

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, *et al.*,

Plaintiffs,

v.

JASON WEIDA, *et al.*,

Defendants.

Case No. 4:22-cv-00325-RH-MAF

PLAINTIFFS' NOTICE OF FILING DEPOSITION TRANSCRIPTS

Pursuant to the Court's direction, Plaintiffs hereby submit this Notice of Filing to file the following deposition transcripts, highlighted to reflect the deposition designations identified in Plaintiffs' Rule 26(3)(a) disclosures (ECF No. 162).

1. Matthew Brackett, Defendant AHCA's 30(b)(6) representative.
2. Ann Dalton, Bureau Chief for Defendant AHCA, Bureau of Medicaid Policy.
3. G. Kevin Donovan, Author of GAPMS Report Attachment.

Dated: May 17, 2023

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CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of May, 2023, a true copy of the foregoing has been filed with the Court utilizing its CM/ECF system, which will transmit a notice of electronic filing to counsel of record for all parties in this matter registered with the Court for this purpose.

/s/ _____

Attorney for Plaintiffs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO. 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiffs,

vs.

JASON WEIDA, et al.,

Defendants

Volume 1, Pgs. 1 - 124

VIDEOTAPED DEPOSITION OF: MATTHEW BRACKETT

AT THE INSTANCE OF: THE PLAINTIFFS

DATE: FEBRUARY 8, 2023

TIME: COMMENCED: 10:00 A.M.

LOCATION: AGENCY FOR HEALTH CARE
ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FLORIDA 32308

REPORTED BY: DANA W. REEVES
Court Reporter and
Notary Public in and for
State of Florida at Large

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21
22 ALSO PRESENT:
23 RL Minnich, Videographer
24
25

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MATTHEW BRACKETT

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*Uh-uh is a negative response

*Uh-huh is a positive response

1 D E P O S I T I O N

2 VIDEOGRAPHER: This is the video-recorded
3 deposition of corporate representative for Agency
4 for Healthcare Administration, in the matter of
5 August Decker, et al. vs. Jason Weida, et al. Case
6 No. 4:22-cv-00325, RH-MAF. This deposition is
7 being held at 2727 Mahan Drive in Tallahassee,
8 Florida. Today's date is February 8th, 2023 and
9 the time is 10:08 a.m. The court reporter is Dana
10 Reeves. My name is RL Minnich. I'm the
11 videographer. Would counsel please introduce
12 themselves and the court reporter please swear in
13 the witness?

14 MS. DEBRIERE: Yes, Katy DeBriere and I
15 represent the plaintiffs.

16 MS. CHRISS: Simone Chriss and I also represent
17 the plaintiffs.

18 MS. DUNN: Chelsea Dunn. I also represent the
19 plaintiffs.

20 MR. JAZIL: Mohammad Jazil for the defense.

21 MS. DEBRIERE: And we have a few people on the
22 Zoom link from the plaintiff's side. That would be
23 Catherine McKee and Omar Gonzalez-Pagan.

24 MR. PERKO: And Gary Perko on behalf of the
25 defendants on the Zoom link.

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

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

5 Whereupon,

6 MATTHEW BRACKETT
7 was called as a witness, having been first duly sworn to
8 speak the truth, the whole truth, and nothing but the
9 truth, was examined and testified as follows:

10 THE WITNESS: I do.

11 COURT REPORTER: Thank you.

12 EXAMINATION

13 BY MS. DEBRIERE::

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

17 A That's fine.

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

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

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

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

6 BY MS. DEBRIERE::

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

15 A Yes.

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

23 A Yes.

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

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

5 A I do.

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

10 A Yes.

11 Q Have you ever been deposed before?

12 A Yes, I have.

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

18 A Okay.

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

24 A I'm fine with that.

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

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

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

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

11 A Okay.

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

14 A No.

15 Q And state your name for the record.

16 A So my full name is John Matthew Brackett.

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

20 A That's correct.

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

25 A Yes.

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

3 A Yes.

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

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

7 Q And who provided them to you?

8 A Those were provided to me by our outside
9 counsel.

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

12 A Yes, I did.

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

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

23 Q Okay. Who did you speak to?

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

1 consulted my supervisor Devona Pickle.

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

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

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

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

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

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

1 BY MS. DEBRIERE::

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

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

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

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

22 Q The conferences, what were those about?

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

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

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

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

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

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

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

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

3 BY MS. DEBRIERE::

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

6 A Yeah, close enough.

7 Q What was your role at the Agency?

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

16 Q And how long did you do that for?

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

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

21 A Yes, I was.

22 Q And what was your role then?

23 A I was a Government Analyst II. And during
24 that time period, that was from January 2017 to November
25 2017, I was -- my role specifically tasked with

1 completing the Generally Accepted Professional Medical
2 Standards reports.

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

5 A Yes.

6 Q And what did you do then?

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

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

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

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

17 A Yes.

18 Q And that was in December of 2017 through --

19 A November 2017 through April of 2021.

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

22 A April 2021.

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

1 familiar, at Section 2.83, and it's incorporated by
2 reference into rule by Florida Administrative Code Rule
3 59-G-1.010.

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

6 MS. CHRISS: Yes.

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

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

11 MR. JAZIL: Thank you.

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

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

16 BY MS. DEBRIERE::

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

19 A Okay.

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

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

24 Q What does AHCA use that medical necessity
25 standard for?

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

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

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

8 Q Okay. Tell me why.

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

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

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

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

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

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

10 A No.

11 Q Okay. Why not?

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

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

18 A No, we wouldn't.

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

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

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

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

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

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

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

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

25 A No, they need to consult with us before

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

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

9 MS. CHRISS: May '22.

10 BY MS. DEBRIERE::

11 Q May 20th, 2022.

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

14 MS. DEBRIERE: Yes. Yes.

15 VIDEOGRAPHER: The one to your right. Thank
16 you.

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

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

21 MS. DEBRIERE: Should I mark this as 3?

22 MS. CHRISS: Yes, the one for him.

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

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

1 committed to memory?

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

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

5 MS. DEBRIERE: Thanks.

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

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

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

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

15 BY MS. DEBRIERE::

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

18 A Yes.

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

21 A Okay.

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

1 A Okay.

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

5 A Yes, this is.

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

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

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

19 A One of our staff pharmacists probably would.

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

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

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

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

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

19 Q Do they compare it to coverage policies or
20 guidelines?

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

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

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

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

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

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

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

25 A Well, so the thing about Medicaid coverage for

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

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

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

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

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

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

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

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

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

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

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

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

9 A Can you repeat that?

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

14 MR. JAZIL: Object to form.

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

23 BY MS. DEBRIERE::

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

1 authorization review?

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

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

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

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

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

25 Q Does that policy list every potential

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

3 A No. So -- because Florida Medicaid covers any
4 drug that's FDA approved, when these medical necessity
5 guidelines, that's kind of an encompassing umbrella.
6 And then, of course, we do have the preferred drug list
7 which is assembled by the Pharmaceutical and
8 Therapeutics Committee. We always just call P&T, so --
9 but because the list is so vast we don't actually
10 reproduce it in any kind of a form. So the prescribed
11 drug services policy, the way it's worded is supposed to
12 be all-encompassing, but there are exclusions in Section
13 5.2 of non-covered service -- of drugs that we won't
14 cover under certain circumstances.

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

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

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

25 A Yes.

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

4 A Oh, are we talking about estradiol.

5 Q Estradiol. Thank you.

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

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

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

13 Q Okay. How about micronized progesterone?

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

16 Q Okay, but not specifically named?

17 A We don't specifically name drugs.

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

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

1 Q Okay. Finasteride.

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

6 Q Dutasteride.

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

11 Q Okay. Testosterone.

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

15 Q Testosterone enanthate.

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

19 Q Okay. Two more. Testosterone undecanoate.

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

23 Q Gonadotropin-releasing hormone antagonists.

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

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

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

5 A Not promulgated into rule.

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

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

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

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

22 MS. CHRISS: This one?

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

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

3 THE WITNESS: I've seen it enough times.

4 BY MS. DEBRIERE::

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

7 A Yes.

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

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

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

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

1 medical necessity is made.

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

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

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

10 A That's correct.

11 Q And how do they do that?

12 A How do they do that?

13 Q Yeah.

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

22 Q Okay. MPI stands for --

23 A Medicaid Program Integrity.

24 Q So that's like a fraud investigation?

25 A Yes, there are two fraud investigation teams

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Q Do you know what a drug compendium is?

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

1 Q Which three are you aware of?

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

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

15 A That sounds correct.

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

18 A Yes.

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

22 A Okay, that's fine.

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

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

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

6 Q Do not require.

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

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

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

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

1 it?

2 A Yes, I recognize that.

3 Q What is the PDL?

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

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

21 Q Okay. Okay.

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

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

25 A And we do program our system with ICD-10

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

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

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

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

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

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

20 A That's correct.

21 Q Okay.

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

1 National Drug Codes.

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

5 A No, they were a little of everything.

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

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

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

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

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

14 BY MS. DEBRIERE::

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

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

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

1 A Yeah.

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

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

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

22 A Pharmacy Benefit Manager.

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

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

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

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

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

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

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

12 A Estradiol.

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

18 A That's correct.

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

21 A That's correct.

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

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

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

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

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

12 Q So that means no prior authorization is ever
13 required?

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

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

20 A Right, not until the claim comes in.

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

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

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

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

7 A Okay.

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

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

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

16 A To program it to deny it?

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

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

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

25 A For estradiol?

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

3 A So we use ICD-10 for --

4 Q ICD. Okay.

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

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

10 A That's correct.

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

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

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

23 A Yes.

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

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

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

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

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

9 Q Okay. Would it also be governed by AHCA's
10 drug criteria? And I'll just -- I'll pull that up. So
11 when I say AHCA's drug criteria, I'm referring to that
12 criteria listed at <https://AHCA> --

13 A-H-C-A -- [.myflorida.com/Medicaid/prescribed_drug/drug](https://myflorida.com/Medicaid/prescribed_drug/drug_criteria.shtml)
14 [_criteria.shtml](https://myflorida.com/Medicaid/prescribed_drug/drug_criteria.shtml).

15 And so would the drug criteria -- I'm looking
16 at the screen. It says testosterone criteria updated
17 6-16-2022. Would the indications for which testosterone
18 will be prior authorized -- prior authorized, would it
19 be contained in this criteria?

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

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

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

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

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

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

6 Q How about for managed care?

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

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

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

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

19 A On the criteria?

20 Q Uh-huh?

21 A After --

22 Q Yes.

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

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

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

10 A I have trouble following that question.

11 MR. JAZIL: Object to form.

12 BY MS. DEBRIERE::

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

15 A Okay.

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

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

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

5 A That's correct.

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

9 A What ICD-10 codes?

10 Q Yes.

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

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

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

23 MS. DEBRIERE: Thank you. Okay.

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

1 (Brief recess.)

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

4 BY MS. DEBRIERE::

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

9 A I really don't know.

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

13 A Not on the PDL, no.

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

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

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

25 A That's correct.

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

5 A That's correct.

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

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

12 Q Because why?

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

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

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

1 policy, that claim would deny.

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

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

7 Q Right.

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

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

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

24 Q What is involved in a clean claim?

25 A No errors.

1 Q Errors of what?

2 A Someone might type in the wrong code by
3 accident. Maybe they -- human error.

4 Q Okay. But you're -- but in that clean claim,
5 there's no requirement to submit the indication for
6 which it's being prescribed or AHCA undertaking a review
7 of that?

8 A I mean, we do do retrospective review of
9 claims.

10 Q At the time the coverage is being requested.

11 A Okay. Can we go back a little bit?

12 Q Yeah, yeah. Yeah. So looking at this
13 formulation of testosterone cypionate, where no clinical
14 prior authorization is required, when the claim is
15 submitted and -- when the claim is submitted, AHCA is
16 not doing a review of whether the indication it's being
17 prescribed for -- sorry. Scratch that.

18 Looking at testosterone cypionate, in the
19 formulation that we've been discussing where no clinical
20 prior authorization was required, when the claim is
21 submitted, AHCA -- neither AHCA nor its contractors does
22 a review to determine for what indication the drug is
23 being prescribed for?

24 A Right, there'd be no manual clinical review
25 process or prior authorization process, if that's what

1 you're asking.

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

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

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

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

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

23 A Yes, we have a procedure for that.

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

1 FDA-approved?

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

5 Q Okay. And what is that process?

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

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

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

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

1 tried other drugs?

2 A That's correct, yeah.

3 Q Okay.

4 A It would be an individualized basis.

5 Q Okay. And then the second step was what?

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

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

11 A Plus support in the peer-reviewed literature.

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

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

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

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

20 BY MS. DEBRIERE::

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

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

25 Q Okay. And that starts with the criteria that

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

4 A Uh-huh.

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

7 A Yes.

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

10 A Okay.

11 Q We are aware, plaintiff's counsel is aware of
12 three pre-2022, at least draft GAPMS reports regarding
13 Medicaid coverage of the treatment for gender dysphoria.
14 One we've already marked as Exhibit 3, and that is the
15 May 20th, 2022 version of the GAPMS for cross-sex
16 hormone therapy. We actually know of two other
17 versions, one dated June 23rd, 2017 and one dated April
18 19th, 2022. So we're going to mark the June 23rd one as
19 Exhibit 5?

20 MS. DUNN: Yes.

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

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

1 BY MS. DEBRIERE::

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

5 A I can give you more --

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

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

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

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

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

19 MR. JAZIL: Thank you.

20 BY MS. DEBRIERE::

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

23 A Okay.

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

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

4 Q Okay. And do we have that routing form?

5 MR. JAZIL: You should.

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

8 BY MS. DEBRIERE::

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

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

13 Q Please.

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

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

25 A She was one of our pharmacists.

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

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

6 BY MS. DEBRIERE::

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

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

15 Q And were any changes made on the April 19th,
16 2022?

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

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

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

24 Q Okay. And why did those questions arise?

25 A Those questions had arisen as part of the

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

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

5 A That's correct.

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

8 A Sarah Craig, I think, left in 2020.

9 Q Okay. Do you know where she went?

10 A I do not.

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

14 A Okay.

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

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

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

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

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

6 Q Uh-huh.

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

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

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

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

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

21 Q Okay. Who had access to this document?

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

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

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

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

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

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

13 Q Would it be Sheena Grantham?

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

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

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

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

21 A Yes.

22 MS. DEBRIERE: Let's flag that.

23 BY MS. DEBRIERE: :

24 Q Was this report ever finalized?

25 A To my knowledge, and I did actually do some

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

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

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

25 Q Okay.

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

5 Q And GAPMS is generally low priority?

6 A It depends.

7 Q What does it depend on?

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

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

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

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

21 A The Capitol.

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

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

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

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

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

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

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

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

24 A Yes.

25 Q Prior to its adoption, prior to AHCA's

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

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

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

14 A Under -- so, well --

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

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

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

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

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

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

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

11 Q Fee-for-service only.

12 A We don't necessarily have that information
13 available.

14 Q Why?

15 A Well, not offhand.

16 Q Why?

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

19 Q Or even just six months prior to August 21st,
20 2022.

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

1 data.

2 Q So we don't have that data in front of us.

3 And, again, you were produced as the 30(b)(6)

4 representative, so what did that data show?

5 A That data did show that some -- that there

6 were a handful of recipients who were receiving the

7 services.

8 Q In fee-for-service?

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

10 care.

11 Q Okay. So there were times, prior to the

12 adoption of the categorical exclusion for the treatment

13 of gender dysphoria, that Florida Medicaid covered

14 cross-sex hormone therapy for treatment of gender

15 dysphoria?

16 A Cumulatively for the whole program, yes, there

17 were.

18 Q Okay. So another previous GAPMS regarding

19 gender dysphoria is the GAPMS entitled puberty

20 suppression therapy, and that begins at DEF_ 000288776.

21 Although, for clarity of the record, I do want to say we

22 received multiple versions of this document, as well.

23 MS. DEBRIERE: Do we have the final one, by any

24 chance? I'm positive it was my mistake in terms of

25 listing exhibits.

1 MS. DUNN: The one that was signed?

2 MS. DEBRIERE: Yeah.

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

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

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

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

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

15 BY MS. DEBRIERE::

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

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

20 Q Okay.

21 A And the one on the puberty suppression.

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

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

1 projects from 2016.

2 Q Okay. Okay.

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

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

12 Chelsea, should we mark it?

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

14 MS. DEBRIERE: Are we on 7? Okay.

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

17 BY MS. DEBRIERE::

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

25 A This would be the final report if he signed

1 it.

2 Q Okay. So it was adopted by the Agency?

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

5 Q Who authored this report?

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

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

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

19 Q Why would she then look at puberty suppression
20 therapy?

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

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

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

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

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

10 A I think she was an RN.

11 Q Okay.

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

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

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

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

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

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

1 BY MS. DEBRIERE::

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

7 A You mean the criteria?

8 Q Yes. Yes. Exhibit 4.

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

13 Q The dates say six days.

14 A The dates say six days?

15 Q Yeah.

16 A I'll defer to that.

17 Q Okay. Are these two documents related?

18 A Can you provide some context on what related
19 means?

20 Q Is one based off another?

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

25 Q Okay. So was the special services criteria at

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

4 MR. JAZIL: Exhibit 4?

5 MS. DEBRIERE: Did I say 3? I'm sorry.

6 Exhibit 4. Thank you, Mo.

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

9 MS. DEBRIERE: Okay.

10 THE WITNESS: Based on the EPSDT consideration
11 portion.

12 BY MS. DEBRIERE::

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

17 A Yes.

18 Q Okay. And this is the -- this policy, Exhibit
19 4, is the criteria that AHCA used prior to its adoption
20 of the categorical exclusion of treatment for gender
21 dysphoria to determine whether gonadotropin-releasing
22 hormone analog would be prior authorized for pubertal
23 suppression and treating gender dysphoria, correct?

24 A Yes, correct.

25 Q Okay. Between the time this policy was

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

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

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

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

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

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

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

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

7 A I do not have those numbers.

8 Q Okay. Can we get those numbers?

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

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

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

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

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

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

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

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

13 BY MS. DEBRIERE::

14 Q Mr. Brackett, while we're looking for that,
15 let's go back to the notice of deposition. In the
16 deposition topics, we do list the number of Florida
17 Medicaid recipients who -- participants who have sought
18 any form of care for gender dysphoria from January 1st,
19 2015 until the enactment of the challenged exclusion.
20 And so as we're sitting here today, you're telling me
21 you can't answer whether -- or how many times AHCA or
22 one of its contractors authorized coverage of pubertal
23 suppression therapy for treatment of gender dysphoria,
24 is that correct?

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

1 information.

2 Q And you will provide us that information?

3 A We will obtain that information.

4 Q Okay.

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

16 MR. JAZIL: Okay. And just so the record's
17 clear, I think I provided objections to the last
18 set of depo topics. There may have been an
19 objection to this particular topic, going back to
20 2015, but we'll work with you. If we can gather
21 the information, we'll provide it.

