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

CHRISTOPHER FAIN, *et al.*,
Plaintiffs,

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

v.

WILLIAM CROUCH, *et al.*,
Defendants.

DEFENDANTS' REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

I. INTRODUCTION

Plaintiffs' Opposition to Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services' Motion for Summary Judgment illustrates that Plaintiffs continue to mischaracterize Medicaid's policy. Plaintiffs continue their attempts to make a false distinction between coverage available to transgender members and cisgender members. Plaintiffs allege that "Defendants exclude coverage for 'transsexual surgery' while covering the same or substantially similar procedures for cisgender people." (ECF 262, p. 4). This is not correct. There are no procedures that are covered for cisgender people that are not covered for all people. Covered surgical procedures are available to all persons who meet the coverage criteria, regardless of gender identity. In order to be accurate, Plaintiffs' statement would need to be revised to state, "Defendants do not provide coverage for 'transsexual surgery' while covering other surgical procedures for all members." When corrected to accurately state the facts, the fallacy of Plaintiff's discrimination claims plainly appears. It removes gender identity from the equation, and demonstrates that it is the procedure, not the identity of the person seeking it, that is taken into account.

Medicaid does not track the gender identity of its members. Currently, its system is based upon binary male or female designations, and it does not ask for or designate gender identity. (ECF 252-10, Tr. pp. 110-112; ECF 252-1 Tr. p. 100).[1] Because it does not keep data regarding a members' gender identity, it is impossible for Medicaid to even make the distinction that Plaintiffs are alleging.

Similarly, Plaintiffs incorrectly allege that Defendants deny "transgender Medicaid participants coverage for medically necessary surgery because they are transgender, when cisgender participants face no such exclusion." Again, this misstates the facts. The coverage available for a cisgender Medicaid member is identical to that available to a transgender member. Comparing apples to apples, the policy does not discriminate based on sex or transgender identity. For example, the coverage criteria for covered services such as hysterectomy for endometriosis or endometrial cancer are the same whether the individual member identifies as cisgender or transgender (and Medicaid does not keep data that makes this distinction). However, if any person of any gender identity would request gender-confirming surgery, it would not be covered because the policy identifying that service as non-covered is uniformly applied. And again, because Medicaid does not keep data identifying a member's gender identity, it is not a consideration. The policy is not discriminatory simply based on the reality that transgender members may be the only members seeking gender-confirming surgery as a benefit.

"Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs." *Alexander v. Choate*, 469 U.S. 287, 303 (1985). As the Court explained in *Alexander*, the State complies with the law by making the same

[1] Medicaid collects gender in a binary field because that is "how it comes from CMS." (ECF 252-10, Tr. p. 110).

benefit equally accessible under its policy. *Id.*, 469 U.S. at 309. The State is not required to assure "adequate health care" to any particular group by providing that group with more coverage than others. *Id.* The State is not required "to fund a benefit that it currently provides to no one." *Rodriguez v. City of New York*, 197 F.3d 611, 616 (2nd Cir. 1999).

The facts confirm that Plaintiffs personally have not been denied any coverage for gender-confirming care through Medicaid based on being transgender or having a transgender diagnosis. (ECF 252-4 Tr. pp. 142, 146; ECF 252-5 Tr. pp. 73-75). All medical claims submitted by Plaintiffs for gender-confirming care have been covered and paid. (ECF 252-1 Tr. pp. 117-119; ECF 252-6). Similarly, none of the Plaintiffs' requests for hormones have been denied based on transgender identity. (ECF 252-4 Tr. p. 142; ECF 252-5 Tr. pp. 62-63; ECF 252-7 Tr. pp. 82-83).

Plaintiffs criticize the Defendants for challenging a "straw man." (ECF 262, p. 6). However, Plaintiffs continue in an effort to overgeneralize the policy at issue or outright misstate how the policy is applied by, for example, repeatedly representing that coverage for cisgender participants is in some way different from coverage for transgender participants or participants of other gender identities.[2] The distinction Plaintiffs attempt to draw between coverage available to transgender members as opposed to cisgender members simply does not exist. It is Plaintiffs, and not the Defendants, that are seeking to mischaracterize the dispute.

