code(s);
    c. Medical necessity criteria.

RESPONSE: These defendants object to this question on the basis it is not calculated to lead to the discovery of admissible evidence due to the fact the Plaintiff's claim regarding hormones has been voluntarily dismissed. Without waiving this objection please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

5. Identify all conditions, diagnostic codes, or instances where coverage for mastectomy, breast reduction surgery, and chest reconstruction surgery is available under the Health Plans offered through West Virginia's Medicaid Program. Include in that identification:
    d. Diagnostic code(s);
    e. Procedure code(s);
    f. Medical necessity criteria.

RESPONSE: With respect to any such care requested or provided through the Managed Care Organizations, these Defendants are not in possession of this information. This question would best be directed to the individual MCOs.

Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

6. Describe in detail the factual basis for the decision to no longer exclude coverage for hormone therapy as treatment for gender dysphoria in the Health Plans offered through West Virginia's Medicaid Program.

RESPONSE: Upon information and belief, in or around 2017 it came to the attention of then-Pharmacy Director that claims were being denied based on gender edits that were in place for estrogen and testosterone containing products. After consulting with the Medical Director, a decision was made to remove the gender edits so that the hormone therapy would not be denied on the basis of gender.

7. Identify all persons, including but not limited to persons affiliated with the Rational Drug Therapy Program, who have been involved in the decision to provide coverage for hormone therapy as treatment for gender dysphoria.

RESPONSE: Upon information and belief, former Pharmacy Director Vicki Cunningham and Medical Director Dr. James Becker were involved in removal of the gender edit.

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

By counsel

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'SFIRST SET OF INTERROGATORIES TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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

Exhibit 19

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

Plaintiffs,

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

v.

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

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

DOCUMENT REQUESTS

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

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

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

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

SUPPLEMENTAL RESPONSE:

Please see documents obtained from Unicare regarding plaintiff, Christopher Fain which include an Excel Spreadsheet, marked as Exhibit 93, Bates No. DHHRBMS016080, and documents marked as Exhibit 94, Bates No. DHHRBMS016081 -016177. Please note, two Excel Spreadsheets were provided by Unicare that contained PHI for other participants which could not be redacted, and therefore, it is not being provided. The spreadsheets are titled, "West Virginia Member Claims—01/01/2016 through Current, Diagnosis F640 through F649 in any position" identified as "102721_Gender Dysphoria claims," and "West Virginia Member Claims—01/01/2016 through Current, Diagnosis F640 through F649 in any position" identified as "102721_Gender Dysphoria claim lines." This information can be obtained by Plaintiffs directly from Unicare.

3. Taking necessary steps to comply with applicable privacy laws and making all necessary

redactions to protect any personal health information. Documents in electronic, delimited, and importable format (e.g., excel spreadsheet) sufficient to show number of individuals who have requested coverage for Gender-Confirming Care, the number of claims each individual has made for Gender-Confirming Care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the Exclusion.

SUPPLEMENTAL RESPONSE:

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

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

SUPPLEMENTAL RESPONSE: Please see information and communications from CMS regarding mandatory coverage, which does not include gender-confirming care, marked as Exhibit 96, Bates No. DHHRBMS016179 - 016223.

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

By counsel

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 3rd day of February, 2022, a true and exact copy of **DEFENDANTS FIFTH SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 19-003

Re: Changes to Modified Adjusted Gross Income (MAGI)-based Income Methodologies

Exhibit 20

August 22, 2019

Dear State Health Official:

The purpose of this letter is to provide guidance to explain several legislative changes to the modified adjusted gross income (MAGI)-based methodologies used for determining Medicaid and CHIP eligibility. These changes stem from the following pieces of legislation: the Tax Cuts and Jobs Act (Pub. L. No. 115-97, "TCJA"), enacted on December 22, 2017; the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123, "BBA of 2018"), enacted on February 9, 2018; and the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (Pub. L. No. 115-120, "HEALTHY KIDS Act"), enacted on January 22, 2018. This guidance provides states with information on how to implement these legislative requirements, consistent with titles XIX and XXI of the Social Security Act ("Act"), for individuals whose financial eligibility is determined using MAGI-based methodologies.

Background

Section 1902(e)(14) of the Act requires that state Medicaid agencies generally use "modified adjusted gross income" and "household income," as defined at section 36B(d)(2) of the Internal Revenue Code of 1986 (the IRC) to determine Medicaid eligibility. Section 2107(e)(1)(H) of the Act requires that MAGI and household income also be used to determine eligibility for the Children's Health Insurance Program (CHIP). For purposes of Medicaid and CHIP eligibility, we refer to these definitions collectively as "MAGI-based methodologies." MAGI-based methodologies for Medicaid and CHIP are implemented in the regulations at 42 CFR 435.603 and 457.315, respectively.[1]

In general, the calculation of MAGI-based income includes all taxable earned and unearned income minus certain expenses such as student loan interest or IRA contributions that are deductible in determining an individual's adjusted gross income (AGI) for federal income tax purposes. Three items must be added to adjusted gross income to determine an individual's MAGI (i.e., *modified* AGI): non-taxable foreign earned income, tax-free interest, and non-taxable Social Security benefits. There are a few discrete ways in which MAGI-based

[1] Certain individuals are exempt from application of MAGI-based financial methodologies. Generally, these include individuals whose eligibility is being determined on the basis of being age 65 or older, living with a disability or blindness or needing long-term services and supports; and individuals for whom the state does not apply an income test. A more detailed description of individuals for whom MAGI-based methodologies do not apply can be found in regulations at 42 CFR 435.603(j).

EXHIBIT 96

methodologies used for Medicaid and CHIP differ from the definition of MAGI and household income in the IRC. For example, MAGI-based methodologies for treatment of irregular income received as a lump sum is different than the treatment of lump sum income under section 36B of the IRC. These differences are set forth in regulations at 42 CFR 435.603(e).

Identifying the members of an individual's household is important to determine the individual's total household income and family size. Under 42 CFR 435.603(f), for individuals intending to file a tax return as well as the individuals they claim as tax dependents, the MAGI-based household generally consists of the tax filer and his or her tax dependents. For individuals who are not tax filers or tax dependents, "non-filer" rules set forth in 42 CFR 435.603(f)(3) are used to determine the MAGI-based household. Under the non-filer rules, an individual's household generally consists of the family members, if living with the individual: the individual; the individual's spouse, if married; the individual's children (including step children); and, if the individual is a child, his/her parent(s) and sibling(s). The non-filer rules also are used for children and tax dependents in certain living situations, as described in 42 CFR 435.603(f)(2)(i)-(iii).

Once the composition of an individual's household has been established, additional rules are applied to determine whose income is counted in household income. Generally, the income of a tax dependent in a household is not counted unless it is expected that the dependent will be required to file a federal tax return – i.e., the income of the dependent is at or above the tax-filing thresholds for tax dependents under the IRC. Under regulations at 42 CFR 435.603(d)(2), the income of children in non-filing households also generally is excluded from household income unless a child's income meets the federal tax filing threshold.[2]

The TCJA, the BBA of 2018 and the HEALTHY KIDS Act each amended the Act as well as tax rules under the IRC in several ways, which impact the MAGI-based methodologies for Medicaid and CHIP. The following discussion explains the changes brought about by these new laws.

Changes to Tax Filing Thresholds

In 2017, a single tax dependent under age 65 and not blind met the federal tax filing threshold if he or she had $6,350 or more of gross income or $1,050 or more of unearned income. Gross income includes both earned and unearned income. This meant that, generally, for a child with unearned income below $1,050 and gross income below $6,350, none of the child's income would be included in determining household income. In contrast, all of the income of a child with unearned income equal to or greater than $1,050 or total gross income equal to or greater than $6,350 generally would be counted in household income.

[2] Under MAGI-based methods, a child's income is always counted when the child is the only person in his/her MAGI-based household (or is living with his/her sibling(s)), regardless of whether or not the child's income exceeds the filing threshold. For example, the child's income is counted in the case of a child living with his or her grandparent(s) and neither parent is living with them nor claiming the child as a tax dependent. 42 CFR 435.603(d)(1)

The TCJA modified the tax filing threshold for most individuals. For tax year 2018, single tax dependents who are under age 65 and not blind must file a federal tax return if any of the following apply for the tax year:[3]

1. Unearned income is more than $1,050;
2. Earned income is more than $12,000;
3. Gross income is more than the larger of –
    a. $1,050; or
    b. Earned income (up to $11,650) plus $350.

Further, the filing threshold is increased for tax dependents who are age 65 or older or who are blind. For tax year 2018, single tax dependents who are age 65 or older and/or who are blind must file a federal tax return if any of the following apply for the tax year:

1. Unearned income is more than $2,650 ($4,250 if 65 or older and blind);
2. Earned income is more than $13,600 ($15,200 if 65 or older and blind);
3. Gross income is more than the larger of –
    a. $2,650 ($4,250 if 65 or older and blind); or
    b. Earned income (up to $11,650) plus $1,950 ($3,550 if 65 or older and blind).

Attachment A includes a table comparing the 2017 and 2018 tax filing thresholds. The IRS updates the standard deduction and filing thresholds annually for inflation.

Impact on Household Composition

For years prior to 2018, tax filers were allowed a deduction for each of their personal exemptions, including their tax dependents. The TCJA reduced the personal exemption deduction amount to $0 for tax years 2018 through 2025, meaning that tax filers will no longer claim a deduction for their tax dependents on their federal tax return. Although taxpayers will no longer claim personal exemption deductions, they must still claim their dependents on their tax return by putting the name and Social Security Number of the dependent on the return to be eligible for certain tax benefits such as the dependent care credit and the premium tax credit for the child's health insurance coverage. Claiming dependents also remains relevant for determining household composition under the MAGI-based methodologies used by Medicaid and CHIP. Thus, there is no change to the rules governing household composition under 42 CFR 435.603(f) for purposes of making MAGI-based eligibility determinations.[4]

Changes to Countable Income

In addition to the changes noted above, the BBA of 2018 and TCJA made several changes to the taxability of certain items, which similarly impact MAGI-based methodologies.

[3] See IRS Publication 501, Table 2. https://www.irs.gov/pub/irs-pdf/p501.pdf.
[4] See: https://www.irs.gov/pub/irs-drop/n-18-84.pdf.

Counting of Qualified Lottery and Gambling Winnings in MAGI-based Methods

Under 42 CFR 435.603(e)(1) of the current regulations describing the MAGI-based methodologies, non-recurring income received as a lump sum is generally counted (if it is taxable) as income only in the month received; if not spent, the money converts to savings, which is a resource.[5] Section 53103 of the BBA of 2018 supersedes this regulatory rule in the case of "qualified lottery winnings" and "qualified lump sum income" (i.e., gambling) of $80,000 or greater. Specifically, section 53103, which added paragraph (K) to section 1902(e)(14) of the Act, requires that covered lottery and gambling winnings of $80,000 or greater, which are received in a single payout, be counted not only in the month received, but over a period of up to 120 months. The statute provides a formula for determining this period, depending on the amount of the winnings. States must apply this formula to qualified lottery or gambling winnings received beginning on or after January 1, 2018.

Qualified Lottery Winnings. Under section 1902(e)(14)(K)(v) of the Act, the term "qualified lottery winnings" is defined as "winnings from a sweepstakes, lottery, or pool" described in section 4402 of the IRC (which generally requires that these particular activities be conducted by a state agency or under the authority of state law), or winnings from "a lottery operated by a multistate or multijurisdictional lottery association." Multijurisdictional lotteries include those that include multiple entities of government.

While lottery winners generally have a choice between receiving a single payment or an annuity that pays out in installments over a period of time (often in annual payments over 20 or 30 years), the definition of "qualified lottery winnings" in section 1902(e)(14)(K)(v) by its own terms applies to the single payout option. Lottery winnings paid out in installments are not required to be considered "qualified lottery winnings" under the statute, and we do not think that interpreting the term to include such winnings would be consistent with the purpose of the statute. In our analysis of the potential impact of the formula for qualified lottery winnings on an annuity paid in installments, we found through many permutations of winnings that some individuals could have winnings counted for a shorter time and others for a longer time under the formula as compared to existing MAGI-based income counting. Due to the complexity of various lotteries, payment amounts and scenarios, and in the absence of rulemaking to implement this law, at this time we are not interpreting the definition of "qualified lottery winnings" beyond the plain language of the statute. Therefore, lottery winnings paid out in installments would be treated the same as other types of recurring income under 42 CFR 435.603(e).[6]

With respect to non-cash prizes, like a car or boat, the statute does not clearly specify whether such prizes are considered "qualified lottery winnings" under section 1902(e)(14)(K)(v) of the Act. As an example, the winner of a sweepstakes may be awarded a boat, which is appraised at a value of $110,000. Unlike a cash prize, however, a non-cash prize like the boat will begin to depreciate immediately. Depending on the length of time that elapses between receipt and sale

[5] There is one exception to this rule in the case of beneficiaries who receive lump sum income in a state that has elected the option to use projected annual household income for current beneficiaries under 42 CFR 435.603(h)(2).
[6] To address the fluctuations in monthly income of a lottery winner receiving annual annuity payments, under MAGI-based rules at 42 CFR 435.603(h)(3), states currently may elect an option to account for "reasonably predictable future income" by prorating lottery payments over a 12-month period to determine an average current monthly income for Medicaid and CHIP.

of the item, the fair market value could be considerably less than the original appraised value. Therefore, we believe that non-cash prizes should continue to be counted as lump sum income in the month in which they are received and not counted as "qualified lottery winnings".