22 MS. DEBRIERE: Okay.

23 BY MS. DEBRIERE: :

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

1 confirmation surgery.

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

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

12 BY MS. DEBRIERE::

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

16 A So this report is authored by Rebecca Buceo.

17 Q Okay. When?

18 A This was authored in the summer of 2017.

19 Q How do you know who was authored by?

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

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

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

1 Centers for Medicaid -- Medicare and Medicaid Services.

2 So I was actually on a kind of a legislative priority
3 project. And so I was not assigned to this one.

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

6 A That's correct.

7 Q Okay. Whose office was it found in?

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

12 Q Okay. And what else was in that binder?

13 A I think some of the research articles she
14 used.

15 Q Is that it?

16 A That was it.

17 Q Okay. Is Rebecca Buceo still with AHCA?

18 A No, she's not.

19 Q When did she leave?

20 A I believe she left in 2019.

21 Q Okay. And what was her subject matter
22 expertise?

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

25 Q Did she have any expertise in surgery?

1 A Not professionally, no.

2 Q What about not professionally?

3 A In other words, she's never worked as a
4 surgeon or anything like that. But, I mean -- but I
5 mean -- or in the formal education in that area.

6 Q Okay. But did she have any experience with
7 surgery that would help her inform the drafting of this
8 GAPMS?

9 A I couldn't speak to that.

10 Q Did AHCA ever rely on the conclusions in this
11 report?

12 A So this report did not get past her immediate
13 supervisor, so, no.

14 Q Okay. Prior to its adoption of the
15 categorical exclusion of treatment for gender dysphoria,
16 did Florida Medicaid ever cover gender confirmation
17 surgery for the treatment of gender dysphoria?

18 A Under fee-for-service, to the best of my
19 knowledge, we didn't. In managed care, there were a few
20 instances where the managed care plan did approve the
21 procedure.

22 MS. DEBRIERE: Okay. Can we look at those
23 exhibits now? The -- I forget what they're called.
24 They're a weird name. ATTB, ATTA. It's a weird
25 name. It wouldn't come to me.

1 BY MS. DEBRIERE::

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

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

12 BY MS. DEBRIERE::

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

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

18 BY MS. DEBRIERE::

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

22 A Yes, that would mean it was approved.

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

25 A Uh-huh.

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

4 A That's correct.

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

6 A That's gender dysphoria.

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

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

13 Q Yeah.

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

15 Q Okay. And how do you know that?

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

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

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

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

25 A Each Medicaid recipient has a unique Medicaid

1 ID assigned to them. That's correct.

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

5 A Yeah, that's correct.

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

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

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

18 A That would be correct.

19 Q Okay. Let's turn to the June 2022 GAPMS. We
20 have this exhibit. And Exhibit 11 will be the June 2nd,
21 2022 GAPMS related to the treatment of gender dysphoria.

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

24 BY MS. DEBRIERE::

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

1 June 2022 GAPMS.

2 A That's fine.

3 Q When was the request to initiate this GAPMS
4 made?

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

7 Q Were there any informal requests prior to that
8 time?

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

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

18 A Our Agency leadership.

19 Q And who is that comprised of?

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

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

1 A Yes.

2 Q Okay. Who else in leadership was aware that
3 this would be coming to AHCA prior to April 20th, 2022?

4 A At the time, Secretary Weida was serving as
5 Assistant Deputy Secretary. He did have knowledge.

6 Q Okay. Anybody else?

7 A To my -- to my knowledge, those two were the
8 ones with the knowledge of this project.

9 Q Okay. When did you have knowledge of the
10 project?

11 A Just probably a few days before we were given
12 the letter.

13 Q Okay. So, like, April 17th?

14 A Something around there. Yeah, I don't
15 remember the exact date.

16 Q Okay. Who did you gain the knowledge -- who
17 did AHCA leadership gain the knowledge from?

18 A As far as the project goes, the decision to do
19 a GAPMS to my -- so that was to do a GAPMS report, that
20 was determined by our legal as the best route to
21 evaluate the medical necessity for treatments for gender
22 dysphoria. It was that -- it was subjected to the GAPMS
23 process.

24 Q Okay. And which counsel was that?

25 A Andrew Sheeran, who's now our General Counsel.

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

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

6 Q Who would have been the first point of
7 contact?

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

10 Q And that was?

11 A Josephina Tamayo.

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

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

16 Q No.

17 A -- or about requesting a Medicaid review?

18 Q Requesting a Medicaid review.

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

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

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

1 Newman and Maureen Farino.

2 Q Okay. What other agencies were involved?

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

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

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

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

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

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

17 A I can't name them with any specificity.

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

20 A So in regards specifically to this project?

21 Q Are there other projects we should be aware
22 of?

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

25 Q Regarding what project?

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

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

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

7 Q No. Centers for Medicare. Great question.

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

10 Q Excuse me, HHS.

11 A It was in regard to that guidance.

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

15 A Right.

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

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

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

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

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

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

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

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

16 A No.

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

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

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

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

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

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

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

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

17 MR. JAZIL: Object to form.

18 MS. DEBRIERE: I can strike that.

19 BY MS. DEBRIERE::

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

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

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

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

8 MR. JAZIL: Object to form.

9 THE WITNESS: No.

10 BY MS. DEBRIERE::

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

13 MR. JAZIL: Object to form.

14 THE WITNESS: Can you rephrase that question?

15 BY MS. DEBRIERE::

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

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

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

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

25 Q So why did AHCA general counsel decide that

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

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

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

17 A To my knowledge, there was not.

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

21 A To my knowledge, yes.

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

25 A Are you talking about the Florida Department

1 of Health folks?

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

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

7 Q So AHCA did not reach out to HHS either?

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

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

13 A Uh-huh.

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

16 A State Medicaid Director, Deputy Secretary.

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

20 A Yes.

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

24 A Because the DOH guidance had just been
25 published.

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

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

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

15 A Yes.

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

18 A To the knowledge of the Agency, yes.

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

21 A We started work on April 20th.

22 Q You didn't do anything prior to that?

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

1 do anything like that.

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

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

8 Q Who worked on the 2022 GAPMS at the Agency?

9 A You mean the June 2022 GAPMS?

10 Q Yes.

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

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

19 A Worked on the maps for Western Europe.

20 Q Okay. And what did Dede Pickle do?

21 A The maps for the State Medicaid programs.

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

25 A That's correct.

1 Q Okay. And did you have any assistance?

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

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

19 A Yes.

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

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

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

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

8 A Nobody assisted me with the drafting.

9 Q Inside or outside the Agency?

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

12 Q Were they a verbal consultations?

13 A They were verbal.

14 Q Only verbal?

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

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

19 A They did not write any of the main report.

20 Q Or outline it or anything?

21 A No.

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

1 after-the-fact request form under 35k.

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

4 BY MS. DEBRIERE::

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

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

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

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

25 Q Okay. So you wanted to make sure that there

1 would be a quick response to the HHS guidance?

2 A Yes.

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

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

6 Q Yes.

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

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

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

24 Q What -- How did you know that?

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

1 clinical indication.

2 Q Okay.

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

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

7 A Not necessarily.

8 Q Why?

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

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

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

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

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

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

24 A Uh-huh.

25 Q Okay. After the checklist was developed, for

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

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

11 Q What was your mental checklist?

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

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

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

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

7 A Went to a GAPMS.

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

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

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

18 A Prior to the request being made.

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

21 A No.

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

24 A No.

25 Q What about HHS?

1 A No.

2 Q And what about Alliance Defending Freedom?

3 A No.

4 Q Liberty Counsel?

5 A No.

6 Q Okay. What consultants were used by AHCA in
7 the development of the GAPMS.

8 A So during the development, we have a few
9 verbal conversations with Doctors Miriam Grossman and
10 Andre Van Mol.

11 Q Okay. And what did those conversations
12 entail?

13 A Well, Dr. Van Mol, he just offered suggestions
14 for articles and research for us to look at. He did
15 provide us with a bibliography for our consideration, as
16 far as -- mostly just leads on research to help save
17 time in finding resources. And Dr. Grossman, of course,
18 she provide us with some history of gender dysphoria
19 treatments, and gave us more reviews of some scientific
20 techniques.

21 Q How did you get connected with Dr. Van Mol?

22 A So Dr. Van Mol, like all of our experts, who
23 also provide published reports, so the process for those
24 was that we did get a name at the very outset of the
25 process, which was Michelle Cretella. And by contacting

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

4 Q So Michelle was the only person who connected
5 AHCA to the consultants it relied on for the 20 -- June
6 2022 GAPMS?

7 A Yeah.

8 Q Okay. And who Michelle?

9 A Michelle -- Dr. Michelle Cretella?

10 Q Uh-huh.

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

15 Q How did you find her?

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

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

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

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

1 A Yes.

2 Q You didn't do any outside research on whether
3 you should seek out other consultants?

4 A Well, we were vouching for our -- for the
5 consultants. I mean and so we did want individuals who
6 had expertise in their respective fields of medicine,
7 and who also were going to take an evidence-based
8 approach.

9 Q Okay. Who at Department of Health recommended
10 Dr. Cretella?

11 A Don't -- we don't have the name of the
12 individual.

13 Q Because it was sent in an anonymous email?
14 Why don't you have the name?

15 A We can get that information for you.

16 Q So you don't have the name, but the Agency has
17 the name, correct?

18 A The Agency might have a name. We need to
19 confirm that.

20 Q And who at the Agency was this communication
21 sent to? I mean, how was it communicated?

22 A To my knowledge, it was verbal. It was a
23 verbal exchange.

24 Q Okay. So who at AHCA was part of that
25 conversation?

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

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

8 A Yes.

9 Q Could it have been anybody else at the Agency?

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

11 Q It seems like you have a name in mind.

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

15 Q Who was the chief of staff?

16 A Cody Farrell.

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

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

22 Q And she recommended everyone, is that correct?

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

1 with. So there were some that we did turn down.

2 Q Who did you turn down?

3 A We can get that -- we can get that -- we can
4 get those names for you.

5 Q With Dr. Cretella, was there any consideration
6 given to the associations, the medical associations of
7 which she was a member?

8 A No.

9 Q Okay. So you didn't look to see if she was
10 associated with any particular medical association?

11 A No.

12 Q You just went off the recommendation of
13 Department of Health?

14 A Yes.

15 Q Was Dr. Cretella paid for her assistance
16 with -- to AHCA?

17 A No.

18 Q So DOH didn't pay her or anything?

19 A Well, I don't know at DOH, that's a question
20 for the Department of Health. AHCA did not -- we did
21 not establish a financial arrangement with her.

22 Q Okay. Are you -- are you personally aware of
23 any financial arrangement between Dr. Cretella and
24 Department of Health?

25 A No.

1 Q Okay. I'm sorry. Who did you turn down?

2 A We would have to get those for you.

3 Q Okay. And so Dr. Grossman and Dr. Van Mol
4 just gave you some article leads, and that's all?

5 A Gave some article leads, some background
6 information. Yeah, it was -- I mean, as far as
7 providing us with content to include in the report, they
8 did not.

9 Q Why not?

10 A Because it was an independent assessment by
11 the Agency.

12 Q Okay. Did -- but they didn't write any of the
13 reports that were in the attachments to the June 2022
14 GAPMS either?

15 A Right?

16 Q Why not?

17 A I think because we had experts. We already
18 had a psych -- one psychologist who was writing one. We
19 already had -- we, of course, we had physicians for,
20 like, plastic surgery. We had a bioethicist, as well.
21 Since those bases were covered, we felt they would best
22 benefit us by helping provide guide -- guidance with
23 research.

24 Q Were they ever given the option of writing a
25 report for one of the attachments?

1 A No, we didn't ask them to write a report.

2 Q Okay. Did they ask if they could write a
3 report?

4 A No, they did not.

5 Q How did you identify Dr. Romina
6 Brignardello-Petersen?

7 A So through the contacts we were making, her
8 name was passed on to us as someone at McMaster
9 University who had some experience in doing evidence
10 evaluation.

11 Q Did Dr. Cretella pass on that name?

12 A As far as the actual contact that gave us that
13 name?

14 Q Uh-huh.

15 A Dr. Cretella was kind of the head of the tree
16 of the contacts. We would have to go back and get that
17 information on who gave us the exact name for Dr.
18 Brignardello-Petersen.

19 Q Okay. But Dr. Cretella was the one who -- so
20 what -- if Dr. Cretella didn't recommend Dr.
21 Brignardello-Petersen, who would have?

22 A We would have to get that information for you.

23 Q Would it have been another physician?

24 A Yes, it likely -- yes, it would have probably
25 been another physician.

1 Q What other physicians provided recommendations
2 for consultants?

3 A We would have to get that information.

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

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

12 Q Okay. So who recommended Dr. Cantor?

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

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

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

20 BY MS. DEBRIERE::

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

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

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

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

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

22 MS. DEBRIERE: Yes.

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

1 what he's talked about, well --

2 MS. DEBRIERE: If someone knows. Because if

3 someone knows at the Agency --

4 MR. JAZIL: -- you know, Bob talked to Jill,

5 Jill talked to Jane, Jane talked to Jason and said,

6 hey, hire Brignardello-Petersen, I'll get that

7 information for you.

8 MS. DEBRIERE: Thank you.

9 BY MS. DEBRIERE::

10 Q Whose decision was it to engage with Dr. Van

11 Meter? I'm sorry. Who recommended Dr. Van Meter? I

12 apologize.

13 A That's information we would have to --

14 Q So you don't know who recommended any of these

15 individuals other than Dr. Cretella?

16 A Right.

17 Q Okay. When did AHCA first become aware of the

18 HHS fact sheet on gender-affirming care in young people?

19 A We became aware of it, since we do follow HHS

20 publications, much of our staff in Medicaid, so forth,

21 they are actually on -- they receive automatic updates,

22 so we became aware of them as they came out.

23 Q What was AHCA's independent reaction to the

24 fact sheet?

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

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

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

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

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

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

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

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

18 Q Any other federal standards?

19 A No.

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

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

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

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

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

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

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

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

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

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

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

9 A That was one element of many elements.

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

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

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

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

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

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

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

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

5 Q What about the American Academy of Family
6 Physicians?

7 A No, we didn't use theirs.

8 Q What about the American Academy of Pediatrics?

9 A We did do an evaluation of theirs.

10 Q Did you rely on them, their conclusions?

11 A So what do you mean by --

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

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

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

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

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

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

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

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

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

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

16 Q And ultimately you disagreed with their
17 standards?

18 A Ultimately, yes.

19 Q What about the American Psychiatric
20 Association?

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

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

25 A No, we did not.

1 Q What about the American Psychological
2 Association?

3 A No, we did not.

4 Q American Medical Association?

5 A We did not.

6 Q When you say we, you mean --

7 A The Agency.

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

10 MS. DEBRIERE: Oh, yes.

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

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

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

17 (Whereupon, the deposition resumes in Volume
18 2.)

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CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF LEON)

I, the undersigned authority, certify that the
above-named witness personally appeared before me and
was duly sworn.

WITNESS my hand and official seal this 21st
day of February, 2023.



DANA W. REEVES

NOTARY PUBLIC

COMMISSION #GG970595

EXPIRES MARCH 22, 2024

CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF LEON)

I, DANA W. REEVES, Professional Court Reporter, certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages, numbered 5 through 120, are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 21st day of February, 2023.



DANA W. REEVES

NOTARY PUBLIC

COMMISSION #GG970595

EXPIRES MARCH 22, 2024

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

3 February 21, 2023
4

5 RE: August Dekker, et al. vs. Jason Weida, et al.
6 February 8, 2023/Matthew Brackett/5696545
7

8 The above-referenced transcript is available for review.
9 The witness should read the testimony to verify its
10 accuracy. If there are any changes, the witness should
11 note those with the reason on the attached Errata Sheet.
12 The witness should, please, date and sign the Errata
13 Sheet and email to the deposing attorney as well as to
14 Veritext at Transcripts-fl@veritext.com and copies will
15 be emailed to all ordering parties. It is suggested
16 that the completed errata be returned 30 days from
17 receipt of testimony, as considered reasonable under
18 Federal rules*, however, there is no Florida statute to
19 this regard. If the witness fail(s) to do so, the
20 transcript may be used as if signed.
21

22 Yours,

23 Veritext Legal Solutions

24 *Federal Civil Procedure Rule 30(e)/Florida Civil
25 Procedure Rule 1.310(e).

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

2 February 8, 2023/Matthew Brackett

3 E R R A T A S H E E T

4 PAGE_____ LINE_____ CHANGE_____

5 _____

6 REASON_____

7 PAGE_____ LINE_____ CHANGE_____

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9 REASON_____

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16 PAGE_____ LINE_____ CHANGE_____

17 _____

18 REASON_____

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

22 _____

23 _____

24 Matthew Brackett

25 DATE

[& - 3900]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

CASE NO. 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,
Plaintiffs,
vs.
JASON WEIDA, et al.,
Defendants

Volume 2, Pgs. 125 - 261

VIDEOTAPED DEPOSITION OF: MATTHEW BRACKETT

AT THE INSTANCE OF: THE PLAINTIFFS

DATE: FEBRUARY 8, 2023

TIME: COMMENCED: 1:30 P.M.

LOCATION: AGENCY FOR HEALTH CARE
ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FLORIDA 32308

REPORTED BY: DANA W. REEVES
Court Reporter and
Notary Public in and for
State of Florida at Large

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*Uh-uh is a negative response

*Uh-huh is a positive response

1 D E P O S I T I O N

2 Whereupon,

3 MATTHEW BRACKETT

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

7 VIDEOGRAPHER: This is beginning of video
8 three. The time is 1:30 p.m. We're on the record.

9 EXAMINATION

10 BY MS. DEBRIERE::

11 Q So prior to break, we were talking a little
12 bit about Dr. Van Mol and Dr. Grossman's involvement in
13 the 2022 GAPMS. How did AHCA identify them to
14 participate in the July 8th rule hearing that was
15 related to?

16 A So the -- are we talking about the rule
17 hearing?

18 Q Yes, related to the June 2022 GAPMS.

19 A So since we had already been working with them
20 in relation to the GAPMS project, because Dr. Grossman
21 is a psychiatrist, and Dr. Van Mol is a family -- family
22 practice practitioner, that's based on their backgrounds
23 and their knowledge of the existing evidence, that was
24 our basis for selecting them to be on the panel for the
25 July 8th hearing.

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

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

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

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

15 Q Okay. Anybody else?

16 A I don't --

17 Q Were you involved?

18 A I was not.

19 Q Was Nai Chen involved?

20 A He was not.

21 Q Was Dede Pickle involved?

22 A She was not.

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

1 so?

2 MR. JAZIL: Object to form.

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

5 BY MS. DEBRIERE::

6 Q Yes.

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

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

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

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

19 A I was not involved in that decision.

20 Q And Nai Chen was not involved in that
21 decision?

22 A That's correct.

23 Q And Dede Pickle was not involved in that
24 decision?

25 A Correct.

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

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

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

12 A Correct.

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

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

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

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

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

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

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

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

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

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

22 A Right, that wasn't a primary consideration.

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

1 gender-affirming care?