Plaintiffs have not demonstrated that non-covered gender-confirming procedures are the same as procedures that are covered. In fact, the record shows that gender-confirming procedures are different procedures with different criteria than covered procedures. The policy, providing

[2] Other examples appear in Plaintiffs' Opposition brief at ECF 262, p. 9, mentioning the word "cisgender" at least four times in an attempt to distinguish care available based on gender identity. However, Plaintiffs cite nothing for the proposition that an individual participant's cisgender identity plays any role in coverage determinations, because it is simply not the case. Plaintiffs intentionally use "cisgender" when referring to care that is available to all members regardless of gender identity in an effort to draw a false distinction.

coverage for one benefit and not for another, is simply part of the balancing that Medicaid must reasonably do in order to provide coverage in the best interests of all of its recipients. It is conceivable that any number or combination of Medicaid members who share certain traits or characteristics may have medical needs or desires specific to their specific traits or characteristics. However, Medicaid is not required to tailor benefits to each group's particular needs. *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Instead, the federal Medicaid Act "gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in "the best interests of the recipients." *Id.*, citing 42 U.S.C. § 1396a(a)(19). Medicaid strikes this balance in an appropriate fashion by covering the vast majority of gender-confirming treatments that may be sought by its members, while not covering gender-confirming surgical treatments, which is one specialized category of treatments. The Constitution and federal law do not require more than this, and Defendants' Motion for Summary Judgment should be granted.

II. ANALYSIS[3]

A. Defendants Crouch and Beane have not deprived Plaintiffs of Equal Protection.

1. Plaintiffs Have Not Been Treated Differently From Others Similarly Situated

"The Clause 'does not take from the States all power of classification,' but 'keeps governmental decision makers from treating differently persons who are in all relevant respects alike.'" *Morrison*, 239 F.3d at 654 quoting *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 271 (1979) and *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). Here, "similarly situated" individuals who are "in all relevant respects alike" can only refer to other Medicaid participants with gender

[3] Defendants incorporate the facts and argument contained in their Response in Opposition to Plaintiffs' Motion for Summary Judgment, ECF No. 261.

dysphoria who seek gender-confirming surgery. Though Plaintiffs seek comparison with cisgender individuals who seek coverage for surgical care such as mastectomy for reasons other than gender-confirmation, those individuals are not "in all relevant respects alike" because the procedures sought by cisgender individuals are not gender-confirming procedures, and transgender individuals also have access to those procedures.

Plaintiffs argue that the Medicaid policy uses explicitly sex-based terms which reveal facial discrimination based on sex. (ECF 262, p. 5). However, as explained above, Medicaid does not in fact make any distinction with respect to the gender identity of the person seeking gender-confirming care. The policy language describes the benefit, not any characteristic of the person seeking the benefit in any particular case.

Plaintiffs argue that "treating, for example, a woman whose sex assigned at birth was female more favorably than a woman whose sex assigned at birth was male is inextricably tied to discrimination based on sex." (ECF 262, p. 5). Similarly, Plaintiffs argue that the policy "'entrenches' the sex-stereotyped 'belief that transgender individuals must preserve the genitalia and other physical attributes of their [birth-assigned] sex[.]'" (ECF 262, p. 5, quoting *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018). The problem with these arguments is that Plaintiffs have not pointed to anything in the record indicating that Medicaid makes a determination relative to its policy based upon "sex assigned at birth." Medicaid's system is based upon binary male or female designations, and does not designate gender identity. (ECF 252-10, Tr. pp. 110-112; ECF 252-1 Tr. p. 100). Thus, Medicaid's system has no way to distinguish whether the designation in the system matches a person's "sex assigned at birth" or not. By extension, a person's "sex assigned at birth" can play no role in Medicaid's decision if it does not collect that data. There is equally no evidence in the record here that Medicaid's policy has any

connection to any sex-stereotyped belief at all, much less one that would favor a person preserving the genitalia of their birth-assigned sex. To the extent that *Boyden* makes that generalization, it is not persuasive as applied to the facts of this case. Moreover, *Boyden* recognizes that where the policy at issue "does not treat individuals differently based on sex," the rational basis test would apply as set forth in *Geduldig v. Aiello*, 417 U.S. 484 (1974)). *Boyden*, 341 F. Supp. 3d at 999-1000.

Plaintiffs argue that discrimination "on the basis that an individual was going to, or had, or was in the process of *changing* their sex . . . is . . . discrimination based on sex." (ECF 262, p. 5, quoting *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 949 (W.D. Wis. 2018) (emphasis added)). Similarly, Plaintiffs argue that the policy discriminates based on transgender status. (ECF 262, p. 5). But Medicaid does not discriminate on this basis. Medicaid covers the vast majority of gender-confirming treatments that may be sought by its members, including hormones. This would not be the case if Medicaid discriminated based upon an individual member being in the process of changing their sex or based upon their transgender status.