Qualified Lump Sum Income. Section 1902(e)(14)(K)(vi) of the Act defines "qualified lump sum income" as "income that is received as a lump sum from monetary winnings from gambling." Under this statute, the Secretary has discretion to define "gambling," except that the activities described in 18 U.S.C 1955(b)(4) must be included in the definition. These activities include: betting pools; wagers placed through bookmakers; slot machines; roulette wheels; dice tables; lotteries; and bolita or numbers games, or the selling of chances therein. The Secretary will consider other activities proposed by one or more states to be included in the definition of gambling. Absent a determination by the Secretary that inclusion of other activities in the definition of gambling is appropriate, states may not include any other activities. Because the statute specifically defines qualified lump sum income as "*monetary* winnings from gambling" (emphasis added), non-cash prizes are not counted as qualified lump sum income for the purposes of section 1902(e)(14)(K) of the Act

Formula for Counting Qualified Winnings. For qualified winnings from lotteries or gambling activities occurring on or after January 1, 2018, states must count the winnings according to the following formula:

Winnings less than $80,000 are counted in the month received;

- Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and
- For every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income.

The maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. A table showing the amount of monthly income attributed to increasing amounts of qualified winnings and the number of months over which the winnings is counted appears in Attachment B.

Treatment of Winnings for Other Household Members. Under section 53103(b)(2) of the BBA of 2018, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individuals receiving the winnings. The determination of household income for other members of the individual's household are not affected. Thus, for example, the total amount of qualified lottery or gambling winnings of a spouse or parent continues to count only in the month received in determining the eligibility of the other spouse and children.

Verification of lottery and gambling winnings. Under regulations at 42 CFR 435.940 through 435.952 and 457.380, states may accept self-attestation or require other verification of lottery and gambling winnings. If a state requires other verification, per regulations at 42 CFR 435.952(c), the agency must first access available electronic data sources (such as a state lottery winner database, if available) and may accept self-attestation of lottery and gambling winnings before requesting documentation from the individual.

Hardship exemption. Section 1902(e)(14)(K)(iii) of the Act requires that states establish an "undue medical or financial hardship" exemption, through a procedure and based on a standard established by the state, in accordance with guidance provided by the Secretary, for individuals impacted by the new treatment of lottery and gambling winnings. Pending further guidance from the Secretary, states should develop a procedure and establish a reasonable standard for this hardship exemption.

State responsibilities to ineligible applicants and beneficiaries. Applicants and beneficiaries affected by the counting of lottery or gambling winnings maintain the ability to request a determination on a non-MAGI basis, as described at 42 CFR 435.911. Individuals determined financially ineligible for Medicaid or CHIP due to lottery or gambling winnings also have the right to purchase health coverage through a Qualified Health Plan (QHP) on the Exchange and, if eligible, claim a premium tax credit (PTC) for such purchase. Section 1902(e)(14)(K)(iv) of the Act addresses certain state responsibilities to such applicants and beneficiaries, related to notices and technical assistance. The Act specifies that the state agency provide notice to affected individuals of the date on which the lottery or gambling winnings no longer will be counted for the purpose of Medicaid or CHIP eligibility. States also must notify affected individuals of the hardship exemption. In addition, the Act requires states to "inform the individual of the individual's opportunity to enroll in" a QHP on the Exchange, which states meet through implementation of notices regulations at 42 CFR 435.917, 435.1200(e) and 457.340(e).

Section 1902(e)(14)(K)(iv)(II) requires states to "provide technical assistance to the individual seeking to enroll in" a QHP. Consistent with coordination regulations at 42 CFR 435.1200(e) and 42 CFR 457.350(i), the state agency takes appropriate action to transfer the electronic account of an individual financially ineligible for Medicaid or CHIP to the Exchange.[7] Inasmuch as the existing account transfer procedures that states use under the coordination regulations afford individuals needed assistance and provide the opportunity to enroll in appropriate coverage, such existing procedure satisfy the requirement to provide technical assistance.

MAGI Exclusion of Parent Mentor Compensation

Section 3004 of the HEALTHY KIDS Act extended the outreach and enrollment grant program for children who are eligible for, but not enrolled in, Medicaid or CHIP. Section 2113(f)(1)(E) of the Act provides that national, state, local, or community-based public or nonprofit private organizations that use parent mentors, are eligible to receive such grants. A "parent mentor," defined in section 2113(f)(5) of the Act, is a parent or guardian of a Medicaid or CHIP-eligible child who is "trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children."

[7] Qualified lottery and gambling winnings are subject to federal income taxation in the year received. Because PTC for subsidized purchase of a QHP is based on taxable income during the tax year, if the amount of winnings results in individuals losing Medicaid or CHIP eligibility and their household income, including the lottery or gambling winnings, exceeds the income limit for PTC (400 percent of the federal poverty level (FPL)), those individuals will not qualify for a subsidized health plan for the year in which the winnings are received. However, because section 1902(e)(14)(K) of the Act applies only to MAGI-based methods for Medicaid and CHIP, such winnings will not be counted in subsequent years for purposes of eligibility for the PTC for purchase of coverage through the Exchange.

In order to protect parent mentors from losing eligibility for Medicaid, section 3004 of the HEALTHY KIDS Act amends section 1902(e)(14) of the Act to exclude parent mentor compensation from their MAGI-based household income. New paragraph (J) provides that "[a]ny nominal amount received by an individual as compensation, including a stipend, for participation as a parent mentor" in a grant-funded program under section 2113 of the Act "shall be disregarded for purposes of determining income eligibility of such individual for medical assistance." The disregard of parent mentor income applies only in the case of parent mentors working with a grantee organization under section 2113 of the Act.

Nominal amounts paid as a stipend to a parent mentor are excluded from income. For payments received as wages or other compensation, states have discretion to determine the threshold of a "nominal amount." CMS will alert states if a grant is awarded under section 2113 of the Act in which the grantee plans to use parent mentors. We will be available to work with those states and grantees to establish a process for applicants and beneficiaries to identify parent mentor income that is not counted in determining eligibility under section 1902(e)(14)(J) of the Act.

Alimony Received

Prior to enactment of the TCJA, alimony as defined in IRC section 71 was considered taxable income to the recipient. Section 11051 of the TCJA modified the alimony rules. Under the TCJA, alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not included in the income of the recipient. For individuals with alimony agreements finalized on or before December 31, 2018, alimony continues to be included in the income of the recipient for the duration of the agreement unless or until the agreement is modified. Treatment of alimony paid is discussed below. The treatment of child support is unchanged: child support is not included in the income of the recipient and thus not counted in MAGI-based income.

Discharged Student Loan Debt

Student loan debt that is discharged, forgiven or cancelled is generally treated as taxable income to the borrower, and therefore the amount of discharged debt is included in MAGI-based income.[8] However, section 11031 of the TCJA amended section 108(f) of the IRC to provide an exception for tax years 2018 through 2025 in cases of discharged debt on account of the death or permanent and total disability of the student. Under the amendment, discharged student loan debt is not included in income (and not counted in the MAGI-based income) of a borrower if the debt is discharged on account of the death or the permanent and total disability of the student. (The borrower and the student may or may not be the same person.) Student loan debt discharged under the foregoing circumstances is not counted as income in determining household income for other members of the borrower's household.

Changes to Deductions

[8] A notable exception is the Public Service Loan Forgiveness program and certain teacher loan/healthcare loan forgiveness programs, which do not lead to taxable income (26 USC 108(f)(1)).

As noted above, certain deductions are allowed under the IRC in determining adjusted gross income, upon which MAGI is based. The TCJA eliminated several of these deductions.

Moving Expenses

Section 11049 of the TCJA, amending section 217 of the IRC, eliminated the deduction for qualified moving expenses for tax years 2018 through 2025. Moving expenses, including expenses incurred by the individual as well as reimbursements from an employer, should no longer be deducted in calculating MAGI. This change does not apply to active duty members of the military who are ordered to move or change duty station.

Alimony Paid

Under the TCJA, alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not deductible by the payer. For individuals with alimony agreements finalized on or before December 31, 2018, alimony payments continue to be deductible. Child support payments remain non-deductible.

Tuition and Fees Deduction

The payment of tuition and fees for qualified education expenses for postsecondary education had been an allowable deduction. Amounts paid for these expenses for the taxpayer, spouse or tax dependent typically could be deducted in computing adjusted gross income. Section 40203 of the BBA of 2018 amended section 222(e) of the IRC to eliminate this deduction, effective January 1, 2018. Such tuition and fees paid are no longer deductible in calculating MAGI, effective January 1, 2018.

The tuition and fees deduction is separate and distinct from the exclusion of scholarships, awards or fellowships used solely for educational purposes from MAGI for purposes of Medicaid and CHIP eligibility. This exclusion, which also applies for determining MAGI under the IRC, remains in effect under the Medicaid regulations at 42 CFR 435.603(e)(2) and CHIP regulations at 42 CFR 457.315.

State Requirement to Report Enrollment in MEC

Under Section 6055 of the IRC, states are required to provide Medicaid and CHIP beneficiaries with IRS Form 1095-B, indicating that the beneficiary had minimum essential coverage (MEC) for the tax year. States also must provide this information to the IRS. Under section 5000A of the IRC, individuals not enrolled in MEC and not exempt are subject to a "shared responsibility payment." The TCJA reduced the shared responsibility payment to $0 beginning in tax year 2019. However, it did not eliminate the requirement for states to furnish Form 1095-B or to provide information about Medicaid and CHIP enrollment to IRS. Therefore, states must continue to send Forms 1095-B for Medicaid and CHIP coverage for tax year 2019 and beyond. If there is any change to these reporting requirements, CMS will communicate the changes to states.

Operational Considerations

In order to implement the changes to MAGI-based methods described in this letter, states may need to make updates to eligibility policies and procedures and changes to eligibility systems logic. In addition, states will need to be able to collect the relevant application information in order to make accurate Medicaid and CHIP determinations. Capturing the information may involve changes to applications and other forms, additional instructions or help text, or new application questions. In order to implement needed systems changes, and in accordance with 42 CFR 433.112(b)(14), states may request enhanced 90 percent federal financial participation for eligibility technology investments funded through an approved Advanced Planning Document. CMS remains available to provide technical assistance to states on implementation of such changes to ensure that states are able to make the changes as soon as possible.

We hope this information will be helpful. Questions and comments about the changes to MAGI-based methodologies discussed in this bulletin may be directed to Stephanie Kaminsky, Director, Division of Medicaid Eligibility Policy, CMCS, at Stephanie.Kaminsky@cms.hhs.gov. Requests for technical assistance on revisions to the state's application and renewal processes needed to implement the changes to MAGI-based methodologies may be directed to Jessica Stephens, Director, Division of Enrollment Policy and Operations, CMCS, at Jessica.Stephens@cms.hhs.gov.

Sincerely,

Calder Lynch
Deputy Administrator and Director

Enclosures

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

Attachment A –
Tax Filing Thresholds

	2017 Tax Filing Thresholds	2018 Tax Filing Thresholds
Personal Exemption Amount	$4,050[9]	$0
Standard Deduction for most people[10]	$6,350 (gross) - single	$12,000 (gross) - single[11]
Tax filing threshold for single tax dependent[12]	$1,050 unearned; or $6,350 earned; or Gross income is more than the larger of: • $1,050; or • Earned income (up to $6,000) plus $350	$1,050 unearned; or $12,000 earned; or Gross income is more than the larger of: • $1,050; or • Earned income (up to $11,650) plus $350
Tax dependents > 65 or blind	$2,600 unearned; or $7,900 earned; or Gross income is more than the larger of: • $2,600; or • Earned (up to $6,000) plus $1,900	$2,650 unearned; or $13,600 earned; or Gross income is more than the larger of: • $2,650; or • Earned income (up to $11,650) plus $1,950
Tax dependent > 65 and blind	$4,150 unearned; or $9,450 earned; or Gross income is more than the larger of: • $4,150; or • Earned (up to $6,000) plus $3,450	$15,200 earned $4,250 unearned income Gross income is more than the larger of: • $4,250; or • Earned income (up to $11,650) plus $3,550

[9] See IRS Pub 17, Chapter 3; and Pub 501.
[10] For individuals who are under age 65, not blind, not head of household and no one else can claim individual as a dependent. See IRS Pub 17, Table 20-1 (2017) and Table 21-1 (2018); and IRS Pub 501, Table 6.
[11] To be increased annually for inflation. See Internal Revenue Bulletin 2018-10 (March 5, 2018).
[12] For individuals under age 65 and not blind. See IRS Pub 501, Table 2.