2 MR. JAZIL: Object to form.

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

5 BY MS. DEBRIERE::

6 Q Contradiction.

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

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

14 A No.

15 Q What about the Heritage Foundation?

16 A No.

17 Q Liberty Council?

18 A No.

19 Q Society for Evidence-Based Gender Medicine?

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

22 Q Okay. And what about the Family Christian
23 Coalition?

24 A No.

25 Q Did you get anybody else's name from the

1 Society for Evidence-Based Gender Medicine?

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

6 Q Maybe?

7 A It could be a maybe at best.

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

11 A No.

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

14 A No.

15 Q The Florida Department of Health?

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

18 Q What about the Governor's office?

19 A No.

20 Q The Surgeon General Ladapo?

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

25 Q Did he personally?

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

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

9 A By any other --

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

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

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

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

22 Q And who was the one who did the contacting?

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

1 was involved in contacting them.

2 Q Okay. And those were all phone calls?

3 A These were verbal conversations, yes.

4 Q So no communication by email?

5 A No.

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

11 A No.

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

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

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

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

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

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

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

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

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

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

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

20 A No, we had not.

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

23 A You know, 35,000 times seven. That'd be
24 210 -- 245,000.

25 Q So each consultant is capped at --

1 A That was the cap of the budget.

2 Q And is that 34,999, or 35 straight?

3 A I'm leaning towards 34,999, so we can subtract
4 \$7 from that amount.

5 Q Okay. Has each consultant been paid in full
6 for that work?

7 A Each consultant has been paid in full for the
8 work they completed.

9 Q Okay. Some of those consultants now, though,
10 are acting as experts in this case and being reimbursed
11 for that, as well?

12 A Those would be under separate agreements.

13 Q Okay. In the example you just gave about
14 using outside physician consultants for the other GAPMS,
15 did AHCA pay those other consultants?

16 A For other GAPMS? Those consultants are
17 usually salaried or have hourly rates from our
18 subcontractors.

19 Q Okay. Okay. But you didn't enter into any
20 kind of vendor agreement with them?

21 A No, they're already employed by one of our
22 subcontractors.

23 Q Okay. Did all of the \$35,000 paid to the
24 vendor -- paid to the consultants come directly from
25 AHCA?

1 A Yes.

2 Q Was AHCA reimbursed by anyone else for those
3 consultant payments?

4 A No.

5 Q Other than through its subcontractors, has
6 AHCA ever previously retained outside consultants to
7 undertake a review of the evidence-based clinical
8 practice guidelines for GAPMS?

9 A Well, previously, we did actually have -- of
10 course, we discontinued it, but we did have PAYS, which
11 was back -- and we had it throughout 2017 -- which was a
12 course and evidence review guide program that I had to
13 subscribed to. We did have that and often referenced
14 that in the early days, but after the amount of time,
15 and because it was an expensive subscription, we
16 discontinue it.

17 Q So that was a subscription service. Do you --
18 can you recall any time that you engaged with an outside
19 consultant, other than those employed by your
20 subcontractors?

21 A No.

22 Q What about to undertake a review of
23 professional literature?

24 A No.

25 Q To actively participate by making a

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

3 A No.

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

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

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

19 A Can you repeat that?

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

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

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

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

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

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

21 A Yes.

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

24 A That's right.

25 Q So why is gender-affirming care different?

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

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

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

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

15 A For the prior ones?

16 Q Uh-huh.

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

25 Q HHS releases guidance all the time, though,

1 about coverage?

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

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

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

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

10 A No, we didn't.

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

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

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

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

1 evidence that we determined was insufficient.

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

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

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

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

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

22 A We did not.

23 Q The Governor's office?

24 A We did not.

25 Q Department of Health?

1 A We did not.

2 Q No one?

3 A No, they stayed internal.

4 Q Did AHCA provide any material to the
5 consultants to review in drafting their reports?

6 A No, we did not.

7 Q Did AHCA edit the reports of the consultants?

8 A There was some copy editing for style and
9 grammar. Other than that, no, we did not make edits to
10 the content.

11 Q So no substantive edits?

12 A No substantive edits.

13 Q And that includes Lappert's report?

14 A That includes Dr. Lappert's report.

15 Q And Dr. Donovan's report?

16 A And that's for Dr. Donovan.

17 Q And did any of the consultants provide edits
18 to the AHCA GAPMS report?

19 A So after we finished the draft, we did send
20 drafts to Doctors Grossman and Dr. Van Wol and they
21 provided some feedback, but none of the feedback met --
22 were made -- resulted in drastic changes. I think -- I
23 think Dr. Van Mol suggested we -- there's one more
24 article we could discuss, and we added some content in
25 there regarding that. They did help us correct some

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

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

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

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

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

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

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

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

25 A Somewhere around there, yeah.

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

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

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

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

12 Q Okay. You stated in your declaration filed
13 with the court on January 25th, 2023, that the only
14 sources you relied on for the June 2022 GAPMS, were
15 those cited in the works cited section of the report; is
16 that a correct statement?

17 A That's correct.

18 Q So that means that the only sources that you
19 consulted or considered -- or cited in the June 2022
20 GAPMS report?

21 A During the -- yeah, during the writing of the
22 GAPMS, those were the sources consulted.

23 Q Nothing else?

24 A During the drafting of the report, nothing
25 else.

1 Q What about after?

2 A Afterwards, more out of intellectual
3 curiosity, I did want to try to see what else was out
4 there, but that was more for personal intellectual
5 curiosity than it was for professional purposes.

6 Q Okay. What were those things that you
7 reviewed?

8 A Articles by Jack Turban.

9 Q Can you spell his last name?

10 A T-U-R-B-A-N.

11 Q I'm not familiar.

12 A Well, it's -- he is cited in our report, but
13 he also is -- he's frequently quoted a lot, so I was
14 curious to see what other in print articles he had
15 produced.

16 Q Quoted in what?

17 A He's often cited in, like, news stories,
18 media.

19 MS. DEBRIERE: Simone just got a note that
20 folks are having trouble hearing me.

21 BY MS. DEBRIERE::

22 Q All right. When you were considering whether
23 the services listed at 59-G-1.050(7) were experimental,
24 did you evaluate whether excluding those services would
25 be budget neutral?

1 A No, we did not.

2 Q Did you consider whether private insurance
3 covers the services excluded by 59-G-1.050(7)?

4 A For this one we didn't, but primarily when we
5 do GAPMS, we really aren't interested in public and
6 private insurers. We're primarily interested in state
7 Medicaid programs and Medicare since, like, Florida
8 Medicaid, they're public payers. So primarily, we
9 really want to know what the public payers say.
10 Usually, our lowest priority for GAPMS is to provide
11 analyses of what private payers pay. And generally,
12 often we need those to supplement if we're unable to get
13 that many policies from Medicaid programs across the
14 nation, but since it's -- for this GAPMS, we actually
15 surveyed all 50 states, then we had adequate information
16 from that. Most GAPMS reports, usually we get maybe 10
17 or 12 when it comes down to coverage policies, it's --
18 it's pretty much what we can find in a certain amount of
19 time. But for this one, we've -- since Dede Pickle was
20 working on it independent, she was able to survey all
21 50.

22 Q And why is it covered under private insurance
23 informative of whether or not a service is experimental?

24 A Can you repeat that?

25 Q Uh-huh. Why don't you rely on -- why don't

1 you consider private insurance coverage to be
2 something -- I'm having trouble formulating what should
3 be a simple question.

4 Why don't you look at private insurance
5 coverage when you're determining whether or not a
6 service is experimental?

7 A Well, private insurance works differently. I
8 mean, Florida Medicaid, like Medicare, is a
9 taxpayer-funded health care system. Private insurers,
10 since they're privately funded, there's a great deal
11 more latitude, what they can cover and what they don't
12 have to cover, and they're more subject to the
13 competition of the market, as opposed to Medicaid
14 programs. So we -- while we do -- some often will look,
15 but often it's -- we often try to find what private
16 payers pay for following what we get from Medicare and
17 Medicaid. So, I mean, when it comes down to it, we can,
18 but it's not an absolute requirement, and we really do
19 want to find out what the Medicaid programs are paying
20 for. That's our first and foremost criteria for looking
21 at the coverage of -- other payers coverage.

22 Q So it's not apples to apples, because in
23 Medicaid and Medicare, you've got state taxpayer dollars
24 to consider, correct?

25 A That's correct.

1 Q Okay. But when you undertook the June 2022
2 GAPMS, you did not evaluate whether or not excluding
3 those services would be budget neutral?

4 A No, we didn't for this one, but we -- but
5 that's also not necessarily unique to this, as well.

6 Q So in other GAPMS, you've not evaluated the
7 budget neutrality of the service, whether or not you're
8 going to cover it?

9 A That's correct. In the GAPMS I did in 2017,
10 for, I think, like the nitrous oxide of -- pretty much
11 like an adjuvant to this, kind of jumped-up asthma test,
12 we didn't do a cost budget analysis because, like, we
13 weren't going to cover, it's not going to affect
14 anything.

15 Q So then you did evaluate whether it was budget
16 neutral. You won't be covering it, so, therefore, it
17 was neutral?

18 A Well, we just -- we just don't -- we just
19 don't do one, because, I mean, we're not covering it.
20 So it comes down to if we were going to make a coverage
21 determination, that's when you do a fiscal analysis. So
22 a coverage determination is definitely turned into a
23 fiscal -- it needs -- it needs a fiscal analysis,
24 because we're -- need to find out whether or not we're
25 going to be able to stay within our budget.

1 Q I see. I see. So in this instance, because
2 we are talking about the only GAPMS that excluded a
3 service previously covered, did you do anything to
4 determine whether or not that would cost or save the
5 state money?

6 A No.

7 Q I think you have -- you brought information
8 with you today about this. How did you collect state
9 Medicaid program coverage data?

10 A So on that spreadsheet, so Dede Pickle, she
11 went across the -- yeah. So she --

12 MR. JAZIL: Do you want to mark it as an
13 exhibit?

14 (Whereupon, Exhibit No. 13 was marked for
15 identification.)

16 THE WITNESS: She surveyed 50 states and I
17 think territories -- even up in the territories --
18 and was looking to see what their stances were on
19 gender-affirming care, to see whether or not they
20 had statements saying that they will cover it or
21 policy saying that they wouldn't. And then
22 there -- those that just didn't have a policy
23 available, or had no policy in place.

24 BY MS. DEBRIERE::

25 Q So Dede Pickle was the one who put together

1 the spreadsheet?

2 A Yes.

3 Q Okay. And where did she look to find this
4 information in each state?

5 A Well, she went to their state Medicaid web
6 pages, looked at their -- like, their coverage guides or
7 materials in each state Medicaid -- Medicaid programs.
8 There can likely be idiosyncrasies. I mean, some
9 have -- some are like ours, have a ton of coverage
10 policies, others are like Texas, Texas has one gigantic
11 coverage policy, which actually does -- despite the fact
12 it's huge, it's actually kind of more efficient.
13 It's -- you can get everything from there. But
14 that's -- that's what they do in Texas. Everything's
15 bigger in Texas. But she went and looked at all of the
16 different state -- various state Medicaid programs and
17 saw what their policies were and saw what was available.
18 And, of course, put the findings in the GAPMS report.

19 Q Did she only do an online search?

20 A Yeah, it was only an online search.

21 Q Did she contact any of the Medicaid programs?

22 A No.

23 Q Did she look at any of the policy reporters?

24 A No, we -- no, we didn't use policy reporter
25 for this GAPMS.

1 Q So just looking at the state's Medicaid Agency
2 websites?

3 A For the Medicaid, yes. But, generally,
4 without having worked in Medicaid, one of our research
5 criteria for across all kinds of reports and projects is
6 that we do want to see what other states do. And so
7 that gives us a great deal of familiarity of how to
8 navigate other states' programs. And one of our side
9 projects is the statewide Medicaid managed care program.
10 And, of course, we're always looking to see what other
11 states are doing. So we get a great deal familiar with
12 how to navigate the web pages of other states.

13 Q So at least half the states' Medicaid programs
14 explicitly cover pubertal suppression treatment for
15 gender dysphoria, is that correct?

16 A Based on -- based on the findings of the map.
17 So what -- so I will defer to the findings on the map.

18 Q Only ten exclude?

19 A Defer to the findings as stated in the map.

20 Q Okay. How about we do this: Based on the
21 findings in the map, only 10 states explicitly exclude
22 pubertal suppression therapy. How did you take that
23 into account when you reached the conclusions that you
24 did about the services being experimental, that
25 particular service being experimental?

1 A As far as that goes, it's informational, but
2 there was -- there was a divide between states that do
3 cover and states that don't. Primarily when making the
4 determination we focus -- we really focused on the
5 evidence and what the evidence said about treatments for
6 gender dysphoria since the Medicaid program -- since
7 there is -- seems like there's an absence of policies
8 for a lot of states. There are some states that come
9 out and say yes, and then there are some states that say
10 no. There is a -- there's a divide and you can even
11 potentially say like there could be a debate between
12 amongst the 50 states plus territories of whether or not
13 coverage is appropriate.

14 Q But you did say earlier on that you -- whether
15 a service is covered under the other state Medicaid
16 programs is usually a factor that you weigh heavily in
17 determining whether a service is experimental.

18 MR. JAZIL: Object to form.

19 THE WITNESS: So when it comes down to it --
20 it's like, so often, it's not just other Medicaid
21 programs, but also Medicaid programs are similar to
22 Florida. There are some Medicaid programs -- I'll
23 name two -- New York and California that are --
24 that cover things very, very liberally, as far as
25 services. Like, these added everything in their

1 fee schedules, where Florida Medicaid -- and
2 Florida Medicaid prides itself on being a very
3 fiscally responsible Medicaid program. So often we
4 try to see what states that are similar to our
5 Medicaid program, what they do. But we also do
6 see, we see overwhelming amounts of coverage from
7 states like us and states across the union, then
8 that does factor in our decision, but for in this
9 circumstance, because there is a split, if we were
10 going to have to more -- rely more so on the
11 evidence, than the notion that all these states
12 cover services, there -- it's not -- it's not
13 unanimous at all.

14 BY MS. DEBRIERE::

15 Q Did you ever contact the states that
16 explicitly exclude and ask them why they explicitly
17 exclude?

18 A We did not.

19 Q Did you ever call those states that have no
20 coverage statement one way or another and ask them?

21 A We didn't reach out to states. I mean, their
22 policy's online. I mean, that -- I mean, their
23 published policy is sufficient to give us the responses
24 we need to look at -- to look at it. Even for other
25 GAPMS, we don't contact other states.

1 Q Did you analyze how much Florida Medicaid
2 spends on -- spent on treatment for gender dysphoria
3 prior to the categorical exclusion?

4 A No, we did not.

5 Q Do you have any plans to reevaluate your
6 findings in the GAPMS report based on the September 2022
7 release of the WPS standards of care version eight?

8 A So in the immediate term, well, we don't,
9 so -- but, I mean, we can reopen the GAPMS later on,
10 there is -- there is a process for that. But generally,
11 I mean, these standards of care, I mean, based on the
12 release of one set of new standards of care, I mean, for
13 the time being we don't have any immediate plans, not
14 based on the release of one new update.

15 Q Okay. How long did you personally work on
16 that initial draft of the June 2022 GAPMS report?

17 A Oh, I was working on it pretty much until the
18 day it came out.

19 Q And you started that second week in May?

20 A Well, no, that was after I had the very first
21 initial draft done.

22 Q Okay. So tell me when you first started
23 working on it.

24 A April 20th.

25 Q Okay. So from April 20th until when it came

1 out. Published on what -- well, we know that it was
2 first reviewed by your higher-ups on June 1st. So April
3 20th to June 1st?

4 A Yeah, that's sufficient.

5 Q Okay. And you worked with Nai Chen and Dede
6 Pickle.

7 A Uh-huh.

8 Q Did you read all of the articles in the
9 work-cited section?

10 A I read every single document in that works
11 cited section.

12 Q 88 articles?

13 A All of them.

14 Q Okay. Were you able to read everything,
15 understand it, and draft a report in --

16 A Yes.

17 Q How often during that time period did you
18 communicate with the consultants?

19 A Oh, I think between four and five times.

20 Q And four or five times over that entire time
21 period?

22 A Yeah, during those time periods, yes, we
23 have -- periodically have, like, a one-hour discussion
24 with them.

25 Q So you talked to them about five hours total

1 over that time period?

2 A I think that's a valid estimate, yes.

3 Q Okay. Do you think it's more than that, like
4 more like 10 hours?

5 A No.

6 Q Okay. Turning back really quickly to the
7 amount of -- the cost of treatment for gender dysphoria.
8 How much was spent on the coverage of gender dysphoria
9 versus how much was spent -- strike that.

10 Do you know how much, prior to the adoption of
11 the categorical exclusion, how much annually AHCA spent
12 on the coverage of gender dysphoria?

13 A We did not.

14 Q Are you able to obtain that information?

15 A Our data analytics between managed care plans
16 paid per claim, and anything in fee-for-service, our
17 data bureau could probably muster that up.

18 Q Is there a way that we should ask for that
19 information to make the question clearer?

20 A You'd want to -- you would -- to put in a
21 request we would need diagnosis code, we'd need NDC, and
22 we would need CPT codes.

23 Q And what's NDC?

24 A National Drug Code.

25 Q Okay. And then for surgery, what would you

1 need?

2 A You would need the corresponding CPT code.

3 Q Okay. So you need the diagnostic code, the
4 NDC for drug coverage, and the CPT code?

5 A And the time -- the date ranges.

6 Q And the date ranges. Okay. And then you
7 could tell us how much AHCA -- or the Florida Medicaid
8 program paid in coverage of -- treatment for gender
9 dysphoria over a given period of time. Okay. When you
10 were communicating with the consultants about drafting
11 the June 2022 GAPMS report, what kinds of questions did
12 you ask?

13 A Generally, questions about -- mostly just
14 questions about, like, articles, like studies, making
15 sure we have our bases covered, things like that. We
16 wanted to make sure we didn't miss anything, or there's
17 anything glaring we -- because it isn't a piece of
18 academic work it is, it is -- mainly it's like a thesis
19 or a dissertation, because we make a case, we have to
20 support that case. So we want to make sure we have our
21 bases covered.

22 Q What were the consultants' positions on WPATH?

23 A Their positions were that -- I think they
24 identified -- all they did was identified it as an
25 advocacy group, like a combination of clinical

1 professionals, plus advocates, community activists can
2 join it. So that -- it's kind of a hybrid organization,
3 that they explained that to us. So that was pretty much
4 all the information they gave.