Plaintiffs argue "the fact that Defendants would cover care for a transgender participant's broken leg" does not justify its policy regarding gender-confirming care. Again, Plaintiffs attempt to compare things that are not alike in an effort to avoid comparing things that are alike and are treated alike by Medicaid. Of course Medicaid would cover care for a transgender participant's broken leg on the same terms as any other individual. Medicaid would also cover care for a transgender participant's mastectomy, hysterectomy, or other covered procedure if the participant met the coverage criteria. Plaintiff Fain's hysterectomy that was covered by Medicaid illustrates this point. (ECF 252-5, Tr. pp. 52-53). Mr. Fain met the coverage criteria that would have been applied to any other individual for the service, regardless of transgender status. In that instance,

Mr. Fain was "similarly situated" "in all relevant respects" to other individuals meeting the criteria for that covered service and was treated in the same manner by receiving coverage.

Plaintiffs argue that no party "genuinely disputes that Medicaid covers the same care that Plaintiffs seek here for cisgender participants." (ECF 262, p. 9). Again, Plaintiffs substitute the word "cisgender" where it does not belong. Defendants dispute that there is any difference in coverage based upon cisgender or transgender status. The record bears this out. The Defendants acknowledge that certain services are partially or fully covered for "some diagnoses not related to Gender-Confirming Care." (ECF 250-4). This coverage is not limited to cisgender individuals as Plaintiffs repeatedly assert, but is uniformly applied to all participants. Plaintiffs apparently assume, and ask this court to adopt, the premise that *only* cisgender members are accessing covered surgical procedures. This assumption has no support and is also is contradicted by Mr. Fain's own claims history. It is not surprising that Plaintiffs fail to acknowledge that transgender members have access to the same coverage as cisgender members or members of any other gender identity, because this is fatal to Plaintiffs' claims.

Plaintiffs assert that Medicaid's argument that there is no differential treatment with respect to vaginoplasty surgery because Medicaid has not had a claim for it since 2016 is "nonsensical," but Plaintiffs miss the point. (ECF 262, p. 11). Plaintiffs assert that Medicaid "regularly cover[s] the same kinds of care Plaintiffs seek here." (ECF 262, p. 12). Defendants are simply pointing to the claims history to demonstrate that, at least with respect to vaginoplasty, that is not true. As a result, there is no basis of comparison to which Plaintiffs can refer to attempt to demonstrate that they are "in all relevant respects alike" to others for whom vaginoplasty may be covered.[4]

[4] Plaintiffs assert that Defendants have made "at least two different binding admissions" that vaginoplasty is covered "for cisgender participants when medically necessary." (ECF 262, p. 11, FN 27). Plaintiffs are correct as to coverage generally, but incorrect as to the qualifying phrase

Plaintiffs attempt to characterize Dr. Schechter's testimony as establishing the similarity in surgical procedures. (ECF 262, p. 10). However, this is contrary to the description he provided which emphasized the differences, rather than any similarities, in the procedures employed. (ECF 252-15, Tr. pp. 70-71, 127-129, 155-156). Similarly, Plaintiffs' expert Dr. Olson-Kennedy describes one such gender-confirming surgery as "masculinizing chest surgery." (ECF 252-18, Tr. p. 130). Plaintiffs argue that Medicaid covers masculinizing chest surgery because InterQual recognizes that this surgery can be medically necessary to treat gynecomastia in men and adolescents. (ECF 262, p. 11). However, Medicaid does not cover surgery for gynecomastia based solely on psychosocial symptoms. (ECF 252-19). The coverage criteria for surgical treatment of gynecomastia require the patient's condition to cause physical symptoms. (ECF 252-19).

Medicaid does not provide surgical coverage for any DSM-V diagnosis. (ECF 252-19). Plaintiffs argue based upon Dr. Schechter's testimony, that "gender dysphoria also is widely recognized as a medical condition." (ECF 262, p. 12). Dr. Schechter's attempt to characterize gender dysphoria as a "medical condition" is speculation based on the fact that Dr. Schechter is a surgeon and does not diagnose gender dysphoria. (ECF 252-15, Tr. pp. 54-57). His testimony conflicts with that of Dr. Olson-Kennedy, who does diagnose gender dysphoria, and who stated that the clinical condition "is outlined in the DSM-V. That is the definition of gender dysphoria." (ECF 252-18, Tr. pp. 20-21, 52-53).

2. There is No Evidence of Intentional or Purposeful Discrimination.

"for cisgender participants." Defendants admit "that Defendants partially or fully cover vaginoplasty procedures for some diagnoses not related to Gender-Confirming Care." (ECF 250-4). The other document cited by Plaintiffs states "[w]e have had no claims or approvals for these services." (ECF 250-8, at Int. No. 9). Defendants stand by these statements, and are not attempting to "walk away from" them. Notably, however, neither of these documents cited by Plaintiffs is specific to "cisgender participants" in any way.