Attachment B –
Lottery and Gambling Winnings:
Months over which Income is Counted by Income Increment

From $	Up To $	# Months Counted for Medicaid
1	79,999	1
80,000	89,999	2
90,000	99,999	3
100,000	109,999	4
110,000	119,999	5
120,000	129,999	6
130,000	139,999	7
140,000	149,999	8
150,000	159,999	9
160,000	169,999	10
170,000	179,999	11
180,000	189,999	12
190,000	199,999	13
200,000	209,999	14
210,000	219,999	15
220,000	229,999	16
230,000	239,999	17
240,000	249,999	18
250,000	259,999	19
260,000	269,999	20
270,000	279,999	21
280,000	289,999	22
290,000	299,999	23
300,000	309,999	24
310,000	319,999	25
320,000	329,999	26
330,000	339,999	27
340,000	349,999	28
350,000	359,999	29
360,000	369,999	30
370,000	379,999	31
380,000	389,999	32
390,000	399,999	33
400,000	409,999	34
410,000	419,999	35

From $	Up To $	# Months Counted for Medicaid
420,000	429,999	36
430,000	439,999	37
440,000	449,999	38
450,000	459,999	39
460,000	469,999	40
470,000	479,999	41
480,000	489,999	42
490,000	499,999	43
500,000	509,999	44
510,000	519,999	45
520,000	529,999	46
530,000	539,999	47
540,000	549,999	48
550,000	559,999	49
560,000	569,999	50
570,000	579,999	51
580,000	589,999	52
590,000	599,999	53
600,000	609,999	54
610,000	619,999	55
620,000	629,999	56
630,000	639,999	57
640,000	649,999	58
650,000	659,999	59
660,000	669,999	60
670,000	679,999	61
680,000	689,999	62
690,000	699,999	63
700,000	709,999	64
710,000	719,999	65
720,000	729,999	66
730,000	739,999	67
740,000	749,999	68
750,000	759,999	69
760,000	769,999	70

From $	Up To $	# Months Counted for Medicaid
770,000	779,999	71
780,000	789,999	72
790,000	799,999	73
800,000	809,999	74
810,000	819,999	75
820,000	829,999	76
830,000	839,999	77
840,000	849,999	78
850,000	859,999	79
860,000	869,999	80
870,000	879,999	81
880,000	889,999	82
890,000	899,999	83
900,000	909,999	84
910,000	919,999	85
920,000	929,999	86
930,000	939,999	87
940,000	949,999	88
950,000	959,999	89
960,000	969,999	90
970,000	979,999	91
980,000	989,999	92
990,000	999,999	93
1,000,000	1,009,999	94
1,010,000	1,019,999	95
1,020,000	1,029,999	96
1,030,000	1,039,999	97

From $	Up To $	# Months Counted for Medicaid
1,040,000	1,049,999	98
1,050,000	1,059,999	99
1,060,000	1,069,999	100
1,070,000	1,079,999	101
1,080,000	1,089,999	102
1,090,000	1,099,999	103
1,100,000	1,109,999	104
1,110,000	1,119,999	105
1,120,000	1,129,999	106
1,130,000	1,139,999	107
1,140,000	1,149,999	108
1,150,000	1,159,999	109
1,160,000	1,169,999	110
1,170,000	1,179,999	111
1,180,000	1,189,999	112
1,190,000	1,199,999	113
1,200,000	1,209,999	114
1,210,000	1,219,999	115
1,220,000	1,229,999	116
1,230,000	1,239,999	117
1,240,000	1,249,999	118
1,250,000	1,259,999	119
1,260,000	or higher	120

Attachment C –
Frequently Asked Questions:
Changes to Modified Adjusted Gross Income (MAGI)-based Income Methodologies

Lottery and Gambling Winnings

Q1. Can you provide some examples of how lottery and gambling winnings would impact individual applicants and beneficiaries?

A1. Consider the following examples:

1. Sally is enrolled in Medicaid with MAGI-based household income of $1,200 per month. She is single and has no dependents. On New Year's Eve 2018, Sally wins $192,000 playing roulette. How do Sally's gambling winnings impact her MAGI-based income and eligibility for Medicaid?
    a. Using the chart in Attachment B, we see that Sally's winnings of $192,000 are counted in her MAGI-based income for 13 months, including the month in which she receives the winnings. So they are counted in December 2018 through December 2019.
    b. An equal amount of $14,769 is counted in each month ($192,000/13 months = $14,769 per month).
    c. Sally's MAGI-based monthly income for December 2018 through December 2019 is $15,969 ($14,769 gambling winnings + $1,200 other MAGI-based income) assuming no changes to her other MAGI-based income.
    d. Because Sally's income exceeds the state's MAGI-based income standard, the agency would provide Sally with a notice alerting her that she is no longer eligible for Medicaid and her coverage will be terminated following the advance notice period. The notice will also tell Sally that beginning January 1, 2020, her gambling winnings will no longer be counted in her MAGI-based income.
    e. The Medicaid agency will transfer Sally's account to the Exchange. Because she is losing eligibility for Medicaid, she qualifies for a special enrollment period and the Exchange will determine if she is eligible for advanced payments of the premium tax credit.

2. Joe is a single individual who has no dependents. He earns $700 per month and has no other income or deductions. Joe wins a scratch-off ticket paying out $50,000 on May 15, 2019. The following month, Joe applies for Medicaid. How do his lottery winnings impact his MAGI-based income and eligibility for Medicaid?
    a. Using the chart in Attachment B, we see that Joe's lottery winnings are counted in MAGI-based methods for only one month. Because his winnings are less than $80,000, they are counted only in the month received. So the full amount of $50,000 is counted in May of 2019.
    b. When Joe applies for Medicaid in June, his MAGI-based income will be $700 and that will be used to determine his financial eligibility for Medicaid.

Q2. How do lottery and gambling winnings received by parents impact their children's eligibility for Medicaid?

A2. The changes to section 1902(e)(14) of the Act made by the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123, "BBA of 2018") only impact the MAGI-based household income of the individuals who themselves receive the lottery or gambling winnings. Therefore, when determining Medicaid eligibility for a child who lives with a parent, the parent's qualified lottery or gambling winnings would be treated the same as any other lump sum income received and included in the child's MAGI-based income only in the month received, as described at 42 CFR 435.603(e)(1). Consider the following example.

Justine is a single parent who lives with her son, Oscar, who is age 7. Justine and Oscar have monthly MAGI-based income of $2,000 from Justine's job. On April 14, 2019, Justine submits a Medicaid application for Oscar. The following week Justine wins the state lottery and receives a lump sum payment of $755,000. How do Justine's lottery winnings impact Oscar's MAGI-based income and eligibility for Medicaid?

For the month of April, Oscar's MAGI-based household income will be calculated as $755,000 in lottery winnings, plus $2,000 in the other MAGI-based income, for a total monthly income of $757,000 for a family of two. For the month of May, Oscar's MAGI-based income will be $2,000. Justine's lottery winnings would count toward Oscar's MAGI-based income only in the month of April. If Justine applies for Medicaid, using the chart in Attachment B, her winnings of $755,000 would be counted in her MAGI-based income for 69 months (or, 5 years and 9 months), beginning in the month in which she receives the winnings. That is, Justine's winnings would be counted in her MAGI-based income in April 2019 through December 2024. An equal amount of $10,942 would be counted in each month ($755,000/69 months = $10,942 per month).

Q3. Do winnings from any state count under the lottery and gambling winnings methodology?

A3. Yes. Lottery and gambling winnings are treated the same regardless of the state in which they were won. The methodology in section 1902(e)(14)(K) of the Act applies to winnings an individual receives from any state.

Q4. How are multiple instances of gambling winnings counted under the lottery and gambling winnings methodology?

A4. If a Medicaid or CHIP applicant or beneficiary wins monetary winnings from gambling multiple times, the lottery and gambling winnings methodology is applied separately to each instance of winning. Where the amount of months over which winnings are counted overlap, those months are counted concurrently (each instance beginning and ending as per the formula) and the countable income attributed to each month is added together for each month.

Q5. Are gambling losses subtracted from gambling winnings for the purposes of the lottery and gambling winnings methodology?

A5. No. Although there are circumstances in which gambling losses may be deducted from income for the purpose of federal income taxes, gambling losses are not deducted from winnings for the purposes of the lottery and gambling winnings methodology under MAGI-based income methodologies for Medicaid and CHIP.

Q6. How should the "gap-filling" rule at 42 CFR 435.603(i) apply to individuals whose income is counted under the lottery and gambling winnings methodology?

A6. The Medicaid "gap-filling" rule at 42 CFR 435.603(i), promulgated in March 2012, was designed to prevent a potential gap in coverage for low-income individuals caused by the slight differences in the MAGI methodologies used for purposes of premium tax credit (PTC) eligibility and the MAGI-based methodologies used for purposes of Medicaid and CHIP eligibility. Under the gap-filling rule, if an individual's MAGI-based monthly household income for purposes of Medicaid eligibility is above the applicable Medicaid income standard and the individual's MAGI-based annual household income for purposes of PTC eligibility is under 100 percent of the FPL (and ineligible for a PTC due to too little income) the state is required to apply the MAGI methodologies generally used for purposes of PTC eligibility in determining the individual's eligibility for Medicaid.

The different treatment of lottery and gambling winnings under the MAGI methodologies for PTC eligibility versus the MAGI-based methodologies used for Medicaid and CHIP may result in a situation in which an individual's household income for purposes of PTC eligibility in a given year will be under 100 percent FPL, but his or her income applying MAGI-based methodologies (for purposes of Medicaid and CHIP eligibility) will be over the Medicaid and CHIP eligibility thresholds. If applied in this situation, the gap filling rule would result in approval of Medicaid or CHIP eligibility in the year after receipt of the winnings. If applying the lottery and gambling methodology would result in income over the Medicaid eligibility standard, applying the gap-filling rule and determining such an individual eligible would not be consistent with the intended result under the BBA of 2018. We believe that the new statutory provision supersedes the regulatory policy in this situation. Thus, we have determined that states should not apply the gap-filling regulation at 42 CFR 435.603(i) if doing so would result in a determination contrary to the determination reached after applying the lottery and gambling methodology added at section 1902(e)(14)(K) of the Act by the BBA.

Q7. Are states required to keep a record of individuals found ineligible for a period of time due to lottery or gambling winnings?

A7. Per regulations at 42 CFR 431.17 and 435.914(a), states are required to maintain case records on each applicant and beneficiary containing, among other things, facts essential to supporting the agency's denial or termination of eligibility. States are expected to follow their standard recordkeeping protocol when an individual is denied or terminated

due to lottery or gambling winnings, including the period of time such records are maintained. States are not required to establish a separate process specific to individuals denied or terminated from coverage due to lottery or gambling winnings.

When an individual previously denied or terminated from coverage subsequently reapplies for coverage, states typically are able to identify the individual's previous application or enrollment in the state's program. Some states may have ready access to the record of the individual's prior winnings, and such states would be expected to take this information into account in processing the individual's new application. Other states may want to establish a process to maintain a record of the monthly amount of winnings of former applicants and beneficiaries to be counted as income as well as the duration for which that amount is counted.

Other Questions

Below we answer frequently asked questions which are not related to the lottery and gambling winnings methodology discussed in this letter.

Q8. Now that alimony payments are treated differently under MAGI-based methodologies depending on the date that the agreement was consummated or last revised, how can states verify the date of execution of separation or divorce agreements that include provision for alimony?

A8. Under the general verification regulations at 42 CFR 435.945(a) and 435.952(c), states have the flexibility to accept attestation of the date of the finalization or modification of a separation or divorce agreement or to require paper documentation, provided that electronic verification is not available or is inconsistent with the individual's attestation.

Q9. Does the change to the treatment of alimony affect or render obsolete the mandatory eligibility group for extended Medicaid due to increased collection of spousal support (42 CFR 435.115)?

A9. No. The discussion of including alimony in income relates only to MAGI-based methods, and not to any particular MAGI-based eligibility group. In particular, the group for extended Medicaid eligibility based on the increased collection of spousal support remains in effect as described under 42 CFR 435.115.