5 Q And you felt like that was an adequate
6 explanation of what WPATH was?

7 A Yes.

8 Q What about the Endocrine Society? What was
9 their position on?

10 A Their position was the Endocrine Society. I
11 mean, it is an established clinical organization. They
12 felt like the other guidelines, they had released
13 guidelines, but the Endocrine Society was transparent in
14 releasing their guidelines. They did clarify that their
15 recommendations were based on weak or very weak
16 evidence. They also clarified that their guidelines
17 were not a standard of care, that they were just
18 guidelines.

19 Q And that's the Endocrine Society. Who does
20 that -- or your consultancy, who did that?

21 A The Endocrine Society. So the Endocrine
22 Society, in the text of their guidelines, they do
23 identify each line of the treatment model, like the
24 puberty suppression, the cross-sex hormones and
25 surgeries. Primarily the hormones is the Endocrine

1 Society, but they are very clear that it's either low-
2 or very-low-quality evidence that supports it, and they
3 also do put that disclaimer on there, this is not a
4 standard of care.

5 Q What was your -- what was the consultants'
6 position on the American Psychiatric Association's
7 recommendations for gender-affirming care?

8 A It didn't come up in the conversations.

9 Q Okay. How about the AAP?

10 A The AAP was that the evidence available to
11 support the AAP's positions wasn't sufficient.

12 Q Okay. What about the AMA?

13 A We didn't talk about the AMA.

14 MS. DEBRIERE: Okay. So I would like to -- do
15 you have the exhibit of the Medicaid policy routing
16 and tracking form for the June 2002 GAPMS?

17 MR. JAZIL: Can you re-mark on this --

18 MS. DEBRIERE: Yes, please. I think -- I need
19 a bigger one.

20 (Whereupon, Exhibit No. 14 was marked for
21 identification.)

22 THE WITNESS: Yeah, that new formulation makes
23 it taste just like the real thing.

24 VIDEOGRAPHER: It's pretty good.

25 MR. JAZIL: See, we're finding common ground.

1 THE WITNESS: Wasn't, like, Coca-Cola and all
2 their peace commercials, they were holding hands
3 around the world? That was from the '70s, I think.

4 BY MS. DEBRIERE::

5 Q Okay. So I'm handing you what's been marked
6 as Plaintiff's Exhibit 14. It's the Medicaid policy
7 Routing and Tracking Form for the June 2022 GAPMS.
8 There's a start date column there. What's that mean?

9 A That's a start with the routing process. So
10 generally, for this, usually -- usually they try to
11 provide like a window. We always have, like, a window
12 of review. So for this, we enter the dates in the
13 system. The GAPMS is routed to first -- well, actually,
14 since my supervisor Dede was out, I was her delegate, so
15 I did sign on her behalf. Then it went to Ann Dalton
16 who signed. And, of course, Secretary Weida, of course,
17 signed in his role, and then went to Deputy Secretary
18 Wallace.

19 Q Okay. So start date's when the document hits
20 their desk?

21 A Yes.

22 Q Okay. And then end date's when they've
23 reviewed it and passed it on?

24 A Yes.

25 Q Okay. Date received is going to measure the

1 date that it hit their desk, but they didn't necessarily
2 pick it up and start reviewing it? I'm trying to
3 understand what's the difference between --

4 A Date received should be when they got it.

5 Q Okay. And the start date's when they start
6 reviewing it? What's the difference there?

7 A Start date, end date -- yeah, that should be.

8 Q And the approval column means that the GAPMS
9 was approved by each person that checked the box and
10 initial by it?

11 A That's correct.

12 Q Okay. So the June 2022 GAPMS report, which is
13 46-pages long and contains five separate reports from
14 AHCA consultants, it was reviewed and approved by each
15 person on this list in one day?

16 A Yes.

17 Q And all four people on this list reviewed and
18 approved the June 2022 GAPMS report in the span of two
19 days?

20 A Uh-huh, that's correct.

21 Q Oh, I see there MB for DVP.

22 A Yeah.

23 Q Why choose to adopt the 2022 GAPMS report into
24 rule?

25 A Because -- so since we had determined it to be

1 experimental and investigational, so we decided that we
2 didn't need to make the -- based on the evidence, based
3 on what the GAPMS said, the categorical exclusion
4 promulgating the rule is necessary.

5 Q Okay. So you adopted into rule because it was
6 a categorical exclusion?

7 A It was going to be, yes.

8 Q When was that decision made?

9 A The decision that was made -- the decision to
10 make -- to make a new categorical exclusion, of course,
11 that was not going to be made until after we had
12 completed the GAPMS report and signed off on, because
13 obviously, had either the experts had they disagreed
14 with one another, or if I'd come up with a different
15 conclusion, can't make a categorical exclusion unless
16 everyone was in sync. So it was one of those things
17 where had -- had the expert opinions disagreed with each
18 other, had I come up with a contradictory conclusion,
19 there -- you had -- we had to wait until after the
20 report was done before we'd sign whether or not to
21 proceed with the categorical exclusion.

22 Q And when was the decision made to adopt it
23 into rule? Was that at the same time that you decided
24 to make it a categorical exclusion?

25 A That was made after we had had the report

1 signed and done.

2 Q Okay. Sorry. I need to be more specific.

3 What date was that decision made?

4 A Well, I think it was probably made June 2nd.

5 Q Okay. And who made that decision?

6 A That would have probably have come down from
7 Secretary Marstiller, that would have come down from
8 now-Secretary Weida, and it would have come from our
9 General Counsel, Josephina Tamayo?

10 Q Why would it have come from those people?

11 A So -- because, of course, with our General
12 Counsel, with our Secretary, I mean, they do make the
13 decisions for the Agency. It's not out of the -- I
14 mean, it is typical in their role to make a decision to
15 promulgate something into rule.

16 Q Would that generally, though, be handled by
17 the Bureau of Medicaid policy?

18 A Sometimes. It depends on -- depends on the
19 nature of the rule change. Depends on where -- where
20 it's originating from.

21 Q How often has that decision come from the
22 Medicaid Secretary?

23 A So let's -- so to talk about the rulemaking
24 process a little bit.

25 Q Yeah.

1 A So rule -- proposes for rule changes come from
2 all different directions and --

3 Q Let's back up. Instead of talking generally
4 about rule changes, let's talk about changes to coverage
5 policies.

6 A Those can be made by our Deputy Secretary.
7 Those can come from the Secretary. I mean, anyone
8 who --

9 Q How often does that happen?

10 A We can't speak to how often it happens. I
11 mean, it does happen.

12 Q Had it happened more with the Bureau of
13 Medicaid policy?

14 A You mean, those in Medicaid policy who
15 initiated these changes?

16 Q More often than not?

17 A I actually would probably say not.

18 Q Oh, okay. I'm just -- I'm surprised because
19 we learned from Ms. Dalton that the -- both the
20 rulemaking process and the coverage policy units are
21 housed within the Bureau of Medicaid policy.

22 A Well, that's correct, they are, but often
23 they're responding to directives given to them from
24 either senior leadership or legislative changes.

25 Q Okay.

1 A So, yeah, while they are the ones that
2 implement and write and craft the new policies or update
3 the policies, they're often not the ones that are
4 piloting these new policies.

5 Q Or initiating the decision as to whether or
6 not --

7 A Precisely.

8 Q -- or adopt them into rule?

9 A Correct.

10 Q So you said that it was the decision to adopt
11 into rule was made on June 2nd, is that correct?

12 A That's correct.

13 Q Okay. And the notice of rule development,
14 that was issued on June 3rd, correct?

15 A Yeah.

16 Q I swear.

17 A Yeah, I'm deferring to the record on that.

18 Q Sure.

19 A The rulemaking process is highly documents, so
20 I'm going to be deferring to the documentation for the
21 rulemaking process.

22 Q Okay. So it took less than 24 hours for AHCA
23 to decide to adopt the conclusion in the 2022 GAPMS
24 report into a rule? And even less than that, because
25 you made it the same day that the report was released,

1 correct?

2 A Yes.

3 Q And at that time, you also knew which section
4 of 59-G it was going to go into?

5 A Yes, we did.

6 Q And who had to sign off on that decision?

7 A So all of our -- so whenever we adopt a rule,
8 it does go through a lengthy routing process. So it
9 does start -- the process starts in the Bureau of
10 Medicaid Policy, starts with the rules -- we have a
11 rules unit. That gets signed off on, then it goes to
12 the AHCA administrator authorities section, they have to
13 sign off. Then after that it goes to the Bureau Chief
14 of Medicaid Policy. Of course, likewise, they have to
15 review and sign off. Then it goes to the Assistant
16 Deputy Secretary of Policy and Quality. They have to
17 sign. Then, of course, the Deputy Secretary for
18 Medicaid has to sign. General Counsel's Office has to
19 sign. And then the Secretary is privy to all the
20 changes. And if Secretary decides like, wait, wait, we
21 can't do this or, no, there's a problem, yeah, that
22 sometimes can result in a frustrating headache, because
23 it takes a lot of work to get something that far.

24 Q Well, so the decision to adopt a categorical
25 exclusion to rule was made on June 2nd and the Notice of

1 Proposed Rule was made on June 3rd. So it was routed
2 through that entire process in less than 24 hours?

3 A Are we talking about the GAPMS or the rule?

4 Q The rule?

5 A Yes. And that -- and that's not unusual
6 sometimes for -- for the process to move very quickly.

7 Q Okay. Because you just made it sound like it
8 was a very lengthy process.

9 A It is with the number of people, but it's --
10 the rule content is very -- it's a very small addition.
11 It's not like a brand new coverage policy, because
12 often -- it depends on the nature of the rules. Like
13 one addition, that can move fast. Sometimes with --
14 like, for instance, in my experience as a program
15 administrator, we completely overhauled the community
16 behavioral health policies. That was five new coverage
17 policies. So that, of course, is going to require a
18 much lengthier review process rather than a quick
19 amendment to a rule. So it really depends on the nature
20 of the rule. If it's a very lengthy coverage policy,
21 yeah, that can take some more time if it's -- but if
22 it's like adding a few bullets or amending a line, that
23 can -- that can move along much faster because the
24 review time's just not -- a lengthy review process is
25 not necessary.

1 Q Or deciding to eliminate three types of
2 services that were previously covered by Florida
3 Medicaid?

4 A Correct. And, of course, but -- and, of
5 course, we have the GAPMS memo to substantiate that.

6 Q Okay. Okay. So speaking to the rule, it bans
7 Medicaid coverage for -- puberty blockers or cross-sex
8 hormone therapy and surgery if done so to treat gender
9 dysphoria, correct?

10 A That's correct.

11 Q But not to treat other diagnoses?

12 A Not to treat other diagnoses. Only for the
13 diagnosis of gender dysphoria.

14 Q Okay. Is this the only time that GAPMS has
15 been used to categorically eliminate coverage of
16 treatment for a particular diagnosis?

17 A For the one -- I think pretty much since the
18 institution of the GAPMS process, I think this was a
19 first.

20 Q Once the decision was made to adopt the
21 conclusions of the 2022 GAPMS report into rule, who was
22 in charge of that process?

23 A So our rule promulgation process, Cole
24 Gerring, he oversees the rule promulgation process for
25 our coverage policies and administrative rules for

1 Medicaid.

2 Q Does he head the Rules Unit under the Bureau
3 of Medicaid policy?

4 A Yes, he does.

5 Q Who drafted the actual language for the rule?

6 A I believe -- I believe he drafted the
7 language.

8 Q Did anybody revise it or have any input
9 that --

10 A There was input. So I mean, there were some
11 discussions. I remember we did have a meeting with
12 everyone to -- between, I think, like, Sheena Grantham,
13 myself, I think Dede Pickle, I think Secretary Weida, I
14 think like Sheena Grantham from General Counsel's
15 office, since rules are her area. I think there were
16 there was a -- there was a discussion on making sure
17 this was the finalized content we wanted.

18 Q And how long did that discussion take?

19 A About an hour.

20 Q Okay. And what kinds of topics were discussed
21 during that?

22 A Just determining how granular we should get,
23 mostly.

24 Q Okay. Okay. Was there any conversation about
25 whether adopting this categorical exclusion might

1 violate comparability under the Federal Medicaid Act?

2 A No.

3 Q What about EPSDT?

4 A No, because since we already have the -- we've
5 already had the GAPMS report to substantiate the
6 overriding EPSDT guideline -- guidance and requirements.

7 Q Because Florida Medicaid does not have to
8 cover a service under EPSDT if it's experimental?

9 A That's correct.

10 Q I had another question. Talking about how
11 granular to get with the language, was there any
12 conversation about what the Federal Medicaid Act
13 requires in terms of prescription drug coverage?

14 A I don't think so. Not during that
15 conversation.

16 Q Any other conversations had about that?

17 A As far as the federal requirements for
18 prescription drug coverage? No, I don't think we had
19 any conversations like that.

20 Q Okay. Any other conversations about
21 comparability under the Federal Medicaid Act?

22 A No.

23 Q So comparability under the Federal Medicaid
24 Act was not taken into consideration when adopting the
25 categorical exclusion?

1 A No.

2 Q Who planned the public hearing regarding the
3 proposed language in 59G-1.050(7)?

4 A So for the public hearing, since we did
5 anticipate a larger than normal crowd, we -- so I think
6 that was a joint effort between Cole Gerring I think,
7 Chief -- now Chief of Staff Brock Juarez, then Chief of
8 Staff Cody Farrell, and I think -- I think Secretary
9 Weida also had a little bit of input when it came down
10 to selecting the venue and making sure that we had
11 adequate staff and then also arranging for security as
12 well.

13 Q Why did you feel a need for security?

14 A Because of this -- the controversial nature of
15 the change and how those with opinions on it -- those
16 with feelings about it, I mean, they are deep-seated. I
17 mean, there's -- so because of the sensitivities
18 involved, we just felt that it would be best in the
19 event -- and we did think it was unlikely, but in the
20 event that someone might get upset or unruly, to have
21 security.

22 Q Why did you pick the venue you picked?

23 A Size and location.

24 Q What factors did you take into consideration
25 for size and location?

1 A That we would have adequate seating. That, of
2 course -- of course, location where it was, being
3 downtown, so --

4 Q Downtown being an easier location to get to?

5 A Yes.

6 Q Why did the location need to be easy to get
7 to?

8 A Because, I mean, since -- I mean, you know, we
9 do government in the Sunshine, we wanted the hearing to
10 be accessible to as many people as possible, so we
11 wanted to be able to fill as many seats as we could.
12 The facilities here at AHCA weren't going to be
13 sufficient for that. The Department of Transportation
14 auditorium was a very, very good venue, not just -- not
15 just to be able to provide those of us who were on the
16 panel visibility to the audience, but also just because
17 of the seating capacity. So it just was an ideal venue
18 compared to what we had available at the Agency.

19 Q Where do you normally hold rule hearings?

20 A We usually hold them here.

21 Q Why were you concerned about adequacy of
22 seating?

23 A Because we did expect a large turnout.

24 Q Why did you expect a large turnout?

25 A Because of the amount of coverage that the

1 GAPMS report had received, because of everything that
2 we'd been seeing, as far as -- per previous news stories
3 prior to the release, we just knew that this was a
4 sensitive subject. A lot of people have a deep-seated
5 conviction about it one way or the other, and we just
6 anticipated a large turnout.

7 Q In the planning of the public hearing, did
8 AHCA communicate with the Governor's office at all?

9 A No.

10 Q Did AHCA communicate with Department of Health
11 at all?

12 A No.

13 Q Who participated in the public hearing from
14 AHCA?

15 A So the participants from AHCA were myself,
16 Sheena Grantham, whose General Counsel's office,
17 Secretary Weida. Those are the -- those are the three
18 of us who were on the panel for AHCA. And, of course, I
19 think Cole Gerring handled the administrative procedures
20 and then I think to help -- help with crowd control, we
21 had, I think, Brock Juarez and some of the staff from
22 communications also helped arrange in making sure that
23 there's adequate seating, and just kind of serve -- just
24 helping out in any way, or any capacity that was
25 necessary, as needed.

1 Q Did anybody at AHCA help facilitate the
2 attendance at the hearing?

3 A There -- I think there's a speaker sign-in
4 sheet at the entrance. I think that -- like, I think
5 one of the Agency staff under Brock at the time was --
6 was allowing people to sign in.

7 Q Were there any particular people that were
8 encouraged to be at the hearing?

9 A No.

10 Q Are you aware of the Governor's office
11 encouraging anybody to attend the hearing, anybody in
12 particular?

13 A No. No.

14 Q Did anybody pay someone to attend the hearing?

15 A So for our -- for our experts, Dr. Grossman,
16 Dr. Van Meter and Dr. Van Mol, they were compensated for
17 their time spent at the hearing, or their time
18 traveling -- for Dr. Van Mol and Dr. Van Meter, their
19 time traveling and their travel expenses. So we did
20 reimburse them, but that was it.

21 Q Did that include the same agreement with the
22 \$35,000 cap or was that a separate agreement?

23 A I don't think it was a separate agreement,
24 because the three of them had not come anywhere close to
25 exhausting their caps.

1 Q Did AHCA provide any materials to those
2 consultants prior to the hearing to review for the
3 hearing?

4 A On the day of the hearing we gave -- we gave
5 them each bound copies of the report, but those
6 materials were already available online, so -- but we
7 just -- we just gave him paper copies or to reference
8 but nothing -- no other additional materials.

9 Q You didn't provide them any other materials
10 other than the GAPMS -- the June 2022 GAPMS?

11 A That's correct.

12 Q To review prior to the hearing?

13 A Correct.

14 Q Did you have any meetings with the consultants
15 prior to the hearing to prepare for the hearing?

16 A We had a couple -- there were a couple Zoom
17 calls.

18 Q How long did those last?

19 A About an hour?

20 Q What kind of things were discussed during
21 those meetings?

22 A Mostly the format. You know, we were talking
23 about, like, of course, Dr. Grossman, who was not going
24 to be able to travel. So we were talking about
25 technological arrangements. I think with Doctors Van

1 Meter and Van Mol, we were mostly talking about travel
2 arrangements and, like, where they'd sit and so forth,
3 so I mean --

4 Q Did you offer any questions that they might
5 anticipate from the audience and how they should
6 respond?

7 A To our experts? We didn't.

8 Q And why was it necessary to have the
9 consultants there?

10 A So -- well, since -- because we were actually
11 anticipating a crowd that was going to be largely
12 opposed to the challenge exclusion, we wanted to be able
13 to respond promptly and articulately to any comments
14 that were provided.

15 Q If you wanted to respond promptly and
16 articulately to any comments that were provided, what
17 was the purpose of having a public hearing?

18 A So the public hearing is to, of course, gather
19 feedback, but we also knew that we were likely going to
20 have either some type maybe medical professionals or
21 advocacy groups, or other advocates, and we did want to
22 be able to provide them with a little bit of engagement
23 to show that we do take their comments into
24 consideration, that we do think about them, that we do
25 engage with them.