Plaintiffs argue that Medicaid's policy facially discriminates based on sex and transgender status, precluding the need to show intent. However, because the policy does not facially discriminate based on sex or transgender status, Plaintiffs must demonstrate discriminatory intent, and there is no evidence of intention on the part of Defendants Crouch or Beane to discriminate. The fact that the policy has been maintained, without more, certainly is not evidence of discriminatory intent. Additionally, CMS does not require coverage for this particular service. (ECF 252-1 Tr. pp. 140, 162). Health and Human Services ("HHS") evaluated the evidence in 2016 and refused to mandate coverage for transgender surgeries, leaving it up to the individual states to decide, due to lack of evidence of long-term benefits. (ECF 252-11, ¶ 24). Medicaid and the officials who administer the state program are acting reasonably in also declining to mandate such coverage, as they rely upon guidance from HHS and CMS to determine required coverages. Plaintiffs argue that CMS guidelines are not a "license to discriminate." (ECF 262, p. 13). However, courts recognize that Medicaid is administered on the federal level by CMS. *Davis v. Shah*, 821 F.3d 231, 238 (2d Cir. 2016). More importantly, Medicaid state plans are subsidized by the federal government only after "CMS approves the state plan as complying with all statutory and regulatory requirements." *Id.*, citing 42 U.S.C. §1396a(b), 1396b; *Rodriguez v. City of New York*, 197 F.3d 611, 613 (2d Cir. 1999). It is certainly relevant to the question of discriminatory intent that Medicaid relies on this approval to conclude that it is in compliance with applicable requirements.

3. The Classification Survives Rational Basis Review.

A policy that affects some, but not all, transgender individuals, is not discrimination on the basis of sex or transgender identity. *Lange v. Houston Cty., Georgia*, 499 F. Supp. 3d 1258 (M.D. Ga. 2020) (healthcare plan exclusion for "sex change surgery" facially neutral for purposes of the

Equal Protection Clause under analysis in *Geduldig v. Aiello*, 417 U.S. 484 (1974)). Such a classification is not a suspect or quasi-suspect class; therefore, rational basis review applies.

The instant case is analogous to *Geduldig v. Aiello*, 417 U.S. 484 (1974)[5], where the Supreme Court considered a challenge to a provision in a California disability insurance program that excluded coverage for disability that accompanies normal pregnancy and childbirth. *Id.* at 492. The Court held that the program exclusion did not constitute invidious discrimination on the basis of sex under the Equal Protection Clause because it did "not discriminate with respect to the persons or groups which are eligible for disability insurance protection under the program." *Id.* at 494. Notably, the Court explained:

> The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition – pregnancy – from the list of compensable disabilities. While it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification . . . [.] Normal pregnancy is an objectively identifiable physical condition with unique characteristics. Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis, just as with respect to any other physical condition.
>
> The lack of identity between the excluded disability and gender as such under this insurance program becomes clear upon the most cursory analysis. The program divides potential recipients into two groups – pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes.

Id., at 496 FN 20. The Court applied rational basis review and acknowledged the state's ability to insure some risks and not others, and specifically found that the state "has an interest in distributing

[5] Congress amended Title VII in 1978 to prohibit discrimination on the basis of pregnancy, childbirth, or related medical conditions. *See Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 678-79, 103 S. Ct. 2622 (1983). However, the Court's analysis in *Geduldig* related to whether an insurance exclusion based on a health condition is facially discriminatory under the Equal Protection Clause remains intact. *Lange v. Houston Cty., Georgia*, 499 F. Supp. 3d 1258, 1276 (M.D. Ga. 2020).

the available resources in such a way as to keep benefit payments at an adequate level for disabilities that are covered, rather than to cover all disabilities adequately." *Id.* at 494-495.[6] By the same analysis, Medicaid's policy does not create a sex-based classification, because it divides potential recipients into two groups – those with gender dysphoria who seek gender-confirming surgery, and all other persons. While the first group is expected to be exclusively comprised of transgender individuals, the second group includes all other persons, whether cisgender, transgender, or other identity, who do not seek gender-confirming surgery.