As noted in the SHO letter, if a separation or divorce agreement (or a modification to a pre-existing agreement) was finalized after December 31, 2018, the alimony payments under the agreement would not be counted in MAGI income and an increase would not trigger the four-month extension of Medicaid eligibility. However, if a separation or divorce agreement was finalized on or before December 31, 2018 (and is not modified thereafter), the alimony payments under the agreement must be included in the income of the recipient. In circumstances in which such alimony income meets the definition of "spousal support" under title IV-D of the Act, and the recipient has an increased collection of such support (e.g., through a scheduled increase, payment of arrears, or

through new collection on an existing support obligation) through the IV-D agency, the family may qualify for the four-month extension of Medicaid eligibility group under 42 CFR 435.115.

Spousal support that does not meet the IRS definition of alimony is not included in income and therefore an increased collection of such support would not trigger the extension under 42 CFR 435.115. The five requirements for spousal support to be alimony are:

1. Payment must be in cash;
2. Payment is received by (or on behalf of) a spouse under a divorce or separation agreement;
3. The divorce or separation instrument does not designate such payment as a payment not includable in gross income and not allowable as a deduction;
4. The payee spouse and the payer spouse are not members of the same household at the time such payment is made; and
5. There is no liability to make any such payment (in cash or property) as a substitute for such payments after the death of the payee spouse.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 20-005

RE: Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment

December 30, 2020

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance about section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. No. 115-271). To increase access to medication-assisted treatment (MAT) for opioid use disorders (OUD), section 1006(b) of the SUPPORT Act requires states to provide Medicaid coverage of certain drugs and biological products, and related counseling services and behavioral therapy.[1] This State Health Official Letter (SHO Letter) also describes available opportunities for increasing treatment options for substance use disorders (SUD) generally. CMS encourages states to consider these opportunities when implementing the mandatory MAT coverage under section 1006(b) of the SUPPORT Act. The new required benefit is limited to the use of MAT for the treatment of OUD, and thus this SHO Letter is generally focused on that topic, not on treatment services for other SUDs, including alcohol use disorders.

Background

Section 1006(b) of the SUPPORT Act, signed into law on October 24, 2018, amends section 1902(a)(10)(A) of the Social Security Act (the Act) to require state Medicaid plans to include coverage of MAT for all eligible to enroll in the state plan or waiver of state plan. Section 2601 of the Continuing Appropriations Act, 2021 and other Extensions Act, Pub. L. No. 116-159, amended the SUPPORT Act to specify that the rebate requirements in section 1927 shall apply to any MAT drug or biological described under the mandatory benefit to the extent that the MAT drug or biological is a covered outpatient drug. (More information on section 2601 is in the section below entitled, "MAT Drug Coverage and Section 1927 Manufacturer Rebates.") Section 1006(b) also adds a new paragraph 1905(a)(29) to the Act to add the new required benefit to the definition of "medical assistance" and to specify that the new required benefit will be in effect for the period beginning October 1, 2020, and ending September 30, 2025.

In addition, section 1006(b) adds section 1905(ee)(1) to the Act to define MAT, for purposes of the new required coverage, as:

> . . . all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section

[1] SUPPORT for Patients and Communities Act, Pub. L. No. 115–271 (2018), https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf.

> 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and[,] . . . with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

CMS interprets section 1905(ee)(1) of the Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. Currently, the FDA has approved the following drugs used for MAT to treat OUD: methadone, buprenorphine, and naltrexone.[2] Only those formulations of drugs or biologicals that are approved or licensed by the FDA for MAT to treat OUD must be covered under the new mandatory Medicaid benefit. There are currently no FDA-licensed biological products to treat OUD.[3]

Medication-Assisted Treatment

While states are required to cover all drugs and biologicals approved or licensed by the FDA used for MAT to treat OUD under the new mandatory benefit, various considerations affect which medication should be provided to a particular patient.[4]

- Methadone is a long-acting synthetic opioid agonist medication with a long history of use in treatment of OUD in adults. Methadone is indicated for the detoxification treatment of opioid addiction as well as maintenance treatment of opioid addiction in conjunction with appropriate social and medical services.[5]

  Methadone for treatment of OUD must be administered by an Opioid Treatment Program (OTP). Currently, solid (non-dispersible) and dispersible tablets, as well as the liquid concentrate, are labeled for use in such outpatient OUD therapy. These products cannot be dispensed from a pharmacy for the purpose of treating OUD. OTPs must have a current, valid certification from the Substance Abuse and Mental Health Services Administration (SAMHSA) and be accredited by an independent, SAMHSA-approved accrediting body.[6] Effective January 1, 2020, the Medicare program began covering and reimbursing OUD treatment services furnished by an OTP.[7]

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[2] U.S. Food and Drug Administration (FDA). Information about Medication-Assisted Treatment (MAT). FDA web site. https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat; Substance Abuse and Mental Health Services Administration (SAMHSA). Medication-Assisted Treatment. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment

[3] "Information about Medication-Assisted Treatment (MAT)," U.S. Food and Drug Administration, last modified February 14, 2019, https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat.

[4] SAMHSA. Office of the Surgeon General. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington (DC). U.S. Department of Health and Human Services. 2016 Nov. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. Available from: https://www.ncbi.nlm.nih.gov/books/NBK424859/.

[5] FDA. Dolophine Highlights of Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/006134s045lbl.pdf

[6] SAMHSA. Certification of Opioid Treatment Programs. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs.

[7] SUPPORT Act, Section 2005, Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs. See also CMCS Informational Bulletin, "Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020" (Dec. 17, 2019), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf

- Buprenorphine is a synthetic opioid medication that acts as a partial agonist, blocking and only weakly activating the opioid receptor, thus blunting the euphoric effects of other opioids for the treatment of OUD.[8]

  Buprenorphine is currently available in several dosage forms, including an oral dissolvable film, sublingual tablet, and injection. It is available as a single ingredient or in combination with naloxone, an antagonist (or blocker) of opioid receptors to prevent attempted misuse by injection. For more information on the FDA approved medications for treatment of OUDs, see SAMHSA's Treatment Improvement Protocol 63 as well as the FDA web site: https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm.[9]

  Long-acting buprenorphine injections are a route of administration that may help to improve patient adherence, may reduce the risk of accidental exposures, theft, or deliberate misuse, and may reduce risks associated with office visits during the COVID-19 pandemic.[10] Sublocade is a once-monthly injection designed to deliver buprenorphine at sustained levels of medication throughout the month.[11]

- Naltrexone is a synthetic opioid antagonist – it blocks opioids from binding to receptors and is FDA-approved for the prevention of relapse to opioid dependence, following opioid detoxification. Naltrexone is well-tolerated following detoxification. It has no potential for abuse, and it is not addictive.[12] Long-acting injectable naltrexone is FDA-approved with recommended dosing once every four weeks[13] for maintenance of abstinence.[14] Naltrexone can be prescribed by any clinician who is licensed in the state to prescribe medications.[15,16]

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[8] FDA. Subutex Highlights of Prescribing Information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020732s018lbl.pdf

[9] SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020. https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

[10] Volkow ND. Collision of the COVID-19 and Addiction Epidemics. Ann Intern Med. 2020; 173(1):61-62. doi:10.7326/M20-1212

[11] Crist, Richard C et al. Pharmacogenetics of Opioid Use Disorder Treatment. *CNS drugs*. 2018; vol. 32 (4): 305-320. doi:10.1007/s40263-018-0513-9.

[12] National Institute on Drug Abuse. (2018, January 17). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies.

[13] FDA. ReVia Highlights of Prescribing Information.https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf

[14] Tanum L, Solli KK, Latif ZE, Benth JŠ, Opheim A, Sharma-Haase K, Krajci P, Kunøe N. Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial. JAMA Psychiatry. 2017 Dec 1;74(12):1197-1205. doi: 10.1001/jamapsychiatry.2017.3206. Erratum in: JAMA Psychiatry. 2018 Mar 14;75(5):530. PMID: 29049469; PMCID: PMC6583381.

[15] SAMHSA. Naltrexone. SAMHSA website. https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone.

[16] We note that in addition to the MAT drugs listed here that are required to be covered for management of opioid dependency under the new benefit at section 1905(a)(29) of the Act, states that provide optional coverage of prescribed drugs under section 1905(a)(12) must do so consistent with sections 1902(a)(54) and 1927, which require coverage of all drugs and biologicals that satisfy the definition of a covered outpatient drug at sections 1927(k)(2)-(4), if the manufacturer has a national drug rebate agreement in effect. In that some medications not defined as MAT

To address the full scope of patients' treatment needs, section 1905(ee)(1) defines the required MAT benefit as including counseling services and behavioral therapy related to the drugs and biologicals covered under the new mandatory benefit. While states have flexibility to specify which counseling services and behavioral therapy they will include in the new mandatory benefit, states that already cover MAT successfully often cover a range of effective behavioral health services for beneficiaries with OUD receiving MAT, including the following:

- Individual/Group Therapy generally helps patients identify treatment goals and potential solutions to problems that cause emotional stress; seeks to restore communication and coping skills; strengthens self-esteem; and promotes behavior change and optimal mental health. Cognitive behavioral therapy is a type of therapy that has been shown to be successful in treating individuals with OUD.

- Peer Support Services are typically understood to be services in which a qualified peer support provider (also called a recovery coach or peer recovery support specialist) assists individuals with their recovery from substance use disorders, including OUD. Peer support services can also be offered in relation to co-occurring mental disorders and OUD. Services can include counseling on coping with symptoms and navigating early stages of the recovery process; modeling appropriate behavior, skills, and communication; engagement with a supportive community of recovering peers; and helping the person access community resources. CMS has issued guidance that addresses requirements for peer support providers.[17]

- Crisis Intervention Services are typically provided to immediately reduce or eliminate the risk of physical or emotional harm. Services can include evaluation, triage, and access to services; and treatment to effect symptom reduction, harm reduction, and/or safe transition of individuals in acute crisis to the appropriate level of care for stabilization.

MAT Provider Landscape

Section 3502 of the Drug Addiction Treatment Act of 2000[18] amended the Controlled Substances Act (CSA) to permit qualified physicians to receive a waiver of the CSA's separate registration requirements for prescribing and dispensing certain opioid medications, such as buprenorphine, to treat OUD. Because of concerns about the lack of access to OUD treatment, Congress expanded the types of practitioners who are eligible for a waiver to prescribe and dispense buprenorphine to treat OUD. The Comprehensive Addiction and Recovery Act of 2016 allowed nurse practitioners and physician assistants to qualify for a waiver.[19] Additionally,

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may be used to assist in short or long-term treatment success for beneficiaries with OUD, such as medications to treat opioid withdrawal symptoms, CMS would encourage states to focus on optimal patient outcomes in decisions that impact coverage and access.

[17] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf.

[18] Children's Health Act of 2000, Section 3501, Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (2000). https://www.govinfo.gov/content/pkg/PLAW-106publ310/pdf/PLAW-106publ310.pdf.

[19] Comprehensive Addiction and Recovery Act of 2016, Section 303, Medication-assisted Treatment for Recovery from Addiction, Pub. L. No. 114–198, 130 Stat. 69, (2016). https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf

section 3201 of the SUPPORT Act[20] extends eligibility for prescribing buprenorphine for the treatment of OUD to clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives until October 1, 2023.

Section 3201 of the SUPPORT Act also expands the eligibility of certain physicians and other qualifying practitioners to treat up to 100 patients in the first year of waiver receipt if they satisfy one of the following two conditions found in regulation:[21]

1) The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology; or

2) The practitioner provides MAT in a "qualified practice setting." A qualified practice setting is one that:

a. Provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
b. Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
c. Uses health information technology systems such as electronic health records in accordance with practice setting requirements;
d. Registers for their state prescription drug monitoring program where operational and in accordance with federal and state law; and
e. Accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

After one year at the 100-patient limit, physicians and qualifying other practitioners who meet the above criteria can apply to increase their patient limit to 275.[22]

Current MAT State Plan Coverage

Currently, all state Medicaid programs cover some form of buprenorphine and extended-release naltrexone for treatment of OUD. In addition, most states also cover some form of the counseling and behavioral therapies that are necessary to provide evidence-based MAT. Methadone is indicated for use as part of an MAT protocol for treating OUD, but also for pain management. When used for treating OUD, methadone can only be administered by OTPs, which must be certified by SAMHSA and registered with the Drug Enforcement Administration (DEA).[23] OTPs must be licensed in the state in which they operate and accredited by a

[20] SUPPORT Act, Section 3201, Allowing for More Flexibility with Respect to Medication-Assisted Treatment for Opioid Use Disorders.
[21] 21 U.S.C. 823(g)(2)(B)(II)(bb) – (cc); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610, 42 C.F.R. 8.615.
[22] 21 U.S.C. 823(g)(2)(B)(II)(dd); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610 – 655.
[23] We note that in contrast, when methadone is used for the treatment of pain, it can be dispensed from pharmacies, which are not able to dispense methadone for OUD unless they are also certified as OTPs.