1 Q Did the consultants respond to any comments by
2 a supporter of the rule?

3 A I don't think they did, actually.

4 Q How about those that were opposed to the rule?

5 A There was really -- I think Dr. Van Meter
6 responded once. I think Dr. Van Mol responded once.
7 And Dr. Grossman didn't respond to anything.

8 Q And that was -- both of those responses were
9 in response to individuals who were speaking in
10 opposition to the rule?

11 A Yes.

12 Q Have you ever participated in another rule
13 hearing where there is direct and prompt response to
14 public comment?

15 A Yes. Yeah, we do. Yeah, I mean, I've
16 participated in numerous rule hearings here at the
17 Agency. We do respond to comments.

18 Q When you say we, do you mean the office staff?

19 A Office staff, yes.

20 Q What about consultants with which AHCA has
21 contracted?

22 A We -- we generally don't -- we generally
23 don't. It's a -- it was a unique experience for this
24 case, but we generally don't have contracted consultants
25 at our hearings.

1 Q And where did the slogan, Let Kids Be Kids
2 come from?

3 A So that came from within, I think, our own
4 Agency, our Communications Department or the Chief of
5 Staff's office.

6 Q Was there any input in developing that from
7 outside entities?

8 A No.

9 Q So AHCA is wholly responsible for that slogan?

10 A Yes.

11 Q Was AHCA responsible for the printing off of
12 the stickers that had the slogan contained on it that
13 were being passed out at the hearing?

14 A No.

15 Q Do you know who was responsible for that?

16 A We do not know where those came from.

17 Q Is it normal to have slogans of an Agency
18 passed out at a rule hearing? Have you ever seen that
19 before?

20 A I have not seen that before, so -- but we --
21 that was not something that the Agency had anticipated,
22 and we certainly were not responsible for the passing
23 out of stickers with a slogan on it.

24 Q Did outside counsel appear at the public
25 hearing? Did AHCA outside counsel appear at the --

1 A Yes, they did.

2 Q Why?

3 A Because, of course, sensitive nature. I mean,
4 there were -- there were attorneys also -- there was --
5 because there was counsel that -- you know, who are
6 representing the plaintiffs who were also there. We do
7 anticipate litigation, so it was -- we did see to it
8 that we had outside counsel there to gather information
9 and be able to observe the procedures.

10 Q So AHCA had -- at the point of the public
11 hearing, AHCA had retained outside counsel to defend
12 against any potential litigation that the rule invited?

13 A Yes.

14 Q What was outside counsel's role at the
15 hearing?

16 A Outside counsel's role, I think -- I think
17 just calling up the speakers as they came. I think they
18 actually -- we had them helping out with the -- with the
19 hearing process and procedures.

20 Q What kind of -- well, okay. Did AHCA give the
21 consultants any instructions to prepare for the hearing?

22 A Basic ones. Most of -- I think, you know,
23 like to when responding that, you know, we would prompt
24 them to respond. Basic -- very basic instructions.

25 Q And so the instruction was that when AHCA

1 wanted someone to -- one of the consultants to respond,
2 you would prompt them to?

3 A So, yes. And during the hearing, Secretary
4 Weida would defer either to Dr. Van Meter or he would
5 defer to Dr. Van Mol when he needed -- when a response
6 was needed from one of them.

7 Q Okay. Just going back to the slogan really
8 quick, who in AHCA came up with that Let Kids Be Kids
9 slogan?

10 A I think -- I think it was a -- I think it was
11 a team effort. I think, like, it was Cody Farrell and,
12 I think, Brock Juarez. I think they worked on the Let
13 Kids be Kids slogan.

14 Q Anybody else?

15 A No, it would have been primarily them.

16 Q Who directed them to develop the slogan, or
17 was it their idea?

18 A So the orders would have been given verbally.
19 We don't know, like, exactly how they were told to do
20 that specific slogan.

21 Q When was the -- when was the slogan developed?

22 A It was developed, I think, in the days
23 preceding the release of the report.

24 Q When was the final draft of your report done?

25 A So the final draft -- so the final draft as

1 far as -- so the very, very final draft, like the last
2 finishing touches, as much as copy edits, was done that
3 week of the 2nd, but as far as the substantive
4 components of the report, that was done probably a few
5 weeks prior to the release.

6 Q So when was the slogan developed?

7 A Slogan was developed -- I think they did --
8 were working on it, like, the week before the release.

9 Q Is it normal for AHCA to develop a slogan for
10 the conclusions found in a GAPMS report?

11 A No, this is -- this was a first.

12 Q Why develop a slogan?

13 A Well, we do develop slogans for whenever we do
14 have -- do releases, or whenever we have new programs.
15 For instance, Canadian Prescription Drug Importation, we
16 do have a slogan for that. We do have a web page
17 dedicated to prescription drug transparency pricing. So
18 we do have -- often to correspond with our press
19 releases, we often will do a logo.

20 Q But you just said it's not normal for a slogan
21 to be developed for GAPMS. So why do it in this
22 instance?

23 A So because HHS had already -- had made
24 announcements with the publication of their documents,
25 Department of Health had done theirs, we, of course,

1 likewise, because we were publishing this document, was
2 to, of course, create the website and to, of course,
3 create some graphics along with that website.

4 Q So was the slogan meant to draw attention to a
5 particular message that the Agency was trying to send?

6 A No, I mean, other than that, we did the report
7 and we did was evidence-based and concluded these
8 treatments were experimental and investigational.

9 Q For children and adults, right?

10 A For children and adults.

11 Q And why was it Let Kids be Kids?

12 A Because -- so for adults with -- when it comes
13 to Medicaid, states -- because you don't have the EPSDT
14 consideration, states can be much more -- have much more
15 discretion in denying coverage. They have a lot more
16 latitude to be able to deny coverage, so -- but for
17 services that are intended for pediatrics, or are under
18 EPSDT considerations, that's partially -- partially why
19 not -- like one of the services that we evaluated was
20 puberty suppression, adults aren't going to use that.

21 Q But the conclusion of the GAPMS report was
22 that all treatment for gender dysphoria was experimental
23 for kids and adults?

24 A That's correct.

25 Q The slogan's just targeted at kids?

1 A Yes, that's correct.

2 Q Why?

3 A So it comes back down to the EPSDT
4 considerations. Because like -- well, for starters, I
5 mean, when it comes to adult coverage, that's a totally
6 different category. But for kids, especially with
7 puberty suppression and especially with the cross-sex
8 hormones, because of the experimental and
9 investigational nature, that's probably why we -- why
10 the Agency embarked on a, I guess, child-based kind of
11 graphic for its web page.

12 Q What does it mean Let Kids be Kids?

13 A I think, well, as far as semantics go, I think
14 that could mean something different to everybody.

15 Q What did AHCA by it?

16 A Let kids be free to explore their own
17 identities and figure out who they are.

18 Q What are some examples of other slogans AHCA's
19 used for its programs?

20 A Well, lower prescription drug costs.

21 Q That's a slogan that we can find?

22 A Yeah. I mean, that's one we've been using for
23 a while. I was using as -- under my signature on my
24 email, so things -- yeah, but, I mean, there are
25 slogans. I think like prescription drug transparency.

1 I mean, that's part of, you know, the state's mission is
2 when it's coming up with new programs -- and obviously
3 it's not isolated to AHCA, I mean, every agency's going
4 to have slogans and graphics for their new programs. I
5 mean, if you look at the Department of Children and
6 Families, they're promoting Hope Florida in a big
7 capacity. So for a lot of these -- so for a lot of
8 these programs that they want to have -- they want them
9 to be now such high profile, of course there's going to
10 be graphics and slogans.

11 Q Prescription Drug Transparency is not very
12 catchy, I'll say. Why create a web page dedicated to
13 supposedly fact-checking Health and Human Services? Is
14 that normal?

15 A No, it's not, but following -- but the thing
16 is following the review of the evidence and how our
17 findings really did contradict what was in HHS
18 documents, because we really wanted to demonstrate --
19 because we do understand, it's a GAPMS report, it's 46
20 pages. Not many people are going to take the time to
21 read it. So we wanted to kind of put it -- we wanted to
22 put the case in more simplistic layman's terms and make
23 it accessible to the audience to show that, hey, yeah,
24 this is a sensitive report. Yeah, if you got an hour
25 and a half and you understand medical terminology and

1 literature, you might have fun reading it, but for quick
2 information, we wanted to provide a resource, because
3 HHS had made all these claims regarding gender dysphoria
4 treatment, we want to make it accessible to everybody
5 that they could look at it and five minutes later
6 understand the gist of what we were saying in the GAPMS
7 report.

8 Q Prior to the July 8th public hearing, did AHCA
9 communicate with anyone from the Christian Family
10 Coalition?

11 A No.

12 Q Anyone from Florida Citizens Alliance?

13 A No.

14 Q Including Pastor Rick Stevens?

15 A No.

16 Q Anyone from Warriors of Faith, the Florida
17 Chapter?

18 A No.

19 Q Including Troy Peterson?

20 A No.

21 Q Anyone from Protect our Children Project?

22 A No.

23 Q That includes Pastor Ernie Rivera?

24 A That's correct.

25 Q Okay. Anyone from Florida Prayer Network?

1 A No.

2 Q And that includes Pam Olsen?

3 A Correct.

4 Q Anyone from Partners for Ethical Care?

5 A No.

6 Q What about Chloe Cole?

7 A No.

8 Q Sophia Galvin.

9 A No.

10 Q Anyone from the Rainbow Redemption Project?

11 A No.

12 Q How many comments did AHCA receive in response
13 to the proposed changes to 59G-1.050?

14 A 600 or so.

15 Q Oh, that's all? Did AHCA read them all?

16 A We did.

17 Q Who at AHCA reviewed them?

18 A It was a combination. So, like, I think Cole
19 Gerring, Nai Chen, myself, I remember we did sit down
20 once and we started going through all the emails. Most
21 of them were very brief, maybe like one or two lines,
22 not substantive whatsoever. For the more substantive
23 ones, those I did careful reviews of.

24 Q So it's three people. You, Nai Chen and Cole
25 Gerring?

1 A Uh-huh.

2 Q Okay. And you split them up amongst each
3 other?

4 A We read them together.

5 Q What process did you use to decide whether or
6 not to incorporate the input into the final rule?

7 A We wanted to look at the -- we looked at the
8 content of every -- of every single comment. A lot of
9 the comments were just saying don't do this, or
10 something -- or something very sensationalist. So a lot
11 of the comments we really couldn't take into
12 consideration because there wasn't -- there wasn't --
13 there was no substance behind them. So there were some
14 comments that were -- we did receive some feedback
15 from -- I think we got something -- we got -- we got a
16 lengthy comment from American Academy of Pediatrics. We
17 got a very lengthy one from Yale University. We got
18 feedback from the Endocrine Society. I think one of
19 UF's gender clinic physicians wrote us up, not a
20 terribly long comment, but wrote us a comment. So we
21 did want to take a look at the substantive ones. But
22 we did them into -- we did take into consideration every
23 comment submitted to us.

24 Q Did you receive any comments from the people
25 who had Medicaid coverage for treatment of gender

1 dysphoria?

2 A During the comment review, there wasn't any --
3 we didn't -- we didn't notice any comments from those
4 offhand, but, of course, that was over six months ago.
5 So we -- because of the volume of comments, we did have
6 to read them fairly quickly.

7 Q Had you received a comment from anyone who was
8 receiving Medicaid coverage for treatment of gender
9 dysphoria, how would you have factored that into your
10 ultimate determination?

11 A Well, we would -- we would have looked at it.
12 We would look at the content. We were wondering, like,
13 what kind of services they were receiving and so forth,
14 but it depends on what the comment was. If they
15 provided a case for why they were getting it, you know,
16 but we didn't -- we didn't receive anything like that.

17 Q For those people who lost Medicaid coverage
18 for treatment of gender dysphoria, or were going --
19 stood to lose based on the categorical exclusion, during
20 any of this process, was there any consideration given
21 to the inability to access that care?

22 A There was. We did have questions. We wanted
23 to make sure that if we were to discontinue individuals
24 who were receiving, particularly cross-sex hormones, we
25 wanted to -- we did have questions like, would there be

1 withdrawal? What would -- would they need some -- would
2 they be weaned off the medication? How would -- how
3 would the Agency take that into consideration? And we
4 actually kind of realized that if, say, if they do need
5 to discontinue testosterone because of the categorical
6 exclusion and their doctor deems, well, they're going to
7 need some small doses to wean themselves off, but we
8 also realized that necessarily wouldn't be for gender
9 dysphoria, that would be because of withdrawal symptoms,
10 and that would be a different diagnosis.

11 Q Did you give that guidance to any treating
12 professionals or Medicaid recipients?

13 A No, we didn't.

14 Q Okay. Why was it necessary to review the
15 comments quickly?

16 A It wasn't necessary to; it was just -- I mean,
17 most of the comments were because the nature, they
18 were -- most of them were sensationalist, a lot of them
19 just hurled insults at us, a lot of them ad hominem
20 attacks, things like that. We just kind of went through
21 a lot of them very fast.

22 Q So that wasn't quite my question. It sounds
23 like you were able to review them quickly.

24 A I think I want to rephrase as we were able to.
25 We weren't really in a hurry. Because, obviously, like,

1 we got a 47-page comment from Yale University. That was
2 not a five-minute skim, obviously. So there were those
3 we deemed to be substantive comments that warranted
4 in-depth attention, and then there were those we deemed
5 non-substantive comments and just read. They're like --
6 yeah, we received some ones that were using, I will say,
7 the colorful metaphors. And then we don't -- I mean,
8 obviously, not going to pay attention to those, so --
9 but the substantive ones that where they're putting
10 together, like, an argument or making points, being
11 something that we have to take back and think over, we
12 did invest time in those, yes.

13 Q Were there any discussions about the comments
14 between you and Cole and Mr. Chen?

15 A As far as the discussions go, no, most of
16 discussions were like, okay, let's move on to that one,
17 that one's just insulting us or that one's -- that one's
18 expletive-laden, let's move on. So when we got the
19 substantive ones, of course, those were -- those were
20 handled differently.

21 Q How were they handled differently?

22 A So those, because they were going to take
23 in-depth review is not something that's going to be a
24 group activity. Of course, we printed those out and
25 started reviewing with a fine-tooth comb.

1 Q Did AHCA review the underlying cases and
2 studies cited in those substantive comments?

3 A Yeah.

4 Q Okay. How did they factor those in to the
5 ultimate determination?

6 A So we did take a look. So we checked to see
7 what studies that Yale University and the AAP brought
8 into it. And we looked at two responses from the Yale
9 University, not just the response that they made to us,
10 because Yale University frequently cited their response
11 to Texas and Arkansas, we pulled that up as well and
12 did -- and analyzed that. So we looked to see what
13 articles they were citing and we were -- so we checked
14 to see whether our GAPMS report or any of the expert
15 reports also did evaluations of those studies to see
16 that -- make sure that we were in alignment.

17 Q Okay. Do you remember any particular
18 underlying cases or studies?

19 A There's -- I think there's one by Jack Turban
20 that they cited. I think there was one that we did cite
21 in GAPMS review. We didn't discuss it at length, this
22 was by Tordoff, et al. And we looked at that. And, of
23 course, but we also captured those in Dr.
24 Brignardello-Petersen's piece that they were evaluated
25 as, like, being very low-quality or in a critical risk

1 of bias.

2 Q Okay. How did you determine whether -- okay.
3 Turning to the implementation. Sorry.

4 A Okay.

5 Q Hold on. One second. Something breaking is
6 coming in. Did you review any comments that reference
7 court cases?

8 A We did see some comments that referenced, I
9 think, like Bostock v. Clayton. I mean, there were some
10 cases referenced in the comments, but, of course, I
11 mean, we were primarily interested in -- we were looking
12 for comments that were providing -- that were either
13 providing examples of literature or anything that was
14 going to contradict the GAPMS report. In other words,
15 we were looking -- we were looking for anything that, I
16 guess you could say, delivered, like, a mortal wound or
17 something like that, something that would foreseeably
18 cause us to have to go back and make revisions or cause
19 us to have to retract the rule, or something that -- or
20 a comment that we couldn't just dismiss or a comment
21 that we couldn't explain. So those were what we were
22 looking for.

23 Q What types of information provided by the
24 public would have mortally wounded your conclusion?

25 A So a mortal wound would have come from a

1 quality study, or a number of quality studies.

2 Q And define a quality study.

3 A So something that -- well, a quality study,
4 well, I mean, that -- that's a pretty broad definition
5 of what you're asking for, and there are different ways
6 a quality study can come about, but something that, of
7 course, lengthy longitudinal histories on participants,
8 either has adequate control groups. And this is not an
9 all-inclusive list. These are just examples. Also
10 follows participants for a lengthy period.

11 Q Well, what's the difference between that and a
12 lengthy longitudinal study?

13 A Long -- when it comes to a longitudinal
14 history, what we mean by longitudinal history, and this
15 is often for behavioral health, is that longitudinal
16 history is necessary to really ascertain the full
17 impacts of somebody's mental health conditions. Because
18 it's -- because mental health, it's not necessarily like
19 an acute illness or a chronic condition diagnosis. So,
20 like there's treatment histories, medications and --
21 like, in other words, and, of course, like activities of
22 daily living, how that all is affected. So it's usually
23 something that has to be obtained over a number of
24 years.

25 So, mental health longitudinal histories, but

1 we also were finding in the studies that we evaluate for
2 the GAPMS process that they lacked participants'
3 longitudinal histories. If they even -- if they even
4 did -- provided any histories or any -- identified the
5 recipients or the participants at all. I mean, there
6 were so many studies where they were -- I think there
7 was one that we came across, and this was during the
8 comment period, that was just a massive survey and they
9 were trying to give gift cards to participants. And, of
10 course, people were just completing it, but it was like
11 a one-time snapshot, and it's subjective self-reports.
12 So I mean, there are a myriad examples that we can say
13 for high-quality evidence, and not to mention RCT's, as
14 well. So --

15 Q What does that stand for?

16 A Randomized control trials. So there -- so,
17 yeah, so that was what we were looking for, evidence
18 that -- evidence that would hold up to questioning, and
19 that's not what we were finding.

20 Q So in undertaking the review of the comments,
21 the only thing you were looking for is anything that
22 would, in your definition, cause a mortal wound to your
23 conclusion in the GAPMS?

24 A That was among one of the things we were
25 looking for.

1 Q What else were you looking for?

2 A I mean, we were looking -- we were looking
3 for -- I mean, we, of course, we were looking to see if
4 there's anything that would directly conflict with the
5 GAPMS report. That was one thing, because the rule's
6 foundation was the GAPMS report. So that's the big
7 reason why we were looking for contradictory evidence or
8 evidence that would be like, well, wait a second, we say
9 it's all -- you know, because our primary argument is
10 it's low-quality evidence and therefore experimental,
11 experimental investigational. That basis doesn't
12 sustain itself if all of a sudden there's modern,
13 high-quality evidence out there. So we want to make
14 sure that we had not left any stones unturned. But we
15 were just -- you know, I mean, we -- this things we
16 weren't -- that was the primary thing we were looking
17 for.