Plaintiffs argue that *Geduldig v. Aiello*, 417 U.S. 484 (1974), was decided before the Supreme Court recognized sex stereotyping as a form of discrimination. However, Plaintiffs have pointed to no facts in this case which suggest that Medicaid's policy is a result of sex stereotyping. Additionally, *Geduldig* was decided after both *Phillips v. Martin Marietta Corp.*, 400 U.S. 542 (1971) and *Sprogis v. United Air Lines, Inc.*, 444 F.2d 1194 (7th Cir. 1971) upon which Plaintiffs rely. Both *Phillips* and *Sprogis*, like *Bostock v. Clayton Cty.*, 140 S. Ct. 1731 (2020), are employment cases decided under Title VII of the Civil Rights Act of 1964 and do not inform an Equal Protection analysis, or any analysis under the ACA or the Medicaid Act.

Plaintiffs criticize the Defendants' reliance on *Toomey v. Arizon*a, 2020 U.S. Dist. LEXIS 224159, *13 (U.S.D.C. D. Ariz. Nov. 30, 2020), arguing that the portion relied upon was rejected by the District Judge. (ECF 262, p. 7). Plaintiffs are correct that the District Judge adopted the Report and Recommendation "only to the extent it recommends denying the Motion for Preliminary Injunction on the grounds that Plaintiff has not met the heightened standard for

[6] Similarly, the Supreme Court applied rational basis review when addressing the Hyde Amendment, which restricted the availability of certain medically necessary abortions under Medicaid, finding that the amendment was not predicated on a constitutionally suspect classification. *Harris v. McRae*, 448 U.S. 297, 322-324, 100 S. Ct. 2671 (1980). The Court found it was rational to authorize "federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions" because of the inherent difference from other medical procedures. *Id.* at 325.

obtaining mandatory preliminary injunctive relief" and otherwise rejected it. *Toomey v. Arizona*, 2021 U.S. Dist. LEXIS 36944 at *18-19 (U.S.D.C. D. Ariz. Feb. 26, 2021). The District Judge did not specify disapproval of any particular analysis employed in the Report and Recommendation, and did not enter any order contrary to the analysis employed. *Id.* Plaintiff's objection included an argument that the Report and Recommendation "erred in concluding that Plaintiff and the class members are unlikely to succeed on the Title VII and equal protection claims." *Id.*, at *11-12. The District Judge overruled Plaintiff's Objection. *Id.*, at *19. Regardless, nothing prevents this Court from applying the analysis as set forth by the United States Magistrate Judge in *Toomey* to the facts of this case.

Although Plaintiffs argue that *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586 (4th Cir. 2020) supports their position, *Grimm* was decided on vastly different facts. *Grimm* was decided in the context of a school's bathroom policy. It had nothing to do with the provision of medical coverage under Medicaid or otherwise.[7] *Grimm* applied heightened scrutiny "because the bathroom policy rests on sex-based classifications and because transgender people constitute at least a quasi-suspect class." *Grimm*, 972 F.3d at 607. As discussed above, Medicaid's policy does not rest on sex-based classifications and it does not discriminate against "transgender people" as a class, therefore *Grimm's* analysis does not apply here. *Grimm* had an abundant factual record regarding adoption of the bathroom policy in question, whereas in the instant case, there is no record regarding the genesis of Medicaid's policy. The Fourth Circuit found that the plaintiff in *Grimm* was "viewed as failing to conform" to sex stereotypes. *Id.*, at 608. Here, there are no facts suggesting that Medicaid's policy is based on any such considerations or stereotypes.

[7] Similarly, *Bostock v. Clayton Cty.*, 140 S. Ct. 1731 (2020) was decided in the context of employment discrimination under Title VII of the Civil Rights Act of 1964, and did not decide any issue in the context of the provision of medical coverage under the Equal Protection Clause, the ACA, or the Medicaid Act.

Under rational basis review, it is Plaintiffs' burden "to negate every conceivable basis which might support" the alleged unequal treatment, and Defendants have "no obligation to produce evidence to support the rationality of the [classification], which may be based on rational speculation unsupported by any evidence or empirical data." *Giarratano v. Johnson*, 521 F.3d 298, 303 (4th Cir. 2008) (citation omitted). The policy complained of by the Plaintiffs is rationally related to the State's interests in providing coverage consistent with what is required by CMS and in conserving financial resources available to the Medicaid program for the benefit of providing services to its members on an ongoing basis. There is also evidence in the record with respect to the disputed medical necessity of gender-confirming surgery, as well as the lack of evidence of long-term benefits as determined by HHS in 2016. Thus, the rational basis test has been satisfied.