SAMHSA-approved accrediting body.[24] Additionally, federal regulations at 42 C.F.R. part 8 impose standards governing, for example, required services, staff credentials, patient admission criteria, and patient confidentiality criteria.[25] In a report on the use of medications to treat OUD in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, SAMHSA found that methadone is covered for MAT to treat OUD by Medicaid in 42 of the 53 states and territories included in the report.[26]

Institution for Mental Diseases (IMD) Exclusion

Frequently, MAT-related counseling and behavioral therapy are provided on-site at clinics and health centers where buprenorphine and/or naltrexone are dispensed. Primary care providers who prescribe MAT drugs often partner with local substance use disorder treatment or mental health care agencies to connect individuals to counseling. Federal regulation requires patients who receive treatment in an OTP to receive access to[27] medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication.[28] Medications for MAT, as well as the counseling and behavioral therapies, can also be furnished in inpatient and residential settings such as psychiatric hospitals, inpatient units, or residential treatment programs, including in IMDs, but Medicaid coverage is generally not available unless the setting is not an IMD or an exception to the IMD exclusion applies, as discussed below.

An IMD is defined in section 1905(i) of the Act as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual under age 65 who resides in an IMD. This is commonly known as the "IMD exclusion." The IMD exclusion applies to any care or services provided inside or outside of the facility or hospital to a Medicaid beneficiary residing in an IMD, unless an exception to the IMD exclusion applies. As specifically relevant here, MAT and counseling and behavioral therapies provided in an IMD would not be covered by Medicaid unless an exception to the IMD exclusion applies.

Currently, there are several exceptions to the IMD exclusion and other authorities that permit short-term stays in IMDs. First, Medicaid payment is permitted for inpatient hospital services, nursing facility services, and intermediate care facility services provided in IMDs to individuals age 65 and older.[29] Second, Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the "psych under 21 benefit," furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility."[30]

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[24] SAMHSA. Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose. HHS Publication No. SMA-18-5093, page 39.
[25] 42 C.F.R. 8.12.
[26] SAMHSA. HHS Publication No. SMA-18-5093, page 39. Published November, 2018
[27] SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020. https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006
[28] 42 C.F.R 8.12(f)
[29] 42 C.F.R. 440.140
[30] 42 C.F.R. 440.160

Third, section 1012 of the SUPPORT Act, entitled "Help for Moms and Babies," added a new limited exception to the IMD exclusion. For more information, see the CMCS Informational Bulletin, "State Guidance for the New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women, July 26, 2019."[31] Fourth, section 5052 of the SUPPORT Act, entitled, "State option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases," amended the IMD exclusion and established a new section 1915(*l*) of the Act. This provision permits states to cover a state plan option to provide services to Medicaid beneficiaries age 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD. The period of this state plan option is from October 1, 2019 through September 30, 2023. For more information, see State Medicaid Director Letter (SMDL) # 19-0003, Re: Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(*l*) of the Social Security Act, November 6, 2019.[32]

Other authorities that permit short-term stays in IMDs include section 1115 demonstrations. CMS announced a section 1115 demonstration initiative where states can receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids or other substances, including services provided to beneficiaries residing in IMDs. For more information, see section 1115 SUD Demonstrations, SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017.[33] Finally, states may receive FFP for monthly capitation payments for beneficiaries age 21 through 64 receiving SUD treatment in an IMD for a short-term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the managed care regulation are met.[34]

SUPPORT Act Section 1006(b) Coverage

Section 1006(b) of the SUPPORT Act requires states to begin implementing MAT as a mandatory Medicaid state plan benefit for categorically needy populations for the 5-year period beginning October 1, 2020. Under the definition of the new mandatory benefit at section 1905(ee)(1) of the Act, states are required to cover all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat OUDs. CMS interprets the statute to require coverage of all forms of the drugs and biologicals that the FDA has approved or licensed for treatment of OUD. States are also required to cover counseling services and behavioral therapies associated with provision of the required drug and biological coverage.

Exception for Provider Shortage

Section 1905(ee)(2) of the Act provides that states may be excused from the mandatory coverage requirement if, before the requirement takes effect on October 1, 2020, the state "certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of

[31] https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf.
[32] https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf.
[33] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.
[34] 42 C.F.R. 438.6(e)

a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3)."

In CMS's view, the purpose of the new requirement is to increase access to MAT to treat OUD for Medicaid beneficiaries, and this can only be accomplished by increasing the enrollment in Medicaid of OTPs and other MAT providers and practitioners. CMS therefore expects states to conduct provider outreach and enrollment as they prepare to meet the new requirements. As discussed above, because methadone for treatment of OUD can only be provided in OTPs, states that do not already enroll OTPs as Medicaid providers will be expected to take action to do so. Additionally, if a state has MAT providers operating in the state that are not currently enrolled in the Medicaid program, states are expected to permit any willing and qualified provider to become a Medicaid provider for the newly required MAT benefit, so that beneficiaries may receive these services from the qualified and willing provider of their choice, consistent with section 1902(a)(23) of the Act and 42 C.F.R. 431.51.

CMS expects a state seeking the exception under section 1905(ee)(2) to document in its exception request that it has made a good faith effort toward enrolling providers of MAT for the Medicaid fee-for-service program, Medicaid managed care organizations (MCOs), and primary care case managers (PCCMs). Such documentation would include information about state review of MCO demonstrations of adequate capacity to furnish services under 42 C.F.R. 438.207; state standards for uniform credentialing policies that MCOs must use in accordance with 42 C.F.R. 438.214(b); and MCO policies and procedures for credentialing and re-credentialing network providers, required under 42 C.F.R. 438.214. A state requesting an exception should conduct a detailed accounting of the current MAT providers in the state, both those that are enrolled in the Medicaid program and those that are not, and should detail in its exception request the process that the state has undertaken to contract with MAT providers (and/or to encourage that MAT providers contract with the state's Medicaid MCOs and/or PCCMs) and the reasons why the providers are not willing to enroll.

We recognize that there may be state-specific administrative challenges with providing CMS with the information necessary for the Secretary to determine that the state has satisfactorily certified to the existence of a shortage of providers, especially in light of the fact that this guidance is being issued after October 1, 2020, the effective date of the new MAT coverage requirement. Therefore, CMS will not require states seeking this exception to have submitted a request for the exception before October 1, 2020. Instead, CMS will accept state requests for this exception on or before January 14, 2021. The request for the exception should be submitted at the same time as a request for flexibility under section 1135 of the Act with respect to state plan amendment (SPA) submission and notice timelines (as described further below). If a state is not granted an exception based on a shortage of providers or facilities, then the state will need to submit a SPA, and requesting flexibility with respect to SPA submission and notice timelines could help the state to safeguard a SPA effective date of October 1, 2020 if the exception request is denied. For further detail, please refer to the "SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines" section below.

CMS remains committed to providing technical assistance to states and other stakeholders in understanding the mandatory MAT benefit and developing implementation approaches that result in the provision of Medicaid services in a manner compliant with program requirements.

States that seek an exception based on a shortage of providers or facilities should submit their request on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new "One CMS Portal," the request for the exception based on a shortage of providers or facilities should be submitted via the portal. The information detailed below should be included with the request, which should include the state's certification that it cannot come into compliance with the new requirement due to a shortage of providers. States may, but are not required to, use the following format.

_____ [Insert name of state] certifies that implementing the MAT benefit specified in section 1905(a)(29) of the Act is not feasible due to a shortage of qualified providers or facilities that will enroll in the state Medicaid program or contract with a Medicaid managed care organization (MCO) or Primary Care Case Manager to furnish one or more of the required MAT benefit components, and requests an exception from the requirement to provide this benefit for this reason.

The state's request should include all of the following information:

a. A description of the state's current qualified provider and facility status, including the number, type, and location of qualified providers and facilities that furnish MAT.
b. A brief description of the process that the state has undertaken to contract with all qualified MAT providers and facilities and reasons why the providers did not contract with the state or a managed care organization or Primary Care Case Manager.
c. For all Medicaid MCOs in the state, the written policies and procedures for selection and retention of network providers required by 42 C.F.R. 438.214, and copies of the assurances of adequate capacity and supporting documentation required by 42 C.F.R. 438.207(b), along with the state's certification and supporting documentation required by 438.207(d).
d. A description of the unmet need caused by the shortage of qualified providers or facilities among eligible children and adults whom the state identifies as individuals with OUD who could benefit from MAT.
e. A description of the state's plan to enroll additional qualified providers or facilities to ensure that all individuals eligible for MAT under the state plan (or a waiver of the state plan) are able to access it, and the date when the state thinks it will resolve the qualified provider or facilities shortage.

All exceptions approved under section 1905(ee)(2) will be for the full five-year period that the new MAT benefit is required. However, if a state decides to come into compliance with the MAT benefit requirement after receiving an exception under section 1905(ee)(2), CMS will be available to provide technical assistance to the state.

Extension of Compliance Deadline Due to Legislative Delay

Section 1006(b)(4)(B) of the SUPPORT Act (which was not codified in any provision of the Social Security Act) provides for an "exception" to the October 1, 2020 effective date of the new MAT benefit "for state legislation." Essentially, this provision provides for an extension to the required start date of the new coverage requirement if the only reason the state cannot come into compliance by October 1, 2020 is due to lack of state legislation that is needed to meet the requirement. Not all states will be able to seek this extension, because it depends on the timing of the state's first regular legislative session that began after the date of enactment of the SUPPORT Act (October 24, 2018). If the Secretary of Health and Human Services determines that state legislation is needed to bring the state plan into compliance with the new coverage requirement, the Secretary will not consider the state to be out of compliance with the new coverage requirement solely on the basis of a failure to enact the required state legislation before the first day of the first calendar quarter beginning after the close of the first regular session of the state's legislature that begins after October 24, 2018. If a state's first regular legislative session beginning after October 24, 2018 was the calendar year that began on January 1, 2019 and ended on December 31, 2019, the state would not be able to seek this extension because it would have had only until December 31, 2019 to enact any required legislation, and the first day of the first calendar quarter that begins after that date is January 1, 2020 – well before October 1, 2020.

If, however, a state's first regular legislative session beginning after October 24, 2018 does not end until on or after October 1, 2020, and the Secretary determines that legislation was necessary to meet the new coverage requirement, but the necessary legislative authorization was not obtained, the state could seek to delay compliance with the new coverage requirement until the first day of the first calendar quarter after the legislative session ends. Such a state is expected to come into compliance with the new coverage requirement by the first day of the first calendar quarter after the end of the legislative session, unless the exception in section 1905(ee)(2) applies. If a state has a two-year legislative session, each year of the session shall be considered to be a separate regular session of the state legislature for purposes of this extension. This means that a state would not have a longer extension if it has a two-year legislative session; such a state is treated like a state with a one-year legislative session, and any applicable extension ends on the first day of the first calendar quarter following the end of the first year of the two-year session.

CMS will grant an extension based on legislative delay only if a legislative delay is the only reason that a state cannot meet the requirement, and only when the first regular legislative session that began after October 24, 2018 ends on or after October 1, 2020, as discussed above. States should submit requests for the legislative delay extension on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new "One CMS Portal," the request for the legislative delay extension should be submitted via the portal. The request should include documentation to support that the state's first regular legislative session that began after October 24, 2018 did not end until on or after October 1, 2020, that state legislation is needed to come into compliance with the new coverage requirement, and that the legislative delay is the only reason the state cannot come into compliance as of October 1, 2020. States are encouraged to submit a request for flexibility under section 1135 of the Act with respect to SPA submission and notice timelines,

as discussed below under "SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines," at the same time as the request for the legislative delay extension, in order to help safeguard a SPA effective date of October 1, 2020 if the state's request for a legislative delay extension is not granted. States may, but are not required to, use the following format for their legislative delay extension submission:

_____ [Insert name of state] requests an exception based on the need for legislative authority to cover the benefit described in section 1905(a)(29) of the Social Security Act, and submits documentation to support that the state's first regular legislative session that began after October 24, 2018 will not end until on or after October 1, 2020. [Describe the documentation that is attached or that accompanies the request and include information about the state's legislative calendar so CMS can determine the state's compliance date.]

States that are granted an extension due to legislative delay will still need to follow the SPA submission requirements below and submit a SPA consistent with the extended compliance deadline.

SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines

SPA effective date requirements outlined at 42 C.F.R. 430.20 provide for an effective date retroactive to the first day of the quarter in which the SPA was submitted. In addition, the public notice requirements at 42 C.F.R. 447.205 require states to publish notice of proposed changes in methods and standards for setting payment rates for services before the proposed effective date of the change. Accordingly, under these rules, states have only until December 31, 2020 to submit a SPA establishing coverage or payment for the new MAT benefit that would take effect October 1, 2020. Additionally, any SPA setting payment rates for the new benefit could take effect only after the state issues public notice of the proposed payment changes. Thus, states would have had to publish notice of their payment rate changes by September 30, 2020, for changes to take effect October 1, 2020.