18 Other things -- I mean, we also, I mean,
19 anything that spoke to the legality of it, but I mean,
20 of course, we wouldn't necessarily evaluate that. We'd
21 turn that over to legal, but anything that was
22 looking -- that was looking at the legality of what we
23 were doing. So I mean -- so, I mean, there were
24 different angles. I think when I was looking at it
25 through my personal lens, that was what I was looking

1 for.

2 Q Are you aware that similar exclusions have
3 been found unconstitutional in other federal districts?

4 A I am aware at the district level that there
5 have been some -- some exclusions that have been tossed,
6 yes.

7 Q All right. Turning to the implementation --

8 MR. JAZIL: We've been going for an hour and a
9 half. Could we do a five-minute break?

10 MS. DEBRIERE: Sure.

11 VIDEOGRAPHER: This concludes video three. The
12 time is 3:00 p.m.

13 (Brief recess.)

14 VIDEOGRAPHER: This is beginning of video four.

15 The time is 3:08 p.m. we're on the record.

16 BY MS. DEBRIERE::

17 Q Just after that break, and I should have asked
18 this earlier, just after that break, did you have any
19 conversations with anyone during that break?

20 A During --

21 Q Just this recent break? Did you have
22 conversations with anyone?

23 A I mean, talked about, like, personality types
24 on 16 personalities, just had a conversation, but as far
25 as the case goes, no.

1 Q Okay. What about at lunch?

2 A Just a quick touch-base with our attorneys.

3 Q Okay. How long did you talk?

4 A 15 minutes.

5 Q Okay. All right. Turning to implementation
6 of the rule with managed care plans. Did Florida
7 Medicaid managed care plans -- well, we've already
8 answered that. What's the purpose of Inter-Qual?

9 A Inter-Qual?

10 Q Uh-huh.

11 A I don't have the answer to that.

12 Q Okay. Are you familiar with it at all?

13 A I'm not familiar with Inter-Qual.

14 Q Did AHCA develop, or help develop language for
15 notices of adverse benefit determinations in order to
16 incorporate the categorical exclusion of treatment for
17 gender dysphoria?

18 A No.

19 Q AHCA didn't assist at all in developing the
20 language for those denials for terminations?

21 A No, managed care plans were -- handled those
22 themselves.

23 Q Okay. Did AHCA review any of the language
24 that managed care plans submitted to AHCA for review?

25 A No.

1 Q Same question for notices of outcome relied on
2 by EQ Health?

3 A No, AHCA wasn't directly involved in those.

4 Q Did they review the notices of outcome
5 language?

6 A No.

7 Q Okay. What about Magellan?

8 A Magellan? No.

9 Q Did AHCA develop or help develop language for
10 any other types of notices used to notify a Medicaid
11 recipient of a denial or termination of treatment for
12 gender dysphoria?

13 A No.

14 Q All right. Can I have the notice of adverse
15 benefit determination, and that's Bates-stamped
16 Defendant_ 000292335, I think. We'll check? Did I get
17 it right? I don't think I did. I'll read the correct
18 Bates-stamp on -- so this is going to be the Molina
19 Health Care Notice of Adverse Benefit Determination.
20 I'm not going to name the Medicaid recipient. And the
21 date stamp appears to be cut off, but it is dated
22 October 26th, 2022, and the initials for the recipient
23 are AS.

24 (Whereupon, Exhibit No. 15 was marked for
25 identification.)

1 MR. JAZIL: Counsel, can we agree that this
2 should be confidential, attorney's eyes only?

3 MS. DEBRIERE: Absolutely.

4 MR. JAZIL: Do you mind if I write that on top
5 of the --

6 MS. DEBRIERE: Not at all. Not at all. So the
7 previous Bates stamp I gave was not correct, but
8 the Bates stamp on this exhibit is cut off, so I
9 can't provide the actual number, but I think I've
10 sufficiently described it. And, of course, it will
11 be Exhibit 15.

12 BY MS. DEBRIERE::

13 Q All right. This particular notice of adverse
14 benefit determination is from Molina. In that second
15 page there, it runs through AHCA's medical necessity
16 definition, correct?

17 A Yes, that's consistent.

18 Q And that's consistent across notices of
19 adverse benefit determinations?

20 A So each health plan is a little idiosyncratic
21 in how they do NABD's. We'd have -- we'd have to verify
22 with managed care plans. I mean, the contracts does
23 provide specific requirements when it comes down NABD's
24 and sending them.

25 MS. DEBRIERE: Mo, do you know if you guys have

1 produced an NABD template to us?

2 MR. JAZIL: We've never --

3 MS. DEBRIERE: I know they exist. They should
4 be pretty easy to --

5 MR. JAZIL: I'll check. What's that stand for,
6 again?

7 THE WITNESS: Notice of Adverse Benefit
8 Determination. It's a long phrase for a denial.

9 BY MS. DEBRIERE::

10 Q Or termination or reduction?

11 A Or termination, or reduction.

12 Q Or partial reduction.

13 A It's --

14 Q Okay. So this particular notice of adverse
15 benefit determination is to an actual Medicaid
16 recipient, correct?

17 A Yes.

18 Q And it looks like it's been it's denying a
19 request for coverage of testosterone cypionate.

20 A That's correct.

21 Q Okay. And what is the reason for the denial?

22 A The box for other authority non-covered
23 benefits is checked off.

24 Q Why isn't the, request service is not a
25 covered benefit, checked off?

1 A We would have to ask that question of the
2 plans.

3 Q Okay. So you don't require some kind of
4 uniform response to not -- that plans must provide when
5 there's a non-covered benefit?

6 A We're not aware of one. There -- I don't
7 think there's one mentioned in the contract.

8 Q Okay, but I guess my other question is, would
9 it be equally sufficient, had they checked off, must
10 meet accepted medical standards and not be experimental?

11 A They could have checked that box. They could
12 have checked, the requested service is not a covered
13 benefit. They could have checked other boxes, as well.

14 Q Okay, but it is accurate to say that it is not
15 a covered benefit?

16 A Yeah, that is accurate.

17 Q Is any plan allowed to currently cover
18 treatment for gender dysphoria of the services listed
19 and 59G-1.050(7)?

20 A For any plan right now currently?

21 Q Yes.

22 A No. No plan can cover them.

23 Q Since the adoption of the categorical
24 exclusion of treatment for gender dysphoria, how many
25 notices of adverse benefit determination have been sent

1 to Medicaid beneficiaries that denied coverage for
2 services on the basis of --

3 A So for MMA plans, so we did a little looking
4 into this -- so for managed medical assistance, which
5 most of these recipients, given their ages, are going to
6 be on MMA, we do not actually require the MMA plans to
7 submit reports regarding how many NABD's that they
8 actually mail out to their enrollees. Long-term care,
9 that process is different. We do require them for
10 long-term care to mail those to report to the Agency how
11 many NABD's they are sending out, but for MMA we
12 currently don't have that as a requirement.

13 Q Okay. So is that -- does the same hold true
14 for notice of appeal plan -- plan appeal resolutions?

15 A As far as that goes, I don't think -- I don't
16 think we're collecting information from the plans on
17 those.

18 Q Okay. So generally, not just as related to
19 treatment of gender dysphoria?

20 A Generally.

21 Q What about notice of outcomes?

22 A Notice of outcomes, I don't think we're
23 collecting them from those informations either.

24 Q Okay. Just generally, do any of those notices
25 include reference to the variance in waiver process

1 described at Florida Statute 120.542?

2 A No. I mean, we definitely -- I mean, so
3 looking at this, this is in compliance with what we do,
4 we require them to have, which is an appeals process.
5 So, no, we don't -- we do not require the plans to
6 include the procedures for variances.

7 Q Okay. So those procedures are not listed in
8 notices of denial?

9 A That would be correct.

10 Q Okay. How many grievances have been submitted
11 to AHCA regarding a claim related to AHCA's adoption of
12 the categorical exclusion of treatment for gender
13 dysphoria?

14 A So that information, we do have a complaint
15 hub for recipients and providers who'd like to submit
16 complaints, be given the -- when the questions came in,
17 we, of course, have to reach out because our complaint
18 hub is actually down in Fort Myers, so it's not -- it's
19 not here locally, so that's information we're still in
20 the process of obtaining.

21 Q And once you obtain that, you'll provide it to
22 us?

23 MR. JAZIL: Yes.

24 MS. DEBRIERE: Can you put that as a follow-up?

25 BY MS. DEBRIERE::

1 Q How many -- how many appeals of Notice of
2 Adverse Benefit Determination denying care on the basis
3 of the exclusion have there been?

4 A As far as appeals going up to the fair hearing
5 level, I think that's zero.

6 Q Okay. What about -- yeah, so that would
7 include both notice of plan appeal resolutions as well
8 as notice of outcome?

9 A Yeah.

10 Q Okay. Prior to August 21st, 2022, did AHCA
11 ever reverse a decision made by AHCA or by a plan to
12 deny pubertal suppression therapy for the treatment of
13 gender dysphoria?

14 A We did not.

15 Q You never reversed a decision to deny?

16 A To deny?

17 Q Yeah.

18 A No, we never did. Sorry. I misunderstood the
19 question.

20 Q Okay. I just want to make sure you're
21 understanding. So prior to the adoption of the
22 categorical exclusion, did AHCA ever reverse a decision
23 to deny puberty suppression therapy for the treatment of
24 gender dysphoria?

25 A So if a plan reviewed for medical necessity

1 criteria decided, no, it didn't meet the criteria and
2 issued denial, no, we never reversed it.

3 Q What about upon a fair hearing review?

4 A Are we talking about, like, since 2015?

5 Q Well, I'm asking ever, but if 2015 is a
6 helpful marker.

7 A I don't have that information offhand.

8 Q Is that information you can obtain?

9 A I think we can.

10 Q Prior to August 21st, 2022, did AHCA ever
11 reverse a decision to deny cross-sex hormone therapy for
12 the treatment of gender dysphoria? And by reverse I
13 include at the fair hearing level.

14 A That's information that we would have to
15 obtain.

16 Q Same question for surgery in furtherance of
17 the treatment for gender dysphoria.

18 A At the fair hearing level, we would have to
19 obtain that.

20 Q So you will tell us the number of times, if
21 ever, that AHCA reversed a decision at the fair hearing
22 level to provide treatment in furtherance of -- services
23 and treatment for gender dysphoria?

24 A We can confirm it. It's probably zero.

25 Q Okay.

1 A As far as overturning a decision that was
2 already a denial, it's probably going to be zero, but we
3 just want to confirm.

4 Q Okay. I'll tell you, we have different
5 information.

6 A Okay.

7 Q How many AHCA fair hearings have been provided
8 where the categorical exclusion of treatment for gender
9 dysphoria was an issue?

10 A Well, can you repeat that?

11 Q How many AHCA fair hearings have occurred
12 where the subject at issue was the categorical exclusion
13 of treatment for gender dysphoria? So where the rule
14 exclusion --

15 A We'll have to obtain those numbers.

16 Q Did any -- do final orders in general
17 reference the variance and waiver process described at
18 Florida Statute 120.542?

19 A You'll have to slow down and ask the question
20 a little bit --

21 Q Sure. Sure. The final orders that are issued
22 at the end of any AHCA Medicaid fair hearing, do those
23 written final orders contain any reference to the
24 variance and waiver process at Florida Statute 120.542?

25 A I don't think the final orders do. I don't

1 think they do.

2 Q Okay. Is there any way you can get
3 confirmation of that answer?

4 A I mean, we could obviously pull up a copy of
5 the final order and see if that information is included.

6 Q If we had a copy of an AHCA final order, would
7 that be sufficient to determine, and it did not list it,
8 would that --

9 A I'll defer to our attorneys, if that's
10 sufficient.

11 MR. JAZIL: That'd be sufficient. If you have
12 one, you can show it to him.

13 MS. DEBRIERE: Well, we can pull one up, can't
14 we?

15 MS. CHRISS: Just one?

16 MS. DEBRIERE: Yeah. Yeah. Why not. Yeah, as
17 long as their name's blocked out, which really
18 shouldn't matter here because we're dealing with an
19 AHCA employee.

20 THE WITNESS: Yeah. I mean, I'm cleared to
21 review PHI and recipient information. It shouldn't
22 be a problem.

23 MS. DEBRIERE: Do you want another one? I can
24 send you another one. Bear with me one second.

25 I'm going to forward you this email. And

1 it's -- I can tell you what the name of the
2 document is. It's the last document, 23. That
3 should be the last one. Chelsea's copied on that
4 one, too.

5 THE WITNESS: Okay.

6 MS. DEBRIERE: Okay. Okay. So feel free to
7 just scroll through it and see if you see any
8 reference -- oh I'm sorry, it isn't a touchscreen?

9 THE WITNESS: I don't know where the scroll
10 bar.

11 MS. CHRISS: It's just -- just use two fingers
12 and just go like that.

13 MS. DEBRIERE: Oh, it's a Mac.

14 MS. CHRISS: I'm sorry.

15 THE WITNESS: Okay. There it goes. Yeah.
16 I pads and iPhones I'm good with, Mac's I never got
17 comfortable with.

18 MS. DEBRIERE: The next exhibit I'm going to do
19 is emails related to the policy transmittal and the
20 policy transmittal itself, if that helps.

21 MS. DUNN: Yep.

22 THE WITNESS: So are we talking about the --
23 that last paragraph on the final page that's, like,
24 notice of judicial review?

25 BY MS. DEBRIERE::

1 Q Yes. So does that relate to the variance
2 waiver process?

3 A I mean, it doesn't point out the variance
4 processes as described in section -- or Chapter 120. I
5 think that's more if they want to appeal to the next
6 level -- next court level. I don't think that's in
7 response to the variance process. That's a different
8 process.

9 Q Okay. Thank you. So it does not mention the
10 variance waiver process --

11 MR. JAZIL: Would it be possible just to read
12 off the --

13 MS. DEBRIERE: Yes, absolutely. So it says at
14 the bottom: Notice of a right to judicial review.
15 A party who is adversely affected by this final
16 order is entitled to judicial review, shall be
17 instituted by filing the original notice of appeal
18 with the Agency clerk of AHCA, and a copy along
19 with the filing fee prescribed by law with the
20 District Court of Appeal and appellate district
21 where the Agency maintains its headquarters or
22 where a party resides. Review proceedings shall be
23 conducted in accordance with the Florida appellate
24 rules. The Notice of Appeal must be filed within
25 30 days at the rendition of the order to be

1 reviewed.

2 THE WITNESS: Our various processes doesn't
3 involve appellate courts, so it would not be an
4 appellate case, so it's a different affair.

5 BY MS. DEBRIERE::

6 Q Thank you. Okay. Did AHCA work with Florida
7 Medicaid managed care plans to implement the exclusion
8 set forth in 59G-1.050(7) in any way?

9 A No. I mean, the publication's in the Florida
10 Administrative Register, that was to provide ample
11 notice -- public notice that the rule's changing, the
12 managed care plans are responsible for keeping up with
13 changes to manage -- to AHCA's coverage policies and
14 administrative policies.

15 Q What about plan transmittal? Are you maybe
16 forgetting those?

17 A We do not do a plan transmittal for this. Are
18 you referring to a policy transmittal?

19 Q Yes.

20 A We did not send out a policy transmittal.

21 Q Okay. Okay. So we have what's marked as
22 Exhibit 16 and Exhibit 17. Exhibit 16 is some emails
23 from Dede Pickle to Jason Weida, cc'ing Ann Dalton. And
24 those are dated August 22, 2022. I believe that's where
25 they start. Also involved are you, Matt, and Ashley

1 Peterson. Also, I just want to note that Exhibit 17 is
2 an SMMC policy transmittal dated August 22nd, 2022.

3 (Whereupon, Exhibit Nos. 16 - 17 were marked
4 for identification.)

5 BY MS. DEBRIERE::

6 Q Getting back to the list of questions. So did
7 AHCA not send the plan policy transmittal out, Exhibit
8 17?

9 A We did not send them out.

10 Q Why?

11 A Pretty much because all it's doing is
12 reproducing what was already stated in the rule. The
13 rules -- the rule -- the policy changes already in rule,
14 that was announced through the FAR. Policy
15 transmittal's a little superfluous at this point.

16 Q Why draft an entire plan transmittal and then
17 not send it out?

18 A Which this happens frequently. Sometimes we
19 will draft something and later decide not to -- not to
20 use it, or not to utilize that content in favor of
21 different strategy. So, in this case, since the rule --
22 since the rule change itself was pretty self-explanatory
23 and pretty direct, just we later deemed wasn't
24 necessary.

25 Q Who made the decision not to send out the

1 policy transmittal?

2 A I think that would have been -- that would
3 have been Secretary Weida.

4 Q Only Secretary Weida? Is it Weida or Weida?

5 A Weida. I mean, as Assistant Deputy Secretary,
6 he would be within his purview to decide whether or not
7 to send something out -- or to send something out, but
8 given that the rule itself was self-explanatory, and we
9 just decided that a policy transmittal wasn't necessary.

10 Q All right. In the email exchanges -- I think
11 it's on the second page -- oh, and Jason Weida, at this
12 time that he made this decision, was not the
13 Secretary -- AHCA's Secretary, correct? At the time
14 this was sent, Mr. Weida was not the AHCA Secretary,
15 correct?

16 A Right, he was Assistant Deputy Secretary for
17 Policy and Quality.

18 Q On the last page, it looks like you were the
19 person who drafted the first policy transmittal, is that
20 correct?

21 A Yes. Yeah, I mean, Dede and I, it was a
22 collaborative effort between the two of us. We were, of
23 course, working on each other's language.

24 Q Why did you think Dede -- why did you and Dede
25 think it was important to draft a policy transmittal?

1 A We were asked to.

2 Q By who?

3 A I think Ann Dalton asked Dede to work on it.

4 Q Okay. And later -- well, let's look to --

5 Ashley Peterson says on August 22, 2022 at 10:35 a.m.:

6 I added one thing to help clarify that these drugs will
7 still be provided, just not for gender dysphoria.

8 Please let me know if you think this is unnecessary or
9 adds confusion.

10 So at least Ashley thought there was some
11 clarity that could be provided to plans on the
12 implementation of the exclusion.

13 MR. JAZIL: Object to form.

14 THE WITNESS: Okay. There's several emails.

15 Which one are you --

16 BY MS. DEBRIERE::

17 Q This one is from Ashley to Dede, copying you.

18 A August 22nd, 11:04 a.m. That's Dede --

19 Q 10:35 a.m.

20 A Okay.

21 Q It's DEF_0002587.

22 A Okay. I think it was just a minor, minor
23 technical catch. I mean, when we worked on this, I
24 mean, we were just fine tuning the drafts.

25 Q And further up Ann wants to include the 60-day

1 language in the alert, which has been later included.