Plaintiffs claim that any argument related to medical necessity is hypothesized or invented in response to litigation. (ECF 262, p. 15). However, the inquiry is relevant and ties into the fact that the state of science was evaluated by HHS. While Medicaid may not have undertaken its own review of medical science specifically with respect to maintaining its policy, and it may not have relied upon any particular document, it has consistently relied upon the fact that it covers what CMS deems to be required. (ECF 252-3, Tr. pp. 32-33, 71-73, 134-142). Medicaid clearly has relied on the absence of mandated coverage, so the conclusion of HHS and CMS in declining to mandate the coverage based on the lack of evidence of long-term benefits is relevant to this inquiry, as well as information that supports such a conclusion.[8] When presented with this same information, the United States District Court for the District of Arizona found this information "instructive that CMS found the clinical evidence is 'inconclusive'" for the Medicare adult

[8] Defendants also rely on and incorporate their Response to Plaintiffs' Motion to Exclude Expert Testimony of Stephen B. Levine, M.D., ECF 260 and 260-1, with respect to the relevance and admissibility of Dr. Levine's opinions.

population. *Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1041 (U.S.D.C. Dist. Ariz. March 30, 2021) (aff'd by Doe v. Snyder, 2022 U.S. App. LEXIS 6217 (9th Cir. Ariz., Mar. 10, 2022).

4. The Classification Serves An Important Governmental Purpose.

Even if intermediate scrutiny were applied, there is evidence to support a finding that the classification is not unlawful. Intermediate scrutiny "does not demand that the challenged law 'be the least intrusive means of achieving the relevant government objective, or that there be no burden whatsoever on the individual right in question.'" *Md. Shall Issue, Inc. v. Hogan*, 2021 U.S. Dist. LEXIS 159168, *34 (D. Md. Aug. 23, 2021) quoting *U.S. v. Masciandaro*, 638 F.3d 458, 470 (4th Cir. 2011) (citation omitted). Medicaid's means are substantially related to important purposes because it cannot add additional covered services without potentially jeopardizing coverage for existing services on an ongoing basis. Thus, Defendants are entitled to summary judgment.

B. Defendants have not violated Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116.

Plaintiffs allege that Defendants have drawn a classification that discriminates against Plaintiffs based on sex. However, as explained above, Medicaid does not in fact make any distinction with respect to the sex or gender identity of the person seeking gender-confirming care. The policy language describes the benefit, not any characteristic of the person seeking the benefit in any particular case. Furthermore, for the reasons discussed in section A. 3. of this Reply, *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586 (4th Cir. 2020), was decided on vastly different facts and did not reach any conclusion in the context of the provision of medical coverage under Medicaid or otherwise. Medicaid's policy does not rest on sex-based classifications and it does not discriminate against "transgender people" as a class, therefore *Grimm's* analysis does not apply here. On the other hand, *Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1045 (D. Ariz. 2021) (*aff'd by Doe v. Snyder*, 2022 U.S. App. LEXIS 6217 (9th Cir. Mar. 10, 2022) more closely fits

the facts of the instant case, and this court should reach the conclusion that Plaintiffs cannot succeed on their claim under Section 1557 where the challenged policy "only excludes gender reassignment *surgery*—it does not exclude coverage for other treatments for gender dysphoria such as hormone therapy." *Id.* (emphasis in original).

As the Supreme Court has explained, "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs." *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Instead, the benefit provided by Medicaid "remains the individual services offered[.]" *Id.* Medicaid does not classify coverage based on transgender identity. Instead, it has designated certain services as non-covered services. This does not violate the ACA, and the Defendants are entitled to summary judgment on this claim.[9]

C. Defendants Have Not Violated the Medicaid Act's Availability Requirements.

Plaintiffs argue that the Defendants have violated the Medicaid Act's Availability Requirements, however, Plaintiffs have not identified under which provision of Section 1396d gender-affirming surgery allegedly falls. Regardless, "nothing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care." *Beal v. Doe*, 432 U.S. 438, 444, 97 S. Ct. 2366, 53 L. Ed. 2d 464 (1977). "Indeed, the statute expressly provides: 'A State plan for medical assistance must… include reasonable standards… for determining eligibility for and the extent of medical assistance under the plan which… are consistent with the objectives of this [Title]….' 42 U.S.C. § 1396a (a)(17) (1970 ed., Supp. V)." *Id.*[10]

[9] Plaintiffs acknowledge that they may not recover damages for emotional distress under the ACA. Because the only compensatory damages sought by Plaintiffs were for emotional distress, any recovery of compensatory damages by Plaintiffs in this matter is foreclosed by *Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562 (2022).

[10] This language appears in the current version of 42 U.S.C. § 1396a(a)(17), though additional language has been added to this section of the statute.