CMS is aware that most states have been unable to submit a SPA for the new MAT benefit that meets these submission and notice timing requirements because they have had to focus almost exclusively on responding to the COVID-19 pandemic throughout much of 2020. At the same time, the opioid crisis has only been exacerbated by the COVID-19 pandemic. During the COVID-19 public health emergency (PHE), disruptions in treatment have resulted in a resurgence of relapses and fatal overdoses among individuals with OUD.[35]

Consequently, in order to help ensure that beneficiaries can access coverage for the new MAT benefit effective retroactively to October 1, 2020, CMS is giving states the opportunity to request that CMS exercise its section 1135 authority to modify the regulatory deadlines associated with SPA submission and public notice for coverage and payment SPAs for the new MAT benefit while the COVID-19 PHE is still in effect.[36] CMS strongly recommends that states submit these

[35] https://qz.com/1889798/covid-19-is-making-the-opioid-crisis-much-worse/

[36] Section 1135 authority permits the Secretary to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements during a PHE, in order to ensure, to the maximum extent feasible, that sufficient health care items and services are available to meet the needs of individuals enrolled in those programs.

requests on or before January 14, 2021. Specifically, if responding to the COVID-19 pandemic has delayed a state's ability to submit a coverage or payment SPA for the new MAT benefit or provide public notice of payment rate changes related to the new MAT benefit under the time frames set forth at 42 C.F.R. 430.20 and 447.205, the state may request flexibility regarding the timing of the SPA public notice and submission process for these SPAs, so that it can submit SPAs adding coverage and payment for the new mandatory MAT benefit at section 1905(a)(29) of the Act in the first quarter of 2021 that would be effective October 1, 2020. If a state does not submit a request for section 1135 flexibility as described herein and submits a SPA after December 31, 2020 to add the new mandatory MAT benefit, then the SPA's effective date would be on (or sometime after) January 1, 2021, beneficiaries might not be able to access all available MAT coverage before that date, and the state would not be in timely compliance with the new coverage requirement.

CMS will provide states with this flexibility only if they meet the following conditions. First, all state requests for modification of the deadlines for MAT SPA submission and public notice under section 1135 must be submitted and approved during the COVID-19 PHE, and all MAT SPAs must be submitted on or before March 31, 2021. Second, states must solicit and should consider public comments and comments received through tribal consultation before finalizing the SPAs that will take effect. States must conduct tribal consultation if required under section 1902(a)(73)(A) before submission of their MAT SPAs, even if CMS approves a modification under section 1135 of the 42 C.F.R. 447.205 notice timelines. Additionally, CMS strongly recommends that states conduct any public notice required under 42 C.F.R. 447.205 before submitting their MAT SPAs, even if CMS approves a modification under section 1135 of the timeline for that notice. If states have had to put in place interim coverage or rate policies for the new MAT benefit while preparing their SPAs for submission and finalizing them for approval, they would be expected to give effect to the rates and coverage policies that are ultimately approved retroactive to the effective date of October 1, 2020. States seeking these section 1135 flexibilities should submit a letter to Jackie Glaze at Jackie.Glaze@cms.hhs.gov by January 14, 2021. In addition to a statement explaining that the state's response to the COVID-19 pandemic has delayed its ability to submit coverage and/or payment SPAs for the new MAT benefit according to the regulatory SPA submission and notice timelines, the letter should include the following language (as applicable):

Request for Modifications under Section 1135

> Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of SPA submission requirements at 42 C.F.R. 430.20, in order to submit a SPA implementing section 1905(a)(29) of the Act by March 31, 2021 that would take effect on October 1, 2020.
>
> Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of the public notice time frames set forth at 42 C.F.R. 447.205, in order to obtain an effective date of October 1, 2020 for its SPA implementing statewide methods and standards for setting payment rates for the benefit described at section 1905(a)(29) of the Act. The state will issue public notice as soon as possible, and in no event later than February 28, 2021.

With respect to SPA submissions related to coverage and payment for the new MAT benefit, states should take the following steps.

States should submit an amendment to their Medicaid state plans (including to Alternative Benefit Plans, if applicable), no later than December 31, 2020 (or March 31, 2021, if CMS has approved section 1135 flexibility as discussed above) after having conducted public notice and tribal consultation, as needed, to cover, under the new mandatory benefit at section 1905(a)(29) of the Act, all FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, as well as all forms of the drugs and biologicals approved or licensed by the FDA for MAT to treat OUD, and associated counseling services and behavioral therapies. States should submit their SPAs to the Regional SPA/Waiver mailbox that is currently used for other Medicaid SPA submissions. If a state is participating in the pilot for the new "One CMS Portal," the SPA should be submitted via the portal.

States that already use existing Medicaid authorities to cover items and services that will now be covered under the new mandatory MAT benefit, including FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, and associated counseling services and behavioral therapies, are expected to submit a SPA to move their coverage of these items and services to a new page in their Medicaid state plans for the new mandatory benefit at section 1905(a)(29) of the Act.

In addition to submitting SPAs to add the mandatory MAT benefit to the state plan, states will need to propose associated changes to the payment section of the state plan. States will need to submit a new Attachment 4.19-B page for the mandatory benefit at section 1905(a)(29) that describes the rate-setting methodology used to pay for the services covered under the mandatory MAT benefit. The rate-setting methodology for the new MAT benefit must be consistent with section 1902(a)(30)(A) of the Act, which requires Medicaid payments to be "consistent with efficiency, economy, and quality of care" and to be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." States may include all medical service costs associated with furnishing the MAT benefit services to Medicaid beneficiaries (such as salaries, fringe benefits, supplies, and equipment) in their rate-setting methodology for the new MAT benefit, and the methodology must be a comprehensive description within the state plan consistent with 42 C.F.R. 430.10. As states have a variety of options to choose from in how they pay for MAT services, CMS is available to provide assistance to states as they develop SPA proposals. We encourage states to reach out to their state lead in the Medicaid and CHIP Operations Group for technical assistance.

As with any SPA submission, CMS expects states to comply with all SPA requirements that are not waived or modified, including those found in 42 C.F.R. 440.200, et seq., and to provide information on the source of the non-federal share of the service payments and information on the rate-setting methodology. Specific guidance related to SPA submission procedures may be found on the Medicaid.gov web page.

MAT Drug Coverage and Section 1927 Manufacturer Rebates

CMS interprets section 1905(ee)(1) of the SUPPORT Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the FDA has approved or licensed for MAT to treat OUD. More specifically, under the new mandatory MAT benefit, states are required to cover such FDA approved or licensed drugs and biologicals used for indications for MAT to treat OUD.

Statutory amendments were made to the original language at sections 1905(a)(29) and 1905(ee) by Section 2601 of the Continuing Appropriations Act, 2021 and Other Extensions Act (Pub. L. No. 116-159) to specify that the rebate requirements in section 1927 shall apply to any MAT drugs or biologicals described under the mandatory benefit at section 1905(ee)(1)(A), that are furnished as medical assistance under sections 1905(a)(29) and section 1902(a)(10)(A), and are covered outpatient drugs, as that term is defined at section 1927(k)(2). In determining whether such a MAT drug or biological satisfies the definition of a covered outpatient drug, such MAT drugs or biologicals are deemed prescribed drugs for such purposes. More specifically, these amendments ensure that MAT drugs and biologicals can be included in the Medicaid Drug Rebate Program (MDRP). Additionally, for MAT drugs or biologicals that are also covered outpatient drugs, the amendments also ensure a state's ability to seek section 1927 rebates and apply drug utilization management mechanisms (such as preferred drug lists and prior approval), and establish a manufacturer's obligation to pay appropriate rebates and comply with all applicable drug product and drug pricing reporting and payment of rebates. The change in law is effective as if included in the enactment of the SUPPORT Act, which was October 24, 2018.

CMS expects that most manufacturers of MAT drugs and biologicals currently have in effect a rebate agreement with the Secretary and pay rebates to states for all drugs and biologicals that meet the definition of covered outpatient drug (COD) in section 1927(k) of the Act, and if not, that manufacturers of these drugs and biologicals will likely enter into a rebate agreement with the Secretary and pay rebates to states. Should an FDA-approved MAT drug or biological for OUD not meet the definition of a covered outpatient drug, or if the drug is a covered outpatient drug, but the manufacturer does not have a rebate agreement in effect with the Secretary, the state would still be required to cover the drug or biological under the MAT mandatory benefit, and the drug or biological would be eligible for FFP, but not rebates. States could subject MAT drugs or biologicals that are not covered outpatient drugs to prior approval or other utilization management mechanisms under 42 C.F.R. 440.230 as described below, including in order to prioritize coverage of those drugs that are covered outpatient drugs, but the state still must provide coverage for MAT drugs that are not covered outpatient drugs if they are medically indicated for the beneficiary, consistent with 42 C.F.R. 440.230(b).

State Use of Utilization Management Mechanisms

As a reminder, states may use utilization management controls to promote the efficient delivery of care and to control costs.[37] States can use the Section 1927 utilization management mechanisms for MAT drugs used for OUD that are covered outpatient drugs, such as

[37] Medicaid and CHIP Payment and Access Commission's (MACPAC) October 2019, Report to Congress: Utilization Management of Medication-Assisted Treatment in Medicaid, https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf

encouraging the use of generic products, creating a preferred drug list, or choosing to implement prior authorization to manage drug classes that may require additional monitoring.

For MAT drugs that are covered outside of a rebate agreement, or would be covered outpatient drugs, except that they are subject to the limiting definition at section 1927(k)(3) (e.g. those that are paid as part of a bundle), states may use the utilization management mechanisms authorized under 42 C.F.R. 440.230. In these cases, states may propose limits on the amount, duration, and scope of these drugs under the MAT benefit, including to encourage the use of the most cost-effective MAT drugs and biologicals.

Support to States for Increasing SUD Treatment Options

Well-supported scientific evidence demonstrates that treatment for substance use disorders – including inpatient, residential, and outpatient treatment – is cost-effective compared with no treatment.[38] Existing Medicaid authorities, as well as new opportunities afforded by the SUPPORT Act, are available to help states expand their SUD service continuum, which can include MAT.

Section 1115 demonstration projects – In November 2017, CMS announced a section 1115 initiative that affords states the opportunity to receive federal financial participation (FFP) for expenditures on the continuum of services to treat SUD, including expenditures on treatment while Medicaid enrollees are residing in residential treatment facilities that are IMDs. Such expenditures can generally not be federally matched under Medicaid due to the IMD exclusion. As part of this initiative, states may develop innovative approaches to inpatient and residential care for individuals with SUDs that are expected to supplement and coordinate with community-based care to provide a robust continuum of care in the state. Participating states are required to ensure residential settings included in these demonstrations are either offering beneficiaries access to MAT on-site or facilitating beneficiaries' access to MAT off-site.[39]

Section 1003 of the SUPPORT Act – Section 1003 requires the Secretary to conduct a demonstration project to increase Medicaid SUD provider capacity. In 2019, CMS awarded planning grants to 15 states to conduct an assessment of SUD treatment and recovery needs of the state. The planning grants may also support activities to recruit, train, and provide technical assistance for providers; to improve reimbursement; and to expand the number or treatment capacity of Medicaid providers. Up to five of the states that received planning grants will be selected to implement demonstrations and receive enhanced federal reimbursement for increases in Medicaid SUD treatment and recovery services expenditures. For more information on this demonstration project, and the 15 states that were awarded planning grants, see the Medicaid.gov web page.[40]

Section 1006(a) of the SUPPORT Act – Section 1006(a) of the SUPPORT Act permits CMS to extend, at state request, the period of 90% federal match from eight to 10 fiscal year quarters for

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[38] Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.* Washington, DC: HHS, November 2016. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[39] SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[40] https://www.medicaid.gov/medicaid/benefits/bhs/support-act-provider-capacity-demos/index.html

health home services provided to SUD-eligible individuals under a SUD-focused Medicaid health home SPA approved on or after October 1, 2018. The Medicaid health home state plan option (authorized under section 1945 of the Act) promotes coordination of primary and acute physical and behavioral health services and long-term services and supports. Specific guidance related to the health home Medicaid state plan option, including guidance on health home services, health home providers, state reporting, and developing payment methodologies, can be found on the Medicaid.gov web page.[41] Information on section 1006(a) of the SUPPORT Act is also available in the policy guidance tab on the Medicaid.gov web page.[42]

Section 7181 of the SUPPORT Act – Section 7181 of the SUPPORT Act reauthorized and modified the "State and Tribal Response to the Opioid Crisis" grants established under section 1003 of the 21st Century Cures Act. Section 7181 requires the grants to be awarded to Indian tribes in addition to states and territories. This provision also expands the types of activities that grants may support to include the establishment of prescription drug monitoring programs and training for health care practitioners in preventing diversion of controlled substances. It also emphasizes flexibility with use of funds by permitting resources to be directed "in accordance with local needs related to substance use disorders."[43]

Section 7181 authorizes $500 million for each of Fiscal Years 2019-2021, which would remain available until expended. It authorizes a set-aside of up to 15% for states with the highest age-adjusted rate of drug overdose death based on the ordinal ranking of states according to the Centers for Disease Control and Prevention (CDC)[44]. SAMHSA will provide state agencies and Indian tribes with technical assistance on grant application and submission procedures, award management activities, and enhancing outreach and direct support to rural and underserved communities and providers in addressing the opioid crisis.