2 What is the 60-day language?

3 A That would be the bottom paragraph of the
4 policy transmittal.

5 Q Okay. And that you're referring to starts
6 with: To ensure the safe discontinuation of puberty
7 blockers or hormone and hormone antagonists for the
8 treatment of gender dysphoria?

9 A Uh-huh.

10 Q Then the managed care plan must notify its
11 subcontractors, providers, enrollees receiving active
12 treatment and changes in coverage, and they must honor
13 any current prior authorization of prescribed outpatient
14 drugs for the treatment of gender dysphoria through 60
15 days after the date of this policy transmittal. So that
16 means that under the 60-day rule for continuity of care,
17 the managed care plans were to continue coverage of the
18 prescribed outpatient drugs for the treatment of gender
19 dysphoria, correct?

20 A Only for those existing prior authorizations
21 had already been approved.

22 Q Okay. So that meant that AHCA was -- or that
23 Florida Medicaid was covering this drugs?

24 A Yeah, just for the sake of honoring existing
25 PA's.

1 Q Was it not important that the plans know that
2 they should maintain continuity of care?

3 A It's actually in the contract. I mean, when
4 you refer to continuity of care, can you clarify what
5 you mean by continuity of care?

6 Q In this instance, I'm talking about the
7 continued coverage for 60 days of those prescribed
8 outpatient drugs for the treatment of gender dysphoria.

9 A As far as the continuity of care went, I mean,
10 there -- as far as medically necessary services,
11 enrollees are always going to have access to those. So
12 when it comes to the continuity of care, whether or --

13 Q They're not going to have access to services
14 that have been previously covered, but now are excluded,
15 correct?

16 A That'd be correct.

17 Q Okay. So the 60-day continuity of care
18 ensures that after that categorical exclusion is
19 adopted, those individuals continue to access that care
20 for 60 days?

21 A This, of course, was a draft. It was never
22 sent out.

23 Q At some point, AHCA thought that the 60-day
24 period of continuity of care should apply in this
25 situation, correct?

1 A Since this was a draft and it was not -- not
2 officially sent out, this is not -- since it is draft
3 language, it is not an official transmittal, we sent out
4 to the health plan, so this does not formally represent
5 the views of the Agency. This is a -- this is a draft
6 that we created, deliberated upon and decided not to
7 send out.

8 Q Who decided?

9 A That would, of course, been leadership. That
10 would have been -- would have gone to Assistant Deputy
11 Secretary Weida.

12 Q And he was the only one who was involved in
13 that decision, correct?

14 A I mean, since he oversees the bureau policy,
15 that's -- which means policy transmittal, yes, he had --
16 is within his -- is within his job description and his
17 responsibilities and rights to veto sending out a policy
18 transmittal.

19 Q Okay. Since the policy transmittal was not
20 sent out, then is it AHCA's position that those who had
21 a current prior authorization at the time that
22 categorical exclusion was adopted, was not entitled to
23 the 60-day continuity of care period -- were not
24 entitled?

25 A So once the rule went into effect, that was,

1 of course, the notice of the plans that the coverage for
2 these services has to stop.

3 Q Immediately?

4 A Well, I mean, that's based on what the rules
5 say, yeah.

6 Q Okay. So they -- that means that the plans
7 were not to implement this 60-day period of continuity
8 of care as described in this transmittal?

9 A Right, we didn't provide notice of -- them of
10 this.

11 Q Okay. And it was AHCA's position that
12 Medicaid beneficiaries were not entitled to that?

13 A That's correct.

14 Q Okay. You previously noted how people on
15 hormones may go through withdrawal, there was something
16 as part of your 2022 GAPMS request. Why wasn't that
17 important to communicate to the plans?

18 A Well, because withdrawal is not gender
19 dysphoria. It's a different -- that's a different --
20 it'd be a different diagnosis altogether.

21 Q But in the decision to no longer cover drugs
22 that may cause withdrawal, was it important to
23 communicate to the plans or providers that they may need
24 to help facilitate transition off those drugs that would
25 no longer be covered?

1 A We were leaving that to the health plans to
2 manage independently, as well as the providers of these
3 services.

4 MS. DEBRIERE: Do we have a document titled
5 Florida Medicaid health alert? You just -- under
6 DEF_000258815. I feel like I've had the same Bates
7 stamp number. So we're marking as Exhibit 18, the
8 Florida Medicaid health care alert sign-off form.

9 (Whereupon, Exhibit No. 18 was marked for
10 identification.)

11 THE WITNESS: I'm familiar with that. I
12 drafted it.

13 BY MS. DEBRIERE::

14 Q That would definitely have been one of my
15 questions.

16 A No, I'm listed on there as the analyst who
17 drafted it.

18 Q And there's Dede and Ann.

19 A Yeah.

20 Q Okay. Did this healthcare alert go out to all
21 providers?

22 A That provider alert did not go out.

23 Q And the provider alert on the back, it lists
24 that same language to ensure the safe discontinuation of
25 puberty blockers or hormones and hormone antagonists for

1 the treatment of gender dysphoria, or allow transition
2 to payment to non-Medicaid funding sources. You
3 incorporated the reference to the 60-day continuity of
4 care period. You drafted that one. Did you include
5 that 60-day language?

6 A Yeah. I -- yeah, I did include that.

7 Q Why did you think it was important to include?

8 A Because at the time we were -- we were
9 creating a provider alert in sync with -- in sync with
10 the policy transmittal, so we wanted to make sure that
11 they used the same language and addressed the same
12 things.

13 Q And why wasn't this sent out?

14 A Because -- because, well, we've deemed that
15 the notice of the rule is sufficient, and that once the
16 rule had said that AHCA will no longer cover these
17 services, we could no longer cover those services. I
18 mean, the rule was clear-cut. It's very -- I mean,
19 language is pretty -- pretty straight to the point and
20 direct.

21 Q Who made the decision not to send this out?

22 A That would have come from Assistant Deputy
23 Secretary Weida at the time.

24 Q Did you agree with that decision?

25 A I thought it was sufficient. I actually

1 thought given that we put the rule out there, the rule
2 is very straightforward, noticing, like, we had the
3 providers, health plans, adequate notice was given.

4 Q Did Ms. Dalton agree with the decision not to
5 send any of this out?

6 A I can't speak to Ms. Dalton. She and I didn't
7 confer on our opinions of whether to -- we didn't confer
8 on how we felt about it.

9 Q Was there any stated opposition to not sending
10 these out?

11 A Not that I'm aware of, no.

12 Q So in managing withdraw, how would a plan or
13 provider know how to navigate that if AHCA wasn't -- if
14 AHCA notified them that they weren't going to cover the
15 service that was needed to help titrate individuals off
16 of their hormones or puberty suppression therapy?

17 A So it comes back down to practitioners
18 delivering treatment to their -- to their patients.
19 Once again, it comes down to how, like -- you know, when
20 they know that they can't treat for gender dysphoria
21 anymore, and they know that the individual might
22 suffer -- might suffer withdrawal symptoms from
23 testosterone. We, of course, did see some conflicting
24 information on that one, whether they would experience
25 symptoms or not, or estrogen, or if there were

1 withdrawal symptoms, you'd be treating the withdrawal.
2 And, of course practitioners, we do trust the medical
3 professionals to know what condition they're treating,
4 when the -- because they do so every day when their
5 course -- when they're, of course, diagnoses. And, of
6 course, when the medical coders come in there to do the
7 billing, it's --

8 Q If transition involved smaller dosages of
9 hormones over time to treat gender dysphoria, how was
10 the provider and the plan to know that they could
11 continue to prescribe that?

12 A It would be coming through a different
13 diagnosis code. And since we only said that for -- we
14 only said in the rule only for the diagnosis of gender
15 dysphoria. So if they're -- so if they're taking on
16 some small doesn't testosterone because of withdrawal,
17 that's a different -- that's a different diagnosis
18 altogether.

19 Q How would they know what diagnosis code to
20 use?

21 A So, practitioners and providers often don't --
22 aren't that familiar with the coding system. That's
23 where their coders do to figure out. So their coders,
24 of course, review the medical records and, of course,
25 put in the CPT codes, they put in the ICD-10 codes, the

1 place of service. So usually the claims process is
2 usually done either by often, like, a clearing house or
3 individual coders that sometimes just rotate like a
4 circuit through different physicians offices and so
5 forth.

6 Q So when we're talking about the safe
7 discontinuation of a medication, wouldn't the prudent
8 thing to do would be to notify providers and plans of
9 the options they had to ensure that individuals who
10 could no longer access this treatment could at least
11 come off of it as safely as possible?

12 A Given that physicians deal with that kind of
13 situation, for other diagnoses and medical services, we
14 just didn't feel it was necessary. That's one area we
15 were going to, like, leave it. Practitioner discretion
16 was how to withdraw their patients from testosterone or
17 estrogen, if it was even necessary at all.

18 Q Did any managed care plan ask questions about
19 how to implement the categorical exclusion of
20 gender-affirming care?

21 A I don't think we received any questions for
22 managed care plans.

23 Q What about from providers?

24 A I don't think we received any provider
25 questions either.

1 Q Did any plan communicate that they will
2 continue coverage in spite of the categorical exclusion?

3 A Definitely no.

4 Q Could a plan do that?

5 A Well, they hypothetically can --

6 Q Would Florida Medicaid allow them to do that?

7 A No, we would not.

8 Q I'm showing you what's marked as -- well, I
9 will be in a second -- what is marked as DEF_ 000169125.
10 It's the template member handbook -- actually, let's
11 skip that one. I'm sorry. I'm sorry.

12 MS. DUNN: Oh, I'm sorry, we have numbers that
13 aren't lining up with --

14 MS. DEBRIERE: Yeah, let's actually -- let's
15 move to the emails from Susan Williams between her
16 and Magellan. I'm not sure what the Bates stamp
17 is. Okay. Thank you.

18 (Whereupon, Exhibit No. 19 was marked for
19 identification.)

20 BY MS. DEBRIERE::

21 Q And that's marked as 19 and it's a series of
22 emails between Susan Williams, Jessica Forbes at AHCA,
23 Ashley Peterson, and the first date on the document is
24 June 3rd, 2022. The subject is for treatment of gender
25 dysphoria for children and adolescents.

1 A Well, this was -- well, we received this prior
2 to the promulgation of the challenge exclusion.

3 Q You did. So, Stephanie McGriff over at
4 Magellan says, Hi, Ashley and Susan, attached are the
5 internal criteria not publicly posted. CCM that the
6 implemented all meds with the gender code equals B, both
7 in the subsequent updated denial letter that includes
8 the non-discriminatory verbiage. What are the internal
9 criteria she's referring to?

10 A So it looks like the email chain started on
11 April 20th, following the release of the Department of
12 Health's guidelines. So there were 14 impressions to
13 AHCA at that time. We had just initiated the GAPMS
14 process for these treatments.

15 Q Yeah. In fact -- so looking at the email from
16 Alicia King Wilson dated April 20th -- so that would be
17 the day that the Florida Department of Health released
18 its guidance, right?

19 A Yes.

20 Q And Secretary Marstiller directed Tom Wallace
21 just to start the GAPMS process.

22 A Yes.

23 Q It says: Leslie noted MMA does have an
24 internal gender dysphoria criteria, which is attached.
25 This internal document serves for a GnRH analog used to

1 delay puberty in adolescence with gender dysphoria, but
2 it does not speak to use of hormone therapy. This
3 document was provided by the Agency due to a fear of
4 hearing requests received from Lupron for recipient with
5 this diagnosis. All requests for use of the drug at
6 that time to delay puberty were to be vetted by AHCA
7 before a final determination is made. Can you explain
8 that a little bit more? What does it mean that AHCA had
9 to vet all determinations? What determinations was AHCA
10 vetting?

11 A I don't -- I mean, it's tough to fully
12 understand the context of this email. I mean, the
13 context level is light throughout the chain, because I
14 mean, Magellan does handle the prior authorization of
15 clinical reviews for drugs in the fee-for-service
16 system.

17 Q Okay, but it says that this document was
18 provided the Agency due to a fair hearing request
19 received from Lupron first, recipient with this
20 diagnosis, all requests required vetting by AHCA before
21 a final determination was made. So, I mean, I interpret
22 that to mean that anytime Magellan received a request
23 for Lupron to treat gender dysphoria, AHCA had to vet it
24 before a decision as to coverage would be reached. Am I
25 wrong?

1 A No, that's what it sounds like. The
2 pharmacy -- the pharmacy processes may involve -- as far
3 as like the pharmacist job descriptions go -- I mean, as
4 far as like vetting, that's the kind of the questions
5 like, are they -- because we don't do in-house prior
6 authorizations or clinical determinations anymore. We
7 haven't done those since SMC went into a fact.

8 Q Was a special exception made for the coverage
9 of hormone therapy to treat gender -- I'm sorry -- for
10 the treatment of puberty suppressant?

11 A No. No. Yeah.

12 Q So not to your knowledge --

13 A I'm just trying to figure out what they mean
14 by vetting. Like, in other words, does this mean --
15 like, is Magellan sending the determination back to AHCA
16 for yes or no approval?

17 Q Yeah.

18 A So they could be doing that.

19 Q But you don't know?

20 A Don't know.

21 Q Can we find that information out?

22 A We might be able to, because like -- because
23 it's only a few emails, and we're trying to go over the
24 process. I mean, it is possible that we could ask
25 people who do oversee this area. I mean, they might

1 give us some information, but they may not be able to
2 describe the exact context of the email because, I mean,
3 sometimes things get lost in translation.

4 Q Does Susan Williams still work here?

5 A Yes, she does.

6 Q Does Ashley Peterson still work here?

7 A Ashley Peterson recently left us.

8 Q What's recent?

9 A Last week.

10 Q Find another opportunity?

11 A Yeah.

12 Q How about Kelly Reuben?

13 A Kelly Reuben's still here.

14 Q Jessica Forbes.

15 A Jessica Forbes is still with the Agency.

16 Q Shantice Green.

17 A No, she's not here anymore.

18 Q She find another opportunity?

19 A I believe so, yes.

20 Q All right. So, as a reminder, all gender
21 codes were removed from programming as directed by the
22 Agency in 2017. What does that mean?

23 A I'm not sure because I'm not sure what they
24 mean by CCM. Generally, when we do -- when we make
25 systems updates, it's either done through a file

1 maintenance or a customer service request to Gainwell
2 Technologies oversees the FMMIS, so --

3 Q You were familiar with the programming of the
4 ICD-10 codes, but you're not familiar with programming
5 of the gender codes?

6 A Well, no, I'm familiar with the -- how
7 diagnosis codes are programmed in the system, but this
8 CCM acronym I'm not familiar with.

9 Q What is a gender code?

10 A You mean a gender code? Well, what they mean
11 by gender codes, I'm assuming that means the ICD-10 Code
12 F64. That's -- that's assuming that's what that means.

13 Q What's a B for both?

14 A Maybe that's written reference to male and
15 female.

16 Q What is the significance of that? Why does it
17 matter if it's -- what are the options? B for both and
18 then, what, M for male, F for female?

19 A That could -- I mean, that's what I'm assuming
20 based on -- based on this email chain. I mean, it's a
21 little difficult because -- I mean, there's a lot of
22 extrapolation and it's -- much of it's open to
23 interpretation, so --

24 Q Sorry, I lost my place. Please prepare a CCM
25 to remove gender code from all the NDC's. What are

1 NDC's? You said that?

2 A National drug codes. So that's almost like --
3 kind of like a procedure code, because each drug has a
4 corresponding NDC. So the system doesn't recognize drug
5 names or recognize national drug codes.

6 Q Okay. And that was actually -- that
7 instruction was provided to someone -- Arlene Elliot
8 sent that instruction to someone back in 2017, to remove
9 the gender code. Do you have any idea why Magellan and
10 AHCA were talking about this on June 3rd?

11 A No. We hadn't announced that we were going to
12 do a categorical exclusion yet.

13 Q Okay. I think this is just a place where
14 we're going to need to reserve some time for deposition
15 after you're able to do some adequate research on what
16 the information this email contains, and then we can do
17 some follow-up questioning. Okay.

18 You mentioned earlier, were there any
19 communications from the plans about the exclusion prior
20 to its adoption?

21 A What do you mean? Do the plans have any -- do
22 we discuss with the plans prior? No.

23 Q All right. Turning to waivers and variances
24 under Chapter 120, are you familiar with that process?

25 A Oh, yes, I am.

1 Q Okay. I'm going to hand you a copy of the
2 statute, Section 120.542. We'll mark that as Exhibit
3 20.

4 (Whereupon, Exhibit No. 20 was marked for
5 identification.)

6 BY MS. DEBRIERE::

7 Q Are you familiar with the statute?

8 A Yes, I'm familiar with it.

9 Q Based on your understanding, what is the
10 purpose?

11 A So the purpose of this is because, of course,
12 agencies are granted rulemaking authority. And because
13 agencies now -- and, of course, the rulemaking process,
14 I mean, it's public, transparent, but there are times
15 that there may be an exception that's required, so it's
16 kind of like the check and balances that if a variance
17 is required on a rule that -- like a party could apply
18 to that agency that administers that rule for
19 consideration of a variance.

20 Q Does the purpose of the underlying rule have
21 to -- the spirit of it have to be met in granting the
22 variance or waiver?

23 A What's meant by the spirit?

24 Q I'm trying to look for the specific language.
25 So under subpart two, variance and waiver shall be

1 granted when the person subject to this rule
2 demonstrates the purpose of the underlying statute -- I
3 guess in this case it would be a rule -- or what statute
4 will we be referencing?

5 A Well, in legal terminology, I mean,
6 differences between rule and statute, I mean, statutes,
7 of course, are approved by the legislature, goes to the
8 Governor, and the rules are done under the authority of
9 the statutes. So, I mean, like agencies are authorized
10 to grant variances and waivers to requirements of the
11 rules consistent with the section and with rules adopted
12 under the authority of the section. So, I mean, they do
13 call out rules, specific. Then, of course, this applies
14 to all state agencies, so --

15 Q Who makes a determination at AHCA whether a
16 petitioner has established a substantial hardship under
17 the statute?

18 A Those come through our General Counsel's
19 office. So if somebody wants to request a variance,
20 they do so through our agency clerk.

21 Q And how is the determination itself made?

22 A So the agency clerk will reach out to
23 individuals to, of course, who have pertinent knowledge
24 about the -- about the circumstances of the request of
25 the variance, will ask for input. And, of course, the

1 determination's made. It rides up to the Secretary.
2 The Secretary has to do the final approval for a
3 variance.

4 Q So same question as to determining whether
5 principle -- principles of fairness are violated, who
6 makes that determination?

7 A So when it comes to waivers and variances,
8 that's same process. Goes to the agency clerk. Then,
9 of course, does an investigation, consults with
10 individuals who are knowledgeable about the pertinent
11 subject, and then it goes up to the Secretary.

12 Q Has AHCA developed any criteria to guide its
13 determination of whether to grant a variance or waiver
14 from the categorical exclusion of gender-affirming care?