The Supreme Court's decision in *Beal* is consistent with the Medicaid Act's accompanying regulations. HHS regulations implement the statutory requirements of "Section 1902(a)(10), regarding comparability of services for groups of beneficiaries, and the amount, duration, and scope of services described in section 1905(a) of the Act that the State plan must provide for beneficiaries[.]" 42 C.F.R. § 440.200(a)(1). The regulations set forth the criteria for availability, including that "[t]he agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230. Thus, it is clear that the regulations permit a State Medicaid plan to place limits on services even if those services are required to be covered. *See Casillas v. Daines*, 580 F. Supp. 2d 235, 245-46 (S.D.N.Y. 2008). Plaintiffs cite to *Cruz v. Zucker*, 116 F. Supp. 3d 334 (S.D.N.Y. 2015) for the proposition that a limitation "based solely on animus towards a disfavored class" would not be an appropriate limit. (ECF 262, p. 22). Medicaid's policy is not based on animus towards a disfavored class, nor does it make any distinction between classes of people based on sex or gender identity. Thus, this reasoning does not apply here. Plaintiffs also argue that "[w]here Defendants have elected to cover this surgical care, they must do so without discrimination within the categories of surgical care they already cover." (ECF 262, p. 20). This is precisely what Medicaid's policy is, because it does not discriminate with respect to covered surgical services.

Plaintiffs selectively quote one portion of *Beal v. Doe*, 432 U.S. 438, 444 (1977), for the proposition that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage." (ECF 262, p. 20). However, the Supreme Court has acknowledged that not all medically necessary services are covered by Medicaid, nor are they required to be covered. *Harris v. McRae*, 448 U.S. 297, 308-310, 325, 325 FN 28, 100 S. Ct. 2671 (1980).

Even if gender-affirming care falls into one of the mandatory covered service categories, State plans are permitted to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. 42 C.F.R. § 440.230(d), *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Numerous courts, consistent with *Choate*, have held that states retain broad discretion to determine the extent of medical assistance offered in their Medicaid programs.[11]

To prevail on their claim for alleged violation of the Medicaid Act's availability requirements, Plaintiffs must prove that Defendants have failed to make available to them care that is required to be covered. Medicaid has exercised its discretion and chosen the proper mix of amount, scope, and duration limitations on coverage for gender-affirming care. As set forth in the Memorandum of Law in Support of Defendants' Motion for Summary Judgment (ECF 253), medical necessity of gender-affirming surgery is still being debated, is not settled science, and the assumption of such carries significant risks. Defendants' Motion for Summary Judgment should be granted on this claim.

D. Defendants Have Not Violated the Medicaid Act's Comparability Requirements.

Plaintiffs argue that the Defendants have violated the Medicaid Act's Comparability Requirements. As part of their argument, Plaintiffs assert that "Defendants state that they only provide coverage for mastectomies to treat breast cancer." (ECF 262, p. 24).[12] However, this is not what Defendants have stated. Rather, Defendants have consistently stated that under Medicaid's policy, individuals diagnosed with breast cancer do not require prior authorization. (ECF 252-14,

[11] *See Mennonite Gen. Hosp. v. Molina Healthcare of P. R.*, 319 F. Supp. 3d 587, 591 (D.P.R. 2018); *DeSario v. Thomas*, 139 F.3d 80, 96 (2nd Cir. 1998).

[12] In support of this contention, Plaintiffs cite to ECF 253, p. 22 ("Defendants assume that Plaintiffs are alleging that, because Defendants do provide coverage for mastectomy for patients with breast cancer, Medicaid is required to provide coverage for mastectomy for any and all diagnoses . . . "). However, this quoted statement does not state that Defendants claim to provide coverage for mastectomy *only* for patients with breast cancer.

Tr. pp. 16-17). To determine whether mastectomy or related reconstructive procedures are covered for any reason other than breast cancer, "a request would have to go through the UM vendor, which is the utilization management vendor which is Kepro. They have a list they could review for medical necessity to determine if that would be covered or not under [Medicaid] policy." (ECF 252-14, Tr. pp. 17-18). Approval is based on many factors other than the diagnosis, such as medical history, previous treatment, severity of diagnosis, and combination of other symptoms and conditions. (ECF 252-13, p. 2). And though Plaintiffs assert that Medicaid covers "masculinizing surgeries for cisgender men and adolescents," Medicaid does not cover surgery for gynecomastia based solely on psychosocial symptoms. (ECF 252-19). The coverage criteria for surgical treatment of gynecomastia require the patient's condition to cause physical symptoms. (ECF 252-19).