Telehealth – HHS developed materials to help clarify how clinicians can use telemedicine as a tool to expand buprenorphine-based MAT for OUD treatment under current DEA regulations. This information includes a clinical practice example that is consistent with applicable DEA and HHS administered authorities. It is hoped that the materials help expand providers' ability to prescribe MAT to patients, including remote patients under certain circumstances. This information can be found on the HHS.gov web page.[45]

Telehealth could be especially helpful in supporting access to buprenorphine in rural areas, where there may be a smaller number of waivered providers able to prescribe buprenorphine for the treatment of OUD in settings other than federally regulated opioid treatment programs.[46]

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[41] https://www.medicaid.gov/medicaid/ltss/health-homes/index.html.

[42] CMCS Informational Bulletin, Guidance for States on the Availability of an Extension of the Enhanced Federal Medical Assistance Percentage (FMAP) Period for Certain Medicaid Health Homes for Individuals with Substance Use Disorders (SUD), May 7, 2019, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib050719.pdf.

[43] https://www.govinfo.gov/content/pkg/PLAW-115publ271/html/PLAW-115publ271.htm

[44] https://www.cdc.gov/drugoverdose/data/statedeaths.html

[45] https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf.

[46] U.S. Department of Health and Human Services. Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder. DHHS web site. September 2018. https://www.hhs.gov/blog/2018/09/18/using-telemedicine-combat-opioid-epidemic.html.

CMS also released a State Medicaid Director Letter (SMDL) in June 2018, "Leveraging Medicaid Technology to Address the Opioid Crisis,"[47] that includes a section on how states can leverage telehealth technologies to improve access to SUD treatment. This SMDL also discusses the potential availability of enhanced federal funding to support telehealth-enabling technologies. Additionally, consistent with section 1009(b)(1) of the SUPPORT Act, CMS issued guidance on federal Medicaid reimbursement for services to treat SUD furnished via telehealth, including in School-Based Health Centers.[48] Services discussed in this guidance include assessment, MAT, counseling, medication management, and medication adherence with prescribed medication regimes.

Conclusion

MAT is an effective, comprehensive, and evidence-based treatment that is integral to addressing the nation's opioid crisis. Section 1006(b) of the SUPPORT Act amended the Social Security Act to require states to cover MAT for all eligible to enroll in the state plan or waiver of state plan. The new mandatory MAT benefit includes all FDA-approved drugs and licensed biologicals used for MAT to treat OUD, as well as associated counseling and behavioral therapies. CMS interprets the statute to require coverage of all forms of drugs and biologicals approved or licensed by the FDA for use as MAT to treat OUD. CMS is available to provide technical assistance and looks forward to working with states to ensure Medicaid beneficiaries with OUD receive the services they need. If you have any questions, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Sincerely,

/s/

Anne Marie Costello
Acting Deputy Administrator and Director

cc: State Mental Health Directors
State Substance Use Directors
State Opioid Treatment Authorities
State Budget Officers
State Pharmacy Directors
National Association of Medicaid Directors
National Association of State Mental Health Program Directors
National Association of State Alcohol and Drug Abuse Directors
Association of State and Territorial Health Officials
National Association of State Budget Officers
National Conference of State Legislatures

[47] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf.

[48] CMCS Informational Bulletin, April 2, 2020. Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard Mailstop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 21-003

RE: Medicaid and CHIP Coverage and Reimbursement of COVID-19 Testing under the American Rescue Plan Act of 2021 and Medicaid Coverage of Habilitation Services

August 30, 2021

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance on Medicaid and Children's Health Insurance Program (CHIP) coverage and reimbursement of COVID-19 testing under the American Rescue Plan Act of 2021 (ARP) (Pub. L. No. 117-2). Additionally, CMS is issuing this guidance to clarify that, only during the COVID-19 public health emergency (PHE), states may cover habilitation services provided to children under section 1915(c) and section 1915(i) of the Social Security Act (the Act) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program.

CMS will apply the interpretations of statute in this guidance on a prospective basis beginning with the date of issuance of this letter.

Mandatory COVID-19 Testing Coverage under the American Rescue Plan Act of 2021

Overview

CMS interprets the ARP to require state Medicaid and CHIP programs to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA)-authorized COVID-19 tests, without cost-sharing obligations, for a period of time that begins March 11, 2021, and generally extends beyond the end of the COVID-19 PHE. In meeting these ARP requirements, states must continue to apply normal third-party liability rules and may continue to apply utilization management techniques, as further described later in this letter.[1]

ARP Sections 9811 and 9821

The ARP was enacted on March 11, 2021 and included COVID-19 testing coverage mandates specific to Medicaid and CHIP. Section 9811(a) of the ARP added a new mandatory Medicaid

[1] Use of the term "state" in this letter includes the territories, as applicable.

benefit at section 1905(a)(4)(F) of the Act. Section 9821 of the ARP added the same mandatory benefit for all CHIP enrollees at section 2103(c)(11)(B) of the Act. Sections 1905(a)(4)(F) and 2103(c)(11)(B) of the Act require states to cover testing for COVID-19 for the period beginning on March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. In addition, section 9811(a)(2)(E) of the ARP amended the statutory language following section 1902(a)(10)(G) of the Act to require coverage of additional testing for COVID-19 for individuals eligible for the optional Medicaid eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Act (the group CMS previously referred to as the "optional COVID-19 testing group").[2]

ARP sections 9811 and 9821 also amended sections 1916, 1916A, and 2103(e)(2) of the Act to specify that states cannot impose cost-sharing with respect to the COVID-19 testing coverage required under the ARP and described in sections 1905(a)(4)(F) and 2103(c)(11)(B). ARP section 9811(a)(5) also amended section 1937(b) of the Act to require states to include the same COVID-19 testing coverage in Medicaid alternative benefit plans, without any deduction, cost-sharing, or similar charge.

CMS interprets the amendments made by sections 9811 and 9821 of the ARP to require states to cover both diagnostic and screening tests for COVID-19 (which includes their administration), consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19. CMS is aligning its interpretation of these ARP amendments with applicable CDC recommendations because the CDC recommendations provide a national reference point for who should be tested during the COVID-19 pandemic and evolve as science evolves.[3] CMS interprets these amendments to require states to cover, without cost sharing, all diagnostic and screening testing that would be consistent with the CDC recommendations. This includes, for example, coverage of screening testing to return to school or work or to meet travel requirements. CMS is available for technical assistance as states design their testing coverage policy and as the COVID-19 pandemic evolves.

An individualized test result must be obtained for both diagnostic and screening testing covered under the amendments made by sections 9811 and 9821 of the ARP to support a Medicaid or CHIP claim. Additionally, all types of FDA-authorized COVID-19 tests must be covered under CMS's interpretation of the ARP COVID-19 testing coverage requirements, including, for example, "point of care" or "home" tests that have been provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider of COVID-19 tests. Home tests include those where a specimen is collected at home and then sent to a clinical laboratory or other certified testing site for testing, and those that are entirely performed at home, meaning the test system includes the ability to perform the test without involvement of a laboratory. States have

[2] Under section 1902(a)(10)(A)(ii)(XXIII) of the Act and the statutory language following section 1902(a)(10)(G) of the Act, states can provide coverage to the optional COVID-19 group (previously referred to as the optional COVID-19 testing group) only through the last day of the COVID-19 PHE. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 testing, after the PHE ends.

[3] See, e.g., https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/sars-cov2-testing-strategies.html.

discretion to condition coverage of a home test on a prescription as part of their utilization management (some FDA-authorized home tests require a prescription). As states establish utilization management techniques, including possible prescription conditions, they are encouraged to do so in ways that do not establish arbitrary barriers to accessing COVID-19 testing coverage, but that do facilitate linking the reimbursement of a covered test to an eligible Medicaid or CHIP beneficiary.

Finally, states may apply medical necessity criteria and other amount, duration, and scope parameters to COVID-19 testing covered under section 1905(a)(4)(F) of the Act and the other amendments made by section 9811 of the ARP, as they may do for all Medicaid services, as a utilization management control, provided that the benefit is sufficient to reasonably achieve its purpose (consistent with 42 CFR § 440.230(b)). States may also apply utilization controls to the COVID-19 testing covered in CHIP under section 2103(c)(11)(B), consistent with 42 CFR § 457.490.

Screening Testing in Schools

Schools can be Medicaid providers of COVID-19 screening testing covered under section 1905(a)(4)(F) and the other amendments made by section 9811 of the ARP. The vast majority of schools that render school-based services covered by Medicaid are reimbursed via a methodology associated with a Certified Public Expenditure (CPE) that requires reconciliation to actual cost via a uniform cost report. If the school obtains and administers a COVID-19 test and the state plan payment methodology is reconciled to cost, the cost of the test could be recorded on a cost report as a medical supply, and any accompanying cost of administering the test, such as the salary of the administering nurse, etc., would also be recorded in the cost report.

Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [Medicaid state] plan at least to the extent that such care and services are available to the general population in the geographic area." If the state plan payment methodology is a rate for school-based services, the cost of the test and any cost associated with administering the test should be factored into the rate. If the school contracts with an outside entity to administer the test, the school, not the outside entity, would be considered the billing provider of the test under Medicaid. If the state plan payment methodology is reconciled to cost, the contractual rate negotiated between the school and the outside entity would be recorded as contracted services in the provider's uniform cost report. If the state plan payment methodology is a rate, the above-contracted cost should be factored into the rate.

While there is no prohibition on Medicaid qualified providers billing for Medicaid covered services and items provided to Medicaid beneficiaries that may be provided free of charge to the general public, there may be sources of federal funding that are also available to cover the cost of testing in schools, which could potentially duplicate Medicaid payments. To avoid such duplication, states should ensure that Medicaid payments are appropriately considered along with other available sources of federal funds or revenue that may be used to fund testing in schools.

All third-party payer provisions continue to apply, and we remind states of the existence of additional funding streams for COVID-19 testing reimbursement not typically available.[4]

As indicated above, states may implement utilization management techniques in the coverage of screening testing in schools.

State Plan Amendments

States will need to submit Medicaid state plan amendments (SPAs) to add testing coverage and reimbursement as required under the ARP, including under the new mandatory benefit at section 1905(a)(4)(F) of the Act. CMS will provide additional information on submission of Medicaid SPAs to reflect ARP changes. CMS is available for technical assistance on SPA development.

States will also need to submit CHIP SPAs pursuant to CMS requirements at 42 CFR § 457.60(a). States will need to indicate that they are providing testing coverage without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. CMS will provide additional information on submission of CHIP SPAs to reflect ARP changes.

Medicaid Coverage of Individuals with Disabilities Education Act (IDEA) Services during Remote Learning

As discussed in State Health Official (SHO) letter 21-001, under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child's individualized education program (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP). These educational services can help children with disabilities achieve their educational goals. Medicaid reimbursement is available for covered services that are included in the child's IEP and IFSP provided to eligible beneficiaries by qualified Medicaid providers.[5] States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting if the children are determined to need those services, the services are furnished by qualified Medicaid providers, and the services meet all of the requirements set forth in the State Medicaid Director Letter 14-006.[6] Typically, however, under section 1915(c) and section 1915(i) of the Act, states must not cover habilitation

[4] Third party liability provisions are found in section 1902(a)(25) of the Act and 42 CFR Part 433, Subpart D.

[5] There are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. As indicated by section 1903(c) of the Act, Parts B and C of the Individuals with Disabilities Education Act (IDEA) is one example of this exception to the payer of last resort rule.

[6] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care), issued December 15, 2014, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

services[7] in the school setting if the services are otherwise available to the individual through a local educational agency.

CMS is clarifying that, in light of the unique circumstances presented by the COVID-19 PHE where students are relying on remote learning in whole or in part, states may cover habilitation services provided to children under section 1915(c) and section 1915(i) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program. For example, schools may be unable to deploy personnel to meet the needs of each individual child participating in remote education. CMS recognizes the significant advances in vaccination rates across the country, including for school-aged children eligible to be vaccinated. As schools return to in-person learning, CMS expects habilitation services will be available through local educational agencies and no longer eligible for coverage under Medicaid.