15 A No. No, we haven't. Variances are determined
16 on a very individualized basis.

17 Q So, again, turning back to the -- ensuring the
18 purpose of the underlying statute, 120.542 specifically
19 states that variance and waivers shall be granted when
20 the person subject to the rule demonstrates that the
21 purpose of the underlying statute will be or has been
22 achieved by other means for the person. So that means
23 the granting of the variance or waiver shows that the
24 purpose of the underlying statute will be or has been
25 achieved by granting it. What statute -- in reviewing

1 any request for a variance or waiver from 159G-1.050(7),
2 how would you demonstrate that the purpose -- well, what
3 statute will be at issue, first of all?

4 A Well, for the statute -- I mean, would be
5 Chapter 409. Those are the Florida Medicaid -- that
6 consists of the Florida Medicaid statute, so --

7 Q What specific -- what specific provision of
8 409 would you be looking at?

9 A I mean, we'd be looking at -- well, for the
10 variance, we'd probably be looking at, like, I mean,
11 somewhere under 409.9, probably under covered services
12 or optional services.

13 Q Okay. So how -- if someone requested a waiver
14 or variance from 59G-1.050(7), under what circumstances
15 would AHCA authorize coverage of the services listed in
16 that rule?

17 A Well, we can't speak to those because I don't
18 think -- we haven't gotten a request for variances on
19 this yet. So like it says, a highly individualized
20 process. We will be looking at in-depth at the
21 recipient, looking at all the records available, and, of
22 course, discussing things with various experts and so
23 forth. But each request is individualized. So because
24 each request is individualized and focuses on the
25 specific individual, we can't project on what grounds we

1 would grant a variance under.

2 Q Well, so the June -- the categorical exclusion
3 of treatment for gender dysphoria was adopted because
4 the certain -- AHCA found that those services were
5 experimental, correct? And Florida Medicaid cannot
6 cover services that are experimental?

7 A That's correct.

8 Q So in what situation could AHCA grant a waiver
9 or variance covering services that AHCA has found to be
10 experimental?

11 A Well, I mean, based on the rule we wouldn't.
12 I mean, based on the rule, we would deny the variance,
13 but because each variance, it's individualized requests,
14 we would have to go through and evaluate each one
15 individually.

16 Q Would the person have to establish that the
17 service they're requesting is not experimental?

18 A We will not be placing the burden on the
19 recipient.

20 Q Who would the burden be on?

21 A Well, that would be on -- it'd be an
22 individualized process, evaluating all the -- all --
23 whatever medical records that we can get a hold of.
24 That's -- that's process that we use in the past, but
25 based on the rule, I mean, yeah, we say that these

1 would -- you have a categorical exclusion. While we --
2 while the variance process is available, but because we
3 have a categorical exclusion, we do declare the services
4 to be experimental, investigational due to
5 very-low-quality evidence that -- yeah, I mean, we would
6 deny variance, but because variance reviews are
7 individualized, we don't want to speak in absolute terms
8 on the variance process. But for -- because, I mean,
9 there's all kinds of questions that could come up in the
10 review of the medical records. Maybe it was a -- maybe
11 it was a misdiagnosis. Maybe something else could come
12 up. That's pretty much why. So --

13 Q Okay.

14 A Everything is different and --

15 Q If a person sought a waiver of the application
16 of 59G-1.050(7) so they can receive Medicaid coverage
17 for a mastectomy that is specifically to treat their
18 gender dysphoria, under what circumstances would that
19 waiver be granted?

20 A For -- under what circumstances?

21 Q Yeah.

22 A Well, I mean, we did declare this service to
23 be experimental investigational.

24 Q So they could not get a waiver, correct? The
25 waiver would be denied?

1 A Based on the very general, hypothetical
2 situation that you provided, straight out just for
3 gender dysphoria, they got denied by their insured so
4 they request a variance.

5 Q Yeah.

6 A Based on our rule language, yeah, it'd be
7 denial.

8 Q And someone is entitled to a fair hearing when
9 Medicaid coverage is denied, correct?

10 A Yes, they are.

11 Q Given that the Agency has found the services
12 in 1.057 -- 59G-1.050(7) to be experimental, and
13 therefore never medically necessary, correct?

14 A Correct.

15 Q Could someone ever prevail at a fair hearing
16 where they sought coverage of the services for gender
17 dysphoria?

18 A Well, based on our rule, based on our
19 findings, no.

20 Q Could someone use the variance or waiver
21 process to get around the final decision issued after
22 the fair hearing?

23 A Well, I mean, they can request a variance, but
24 then they would go through the process, but based on our
25 rule and our findings, no.

1 Q How often do Medicaid beneficiaries file
2 variance requests?

3 A So in the research for this case, we found 10
4 requests, and that's since going back to about 2015,
5 2016.

6 Q Okay. So between 2015, 2016 to present, there
7 has been 10 requests?

8 A That's correct.

9 Q Okay. These variances -- and I have copies of
10 all of them, if you'd like to reference them. They
11 request that a service that AHCA affirmatively covers.
12 So there's -- there's a few types of variances we found
13 in our review. There's situations in which AHCA
14 affirmatively covers the service, but the individual
15 wants an amount greater -- in a greater amount or
16 duration.

17 A Yeah, I'm familiar with that one. It's --
18 there was a variance request -- and it was actually
19 several various requests, because they were granted for
20 six months at a time. We're talking about our recipient
21 under our I-budget waiver. So, of course, our I-budget
22 waiver -- and no, it isn't, it's codified in rule. So,
23 of course, there was a service limit on these behavior
24 assistance services at the time. They were requesting
25 additional behavior assistance services. So while -- so

1 because we already covered the service, and they're just
2 looking for additional services, you know, and that
3 that's -- that's flexibility that we can grant because
4 we haven't actually gone through -- the service they are
5 requesting, we have not codified as a categorical
6 exclusion, and we've not deemed that service be
7 experimental investigational.

8 Q Okay. And that's true for all the services
9 that are contained in the variances --

10 A Yeah, from what I could tell, they're pretty
11 much all I-budget.

12 Q Okay. And they -- none of the services that
13 they were requesting some kind of variance on had been
14 categorically excluded, correct?

15 A Correct.

16 Q Okay. And none of them have been determined
17 experimental?

18 A Right.

19 Q Okay. Do you know of every Medicaid recipient
20 who made a request for a variance, if they were
21 represented by counsel?

22 A No, we don't know if they were all represented
23 by counsel or not.

24 Q Because I did notice that the recipients were
25 all listed.

1 A Yeah, the recipients were listed. The
2 information is referred to the agency clerk. Then the
3 Agency does its internal processes.

4 Q Do you know what pro se means?

5 A No.

6 Q So, in any of the requests for variances to
7 the Medicaid recipient, him or herself, do any of the
8 direct request for the variance, or did they need
9 assistance?

10 A Given the complexities of request and
11 legalities of it, I would -- I think it's safe to say
12 that they had some assistance, although it's not
13 required.

14 Q Okay. Between April of 2022 and August 21st
15 of 2022, did anyone at AHCA ever discuss the variance or
16 waiver process for use in challenging a denial based on
17 the categorical exclusion of treatment for gender
18 dysphoria?

19 A No.

20 Q All right. Turning to our specific clients,
21 at anytime prior to August 21st, 2022, did Florida
22 Medicaid cover any of the services listed at
23 59G-1.050(7) for the treatment of gender dysphoria and
24 that actually --

25 A You're talking about --

1 Q Everyone.

2 A You're talking about after the hard date when
3 the ruling took effect?

4 Q Anytime prior to that, did Florida Medicaid
5 cover any of the services listed at 59G-1.05 --

6 A Prior to the effective date, yes.

7 Q Okay. So they covered puberty blockers?

8 A Yes. Well, for that small handful of
9 recipients we pulled the data on, yes.

10 Q They cover cross-sex hormone therapy for the
11 treatment of gender dysphoria?

12 A Yeah. I mean, as far as data showed.

13 Q Did they cover surgery for the treatment of
14 gender dysphoria?

15 A From our data revealed, yes.

16 Q At any time prior to August 21st, 2022, did
17 Florida Medicaid cover any of the services listed at
18 59G-1.050(7) for August Dekker?

19 A We did go through our -- we did go through
20 there the recipient's histories, yeah.

21 Q Did Florida Medicaid cover puberty blockers
22 for August Dekker to treat gender dysphoria?

23 A For August Dekker?

24 Q Yes.

25 A Puberty blockers?

1 Q Yes.

2 A I don't believe so, no.

3 Q Did Florida Medicaid cover hormone therapy for
4 August Dekker in treatment of gender dysphoria?

5 A For August Dekker, yes. I think -- I think
6 his managed care plan, Humana was providing him those.

7 Q And he's still currently eligible for Florida
8 Medicaid?

9 A Last time we checked he was still Medicaid
10 eligible.

11 Q Okay. And he's still enrolled in Humana, or
12 did he switch to another plan?

13 A Well, we haven't -- we haven't verified
14 since -- we did have an enrollment period and recipients
15 are eligible to switch plans during that enrollment
16 period.

17 Q In the coverage of hormones for treatment of
18 August Dekker's gender dysphoria, how long -- for how
19 long did AHCA authorize that treatment? For how long
20 did Florida Medicaid cover that treatment?

21 A I don't know the exact length. We would have
22 to go back and take a look at the records we received
23 from Humana on the case.

24 Q More than six months?

25 A I think it was more than six months.

1 Q More than a year?

2 A That's where it gets hazy.

3 Q Was coverage for hormones to treat gender
4 dysphoria terminated for August Dekker after August
5 21st?

6 A According to rule, yes, it would be
7 terminated.

8 Q Did Florida Medicaid cover surgery for August
9 Dekker and treatment of gender dysphoria?

10 A Yes.

11 Q When?

12 A So that would have been prior to the -- that
13 would have been prior to the challenge exclusion being
14 implemented. Then to clarify, that was -- is -- the
15 managed care plan was covering that outside our state
16 plan benefits.

17 Q How do you know that?

18 A Because our state plan does not -- does not
19 specify the service as being -- as being mandated for
20 coverage. In other words, if Humana had denied the
21 service, well, it would have just been a denial because
22 it's not a -- Medicaid doesn't -- we don't have that in
23 our state plan. Managed care plans have to cover all
24 state plan services. Sex change operations are not a
25 state plan covered service.

1 Q Surgery is a state plan covered service?

2 A Surgery, yes, but for -- but not for this --
3 necessarily this condition.

4 Q Does the state plan specify for what
5 conditions services are provided?

6 A No, it doesn't break down the diagnosis codes,
7 but this was one -- was the plan's discretion. The plan
8 could have said yes. The plan could have said no. It
9 was up to the plan.

10 Q Were federal Medicaid match dollars used to
11 pay for August Dekker's surgery?

12 A So capitation rates that we pay to the plans
13 are per-member per-month rate. That is a combination of
14 federal matching dollars and state revenue.

15 Q Okay. At any time prior to August 21st, 2022,
16 did Florida Medicaid cover any of the services listed at
17 59G-1.050(7) for Brit Rothstein?

18 A Based on the -- based on the records that we
19 pulled, based on the recipient's individual histories
20 that we were -- we were able to locate, looked like,
21 yes, we did.

22 Q Okay. Did Florida Medicaid ever cover puberty
23 blockers for Mr. Rothstein?

24 A So for Mr. Rothstein -- so for Mr.
25 Rothstein -- I -- so. Sorry. I think he's one of the

1 adult plaintiffs?

2 Q Yes. Yes. And you said that he -- I'm
3 sorry -- pulled in a lot of directions.

4 A We did cover services that we did determine to
5 be experimental investigational prior to the challenge
6 exclusion.

7 Q And no longer cover them, correct?

8 A Yes, because of the challenge exclusion.

9 Q Same question for KF.

10 A Since -- with KF, we did have a hard time
11 since for the minors we didn't have, like, their full
12 identification information. Trying to locate their
13 records in the system, I think there were encounters,
14 based on information we had, that did show they were
15 receiving GnRH.

16 Q Okay. For the treatment of gender dysphoria?

17 A Yeah.

18 Q Okay. And that includes Susan Doe, as well?

19 A Based on what we could find, looked like
20 they -- that there had been some coverage.

21 Q And they're -- KF is still currently eligible
22 for Florida Medicaid, is that correct?

23 A We would have -- I think -- I think they would
24 be, because we haven't been doing these determinations
25 because of COVID. So, yes, they would still be

1 Medicaid-eligible. That would go for all the
2 plaintiffs.

3 MS. DEBRIERE: Okay. Let's -- can we take a
4 five-minute break?

5 MR. JAZIL: Sure.

6 VIDEOGRAPHER: Okay. This concludes video
7 four. The time is 4:15 p.m.

8 (Brief recess.)

9 VIDEOGRAPHER: This is the beginning of video
10 five. The time is 4:30 p.m. We're on the record.

11 BY MS. DEBRIERE::

12 Q All right. Turning back quickly to plaintiff
13 August Dekker, did Humana violate Florida Medicaid
14 policy by covering his surgery for treatment of gender
15 dysphoria?

16 A No, they did not at the time.

17 Q Okay. And then I just want to talk about a
18 few more exhibits. One labeled -- we've marked as
19 Exhibit 21, and that is the GAPMS queue that was
20 provided to us.

21 (Whereupon, Exhibit No. 21 was marked for
22 identification.)

23 BY MS. DEBRIERE::

24 Q And it looks like the most recent date on that
25 queue was maybe an update to one of the GAPMS in 2019.

1 That's as far as it goes. Are all -- are these the only
2 GAPMS that are currently pending?

3 A So the requests came in to pull the most
4 recent GAPMS queue.

5 Q Yeah.

6 A So at this -- when I went through our -- we
7 have a GAPMS folder that's on our shared drive. I did
8 look through to see what -- we have a folder for the
9 GAPMS queues. I did pull the most recent one. This was
10 the most recent one that had been updated that was in
11 there --

12 Q I'm sorry. Go ahead.

13 A This does -- this does consist of a lot of
14 GAPMS reports, which I do remember drafting some of
15 those as well, but this was our most recent one.

16 Q And have there been GAPMS reports created
17 after 2018?

18 A Yeah, I think there have been.

19 Q Why aren't they on this list?

20 A I'm not -- I'm not sure why they wouldn't be
21 included on this list. This list should be updated on
22 regular basis, so I'm not sure why they wouldn't be
23 included on this, or on the list on the share drive,
24 because the GAPMS queue is really is not so much for the
25 GAPMS analyst, because GAPMS analysts generally have a

1 pretty good idea of what's outstanding, what's pending,
2 and what's been turned in. It's more for leadership --
3 or their supervisor to pull and take a look at when
4 necessary, so I'm not sure why this hasn't been listed
5 to update in this current.

6 Q So whoever's working in GAPMS at the time has
7 a good understanding of which GAPMS are pending.

8 A When I was -- when I had the role, I could
9 tell you exactly where all my reports were, what their
10 status was and where they stood in the queue. So, yeah,
11 I kind of had all committed to memory.

12 Q Okay. Would that be true of anyone holding
13 that GAPMS position?

14 A As far as pulling it from memory, I couldn't
15 vouch for the other employees as to their memories, when
16 it came down to their reports that are outstanding.

17 Q But they should have a good sense?

18 A They should have a good sense of what's
19 pending and what's been turned in.

20 Q Can you provide us a list of what's pending
21 that's not listed on this queue?

22 A So I think -- so I think the ones that are
23 still pending aren't -- I think there were, like,
24 reopened reports. I think we had gotten requests from
25 the manufacturers of Atheno, was the asthma tests that I

1 discussed earlier. That was one I had to have
2 finalized. We've gotten a request for them to -- for us
3 to review it, provided that they don't send some more
4 evidence and more studies that have been done after our
5 original report. So I think that one was reopened.
6 That one should still be pending. Then there was
7 specially modified low-protein foods. That was another
8 one that I had written up. We had gotten requests to
9 reopen that one that, and to reevaluate that service. I
10 think there was another one, which was the -- which was
11 a bone growth stimulator called Exigent. I think that
12 one is still outstanding and pending. Now, those are
13 just some examples of ones I can think are still
14 pending.

15 Q Were there any new requests made after
16 December of 2018?

17 A Yeah. I mean, there have been some new
18 requests for either, like, expedited GAPMS or full
19 GAPMS. I mean, we do get the service requests in fairly
20 frequently, so --

21 Q Because it would be odd if any new requests
22 hadn't come in almost five years --

23 A Correct. Yeah.

24 Q Okay. But there's no way -- all right. And
25 then I just want to put into the record, because we've

1 been referring to it quite a bit, we'll Mark it as
2 Exhibit 22, and that is the document from Health and
3 Human Services that we've referenced multiple times
4 during the deposition. Is that the one you're referring
5 to?

6 A That's correct. This is it.

7 (Whereupon, Exhibit No. 22 was marked for
8 identification.)

9 BY MS. DEBRIERE::

10 Q Thank you. And then the guidance from the
11 Florida Department of Health regarding treatment of
12 gender dysphoria for children and adolescents dated
13 April 20th, 2022. That's Exhibit 23. Is that the
14 document that we've been referring to when we're talking
15 about DOH guidance?

16 A Yes, it is.

17 (Whereupon, Exhibit No. 23 was marked for
18 identification.)

19 MS. DEBRIERE: And then -- I think that's it
20 for my questions. The only thing I wanted to put
21 on the record, Mo, is we are at what time,
22 Videographer?

23 VIDEOGRAPHER: Do you mean the whole run time
24 or --

25 MS. DEBRIERE: Just the questioning time.

Yeah, the time that we've been live and active on the record.

VIDEOGRAPHER: Five hours, eight minutes plus
five and a half minutes.

MS. DEBRIERE: Okay. So want to just say that we have an hour and 45 minutes of questioning --

MR. JAZIL: Sure.

MS. DEBRIERE: -- to reserve?

MR. JAZIL: And so the depo is open. I'd like to ask questions at the end. So I'll just reserve that until after our second session, is that okay, or would you like for me to --

MS. DEBRIERE: Can I confer with my team quickly? Okay.

VIDEOGRAPHER: We will remain on the record?

MS. DEBRIERE: We'll go off the record.

VIDEOGRAPHER: Okay. Off the record at 4:36 p.m.

(Discussion off the record.)

VIDEOGRAPHER: We're back on the record. The time is 4:37 p.m.

MS. DEBRIERE: And plaintiff's counsel is all finished with their questioning.

EXAMINATION

BY MR. JAZIL::

1 Q This is Mohammed Jazil for the defense. I'll
2 try to be brief, recognizing we have time limitations
3 here. Mr. Brackett, I'd like to have you look at
4 Exhibit 3 again.

5 A Okay.

6 Q Exhibit 3 has a date on it, May 20th, 2022. I
7 want the record to be clear, why is that date not
8 accurate?

9 A This date isn't accurate because that date
10 is -- automatically sets to the date you print it out.

11 Q And what sets that