Davis v. Shah, 821 F.3d 231 (2d Cir. 2016), is readily distinguishable because it did not involve a claim alleging any form of sex discrimination. And, notably, *Davis* acknowledged as a general principle that courts "owe a 'significant measure of deference to CMS's interpretation' of the Medicaid Act, including to its 'implicit judgment' that 'a state plan complies with federal law' in approving that plan[.]" *Id.*, at 247, quoting *Cmty. Health Ctr. V. Wilson-Coker*, 311 F.3d 132, 137, 140 (2d Cir. 2002). Plaintiffs do not dispute that CMS has approved Medicaid's plan. Additionally, Medicaid complies with *Davis*' recognition that "[E]ach person . . . shall be eligible for the same 'amount, duration and scope' of coverage as all the others in his or her group . . . [.]" *Id.*, at 256, quoting *Becker v. Toia*, 439 F. Supp. 324, 333 (S.D.N.Y. 1977).

Similarly, *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977), is readily distinguishable and did not involve alleged sex discrimination. In *White*, the Third Circuit determined that a state plan could discriminate in benefits based upon the degree of medical necessity but not upon the medical

disorder from which the person suffers. *Id.*, at 1152. The court explained its rationale, stating "a state plan providing eyeglasses only to those with a specified amount of visual impairment, regardless of its cause, would be consistent with the regulations." *Id.* Such analysis has no applicability to the instant case because the benefit at issue is not the same. Unlike in *White*, where the court determined that "amount of visual impairment" could be compared, there is no equivalent way under the facts of this case to utilize a similar analysis.

The plain language of the regulations prohibits three types of discrimination: (1) against the categorically needy, (2) among the categorically needy, and (3) among the medically needy. *See Schott v. Olszewski*, 401 F.3d 682, 686 (6th Cir. 2005). Here, Plaintiffs do not allege that they are treated differently than other Medicaid recipients based on their status as categorically needy, and thus they do not state any claim. Plaintiffs' argument was advanced and correctly rejected in *Rodriguez v. City of New York*, 197 F.3d 611, 615-16 (2nd Cir. 1999). This same reasoning was later applied to gender-affirming surgeries in *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008). There, the plaintiff argued that, "because a mastectomy is an indicated and reimbursable treatment for breast cancer, then a female-to-male transsexual with a diagnosis of [gender identity disorder] would be entitled to reimbursement for the same treatment." *Id.* at 244. The Court rejected the plaintiff's argument and adopted *Rodriguez*, stating, "[i]f Congress had intended to compel a state to provide a treatment for all diagnoses if the treatment were provided for any diagnosis, one would have expected it to have done so in clear language." *Id.* at 245 (internal citation omitted). In order to prevail on this claim, Plaintiffs must prove that Defendants' policy discriminates among categorically needy beneficiaries, and there is no such evidence. Therefore, the Defendants are entitled to summary judgment on this claim.

E. Plaintiffs Have No Standing.

Plaintiffs have failed to establish standing because neither has suffered an injury in fact. Neither has submitted a claim for and been denied gender-affirming care by Medicaid. Neither has submitted a claim for gender-affirming surgery. (ECF 252-4 Tr. pp. 170-171); (ECF 252-5 Tr. pp. 86-89). Mr. Fain testified that he is not willing to undergo surgery until he has kicked his smoking habit, which has not yet occurred. (ECF 252-5 Tr. pp. 87-88). Ms. Anderson has never had a treating physician find that she requires gender-affirming surgery to treat her gender dysphoria. Plaintiffs argue that the Defendants mischaracterize Mr. Fain's testimony. However, his self-serving statement that he could quit smoking any time does not change the fact that, during the entire pendency of this case to the present time, Mr. Fain is not in a position to undergo surgery. Thus, neither Plaintiff has established a concrete and particularized injury that is actual or imminent. Therefore, both Plaintiffs lack standing, and Defendants are entitled to summary judgment.[13]

III. CONCLUSION

Because Plaintiffs have failed to prove that Defendants have engaged in discrimination against them, or violated either the ACA or the Medicaid Act, and because all of the genuine material facts in the light most favorable to the Plaintiffs cannot support Plaintiffs' case, Defendants request judgment in their favor as a matter of law.

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

By counsel

[13] Additionally, to the extent that Plaintiffs seek any relief based upon any alleged policy regarding coverage for puberty-delaying treatment, Plaintiffs are not seeking puberty-delaying treatment and have no standing to assert any claims related to coverage or non-coverage for puberty-delaying treatment on behalf of themselves or any putative class. (ECF 251 p. 3 FN 1, p. 8 FN 38).

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

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

Plaintiffs,

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

v.

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

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources Bureau for Medical Services, by counsel, and do hereby certify that on the 21st day of June, 2022, a true and exact copy of **"DEFENDANTS' REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT"** was served on counsel via electronic means as follows:

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