However, *to the extent necessary given local conditions*, states may choose to avail themselves of this flexibility where services are, in fact, not available through the local educational agency. Local educational agencies must prioritize use of funding available in the ARP, prior to indicating an inability to provide covered habilitation services. This flexibility is available prospectively from the issuance of this guidance. If applicable, states will need to submit an Appendix K application, disaster-related SPA, or 1115 application to implement this flexibility.

CMS notes that states must also continue to provide medically necessary services authorized under section 1905(a), in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) responsibilities.

Conclusion

This guidance describes Medicaid and CHIP coverage and reimbursement of COVID-19 testing under the ARP, and habilitation services during the COVID-19 PHE. As previously stated, CMS will apply the interpretations of statute in this guidance for both COVID-19 testing and habilitation services on a prospective basis beginning with the date of issuance of this letter. Please contact Kirsten Jensen at Kirsten.Jensen@cms.hhs.gov for additional information on COVID-19 testing and Ralph Lollar at Ralph.Lollar@cms.hhs.gov for additional information on habilitation services.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

[7] Defined at section 1915(c)(5) as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."

Mandatory & Optional Medicaid Benefits

This page outlines mandatory Medicaid benefits, which states are required to provide under federal law, and optional benefits that states may cover if they choose.

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

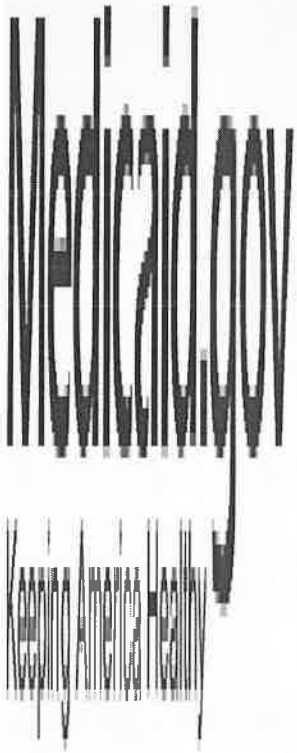
Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy

- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*
- Health Homes for Enrollees with Chronic Conditions – Section 1945

*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).

Mandatory & Optional Medicaid Benefits



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7500 Security Boulevard Baltimore, MD 21244

DHHRBMS016222

Centers for Medicare & Medicaid Services

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

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

Plaintiffs,

Exhibit 21

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

v.

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

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

REQUESTS FOR ADMISSIONS

1. Admit that Gender-Confirming Care can be medically necessary care for the treatment of gender dysphoria.

   RESPONSE: Upon information and belief, experts may differ in opinion as to whether gender-confirming care is medically necessary, both in general and with respect to a particular patient. This Request is admitted with the understanding that this area of treatment continues to evolve.

2. Admit that Defendants partially or fully cover counseling and/or therapy for some diagnoses not related to Gender-Confirming Care.

   RESPONSE: Admitted.

3. Admit that Defendants partially or fully cover mastectomy, breast reduction surgery, and chest reconstruction surgery for sone diagnoses not related to Gender-Confirming Care.

   RESPONSE: Admitted.

4. Admit that Defendants partially or fully cover hysterectomy and oophorectomy surgical procedures for some diagnoses not related to Gender-Confirming Care.

   RESPONSE: Admitted.

5. Admit that Defendants partially or fully cover vaginoplasty procedures for some diagnoses not related to Gender-Confirming Care.

   RESPONSE: Admitted.

6. Admit that Defendants partially or fully cover orchiectomy, penectomy, and /or phalloplasty procedures for some diagnoses not related to Gender-Confirming Care.

   RESPONSE: Admitted.

7. Admit that the Medicaid Plan only covers care that is medically necessary.

   RESPONSE: Admitted. However, these Defendants deny any suggestion that Medicaid covers all care that is medically necessary.

8. Admit that the Medicaid Plan has covered all hormone therapy for the treatment of gender dysphoria from November 2017 to the present.

   RESPONSE: It is admitted upon information and belief that from November 2017 to the present, coverage for hormone therapy has not been denied on the basis that it is for treatment of gender dysphoria. Upon information and belief, "hormone therapy for the treatment of gender dysphoria" may broadly involve several separate medications, doses, and formulations, and it is possible that coverage has been denied on other criteria, therefore, it cannot be admitted or denied that "all" such therapy has been covered.

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

By counsel

/s/ Kimberly M. Bandy
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS' RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR ADMISSIONS TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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

Exhibit
22

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

Plaintiffs,

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

v.

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

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

DOCUMENT REQUESTS

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

   RESPONSE: Reports have been requested.

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

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

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

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

RESPONSE: Upon entry of an appropriate Protective Order, these Defendants can produce an excel spreadsheet with the pharmacy claims detail for Christopher Fain. Any communications to or from Mr. Fain's Managed Care Organization would not be in the possession of these Defendants.

3. Taking necessary steps to comply with applicable privacy laws and making all necessary redactions to protect any personal health information. Documents in electronic, delimited, and importable format (e.g., excel spreadsheet) sufficient to show number of individuals who have requested coverage for Gender-Confirming Care, the number of claims each

individual has made for Gender-Confirming Care, whether those claims were approved or denied, the factual reasons for each decision, and whether any denials were based in whole or in part on the Exclusion.

RESPONSE: Any requests made for gender-confirming care to Managed Care Organizations would not be in the possession of these Defendants.

Upon information and belief, counseling is a covered service. However, the data is not kept in a manner which would allow these Defendants to identify which patients have requested counseling for gender confirming care. These defendants would not necessarily know the reason for counseling and whether it was related to gender-confirming care or some other reason. Therefore, these Defendants are unable to further respond to this Request as stated.

Similarly, with respect to hormone therapy, upon information and belief hormone therapy is not denied on the basis that it is for gender-confirming care. However, the data is not kept in a manner which would allow these Defendants to identify which patients have requested hormone therapy for gender confirming care. These defendants would not necessarily know the reason for hormone therapy and whether it was related to gender-confirming care or some other reason. Therefore, these Defendants are unable to further respond to this Request as stated.

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

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

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

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

RESPONSE: Upon information and belief:

a. These Defendants are conducting a search for any responsive documents;

b. Please see Exhibit 1. (Bates No. DHHRBMS000001-5), relating to the removal of the gender edit for most estrogen and testosterone containing products;

c. These Defendants are conducting a search for any responsive documents.

5. All Documents and communications relating to gender dysphoria, transgender people, and/or Gender-Confirming Care.

RESPONSE: Objection to the scope of the request to the extent that it requests all documents and communications relating to gender dysphoria, transgender people, and/or Gender-Confirming Care throughout the Bureau of Medical Services. Without waiving this objection, these defendants are conducting a search for any responsive documents. A search of communications of Dr. James Becker, Medical Director, Jennifer J. Myers, Director of Professional Services, and Tanya Cyrus, for the terms "gender dysphoria," "transgender people" and "Gender-Confirming Care" is being requested through the Office of Technology.

6. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care considered by the individuals responsible for adopting and/or maintaining the Exclusion in the Health Plans. Please identify the responsive Documents by Bates number. This includes, but is not limited to:

    a. Documents and communications regarding the safety or efficacy of Gender-Confirming Care;

    b. Documents and communications regarding the medical necessity of Gender-Confirming Care; and

    c. Documents and communications regarding the cost of Gender-Confirming Care.

RESPONSE: These defendants are conducting a search for any responsive documents. These Defendants would not be in possession of responsive information related to exclusions contained in Managed Care Organization plans.

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

RESPONSE: These Defendants are unaware of any responsive documents.

8. Documents sufficient to identify the circumstances in which counseling and/or therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or

criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 519.22 that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.22_Mental_Health_Counseling_and_Substance_Abuse_Treatment_2018%20update_final.pdf.

9. Documents sufficient to identify the circumstances in which hormone therapy is covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, Health Plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 518 Pharmacy Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter_518_Pharmacy_Services%20.pdf

and the most recently updated Preferred Drug List with Prior Authorization Criteria that can be accessed online at:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Preferred%20Drug%20List/2021/WV%20PDL%202021.Q3b%20v11.pdf.

Please note that to the extent that the Provider Manual states in section 518.4 that "Other drugs may be limited in quantity, duration, or based on gender. The information regarding these drug products and their limitations is available on the BMS website[,]" the "Drug Limits" list available online was last updated June 1, 2016, and does not reflect the removal of the gender edit for most estrogen and testosterone containing products.

10. Documents sufficient to identify the circumstances in which orchiectomy, penectomy, vaginoplasty, hysterectomy, phalloplasty, mammoplasty, breast reconstruction surgery, and/or mastectomy are covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

RESPONSE: Please see BMS Provider Manual Chapter 519.16 Surgical Services that can be accessed online at:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.16_Surgical_Services.pdf.

11. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care in relationship to the federal Medicaid Act, 42 U.S.C. Sections 139a(a)(10)(A)-(B) and/or any regulation promulgated thereunder.

    a. With the exception of Documents and communications protected by attorney-client privilege, this Request includes, but is not limited to, all Documents and communications relating to the legal requirements of the federal Medicaid Act, 42 U.S.C. Sections 1396a(a)(10)(A)-(B) and/or any regulation promulgated thereunder with respect to the Exclusion and/or Gender-Confirming Care.

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

12. All Documents and communications relating to the Exclusion and/or Gender-Confirming Care in relationship to Section 1557 of the Patient Protection and Affordable Care Act and/or any regulation promulgated thereunder.

    a. With the exception of Documents and communications protected by attorney-client privilege, this request includes, but is not limited to, all Documents and communications relating to the legal requirements if Section 1557 of the Patient Protection and Affordable Care Act and/or any regulation promulgated thereunder with respect to the Exclusion and/or Gender-Confirming Care.

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

13. Documents sufficient to show all steps taken by Defendants and/or West Virginia Department of Health and Human Resources, Bureau for Medical Services to comply with any and all requirements of the federal Medicaid Act, 42 U.S.C. Sections 1396a(a)(10)(A)-(B), whether or not related to Gender-Confirming Care.

RESPONSE: This request is vague and does not describe the documents requested with sufficient particularity, and is overly broad and burdensome.

14. Documents sufficient to show all steps taken by Defendants to comply with any and all requirements of Section 1557 of the Patient Protection and Affordable Care Act, whether of not related to Gender-Confirming Care.

RESPONSE: Objection. This request is vague and does not describe the documents requested with sufficient particularity, and is overly broad and burdensome.

15. The Rational Drug Therapy Program's criteria for coverage of hormone therapy for transgender and non-transgender West Virginia Medicaid participants.

RESPONSE: These Defendants are conducting a search for any responsive documents.

16. All statements of witnesses or potential witnesses or persons interviewed in connection with this lawsuit.

RESPONSE: Please see Affidavits of Brian Thompson, Angela Wowczuk and Tadd Haynes, Exhibit 2, (Bates No. DHHRBMS000006-12).

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

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

18. Documents that Defendants intend to use as exhibits at deposition, summary judgment, or trial, or that may be used to refresh the recollection of a witness at depositions or trial.

RESPONSE: Exhibits have not yet been determined. These Defendants reserve the right to use any documents or materials produced in discovery by any party.

19. All Documents relating to audits, advice, and/or communications from any government office relating to the Exclusion.

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

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

RESPONSE: These Defendants are conducting a search for any responsive documents.

21. All Documents that Defendants may identify in their initial disclosures pursuant to Federal Rule of Civil Procedure 26(a)(1)(A)(ii).

RESPONSE: Please see Exhibit 1 to these responses, and the documents referenced by links to online sources. Please see Unicare Health Plan of West Virginia, Inc., Handbook attached as Exhibit 3, (Bates No. DHHRBMS000013-106). Additionally, upon entry of an appropriate Protective Order, these Defendants can produce an excel spreadsheet with the pharmacy claims detail for Christopher Fain.

22. All documents upon which Defendants considered, relied upon, or intend to rely upon, in support of their admissions and/or denials of any of the allegations contained in the Complaint.

RESPONSE: Please see the Medicaid State Plan available online at: https://dhhr.wv.gov/bms/CMS/SMP/Pages/WV-State-Medicaid-Plan.aspx.

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

RESPONSE: Please see Exhibits 1 and 2 to these responses.

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

RESPONSE: These Defendants are conducting a search for any additional documents.

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

By counsel

/s/ Lou Ann S. Cyrus
Lou Ann S. Cyrus, Esquire (WVSB #6558)
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

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

Plaintiffs,

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Hon. Robert C. Chambers, Judge

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, and do hereby certify that on the 27th day of August, 2021, a true and exact copy of **DEFENDANTS RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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

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

Exhibit 23

Plaintiffs,

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

v.

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

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

DOCUMENT REQUESTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUPPLEMENTAL RESPONSE: See all documents produced in this matter.

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

By counsel

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

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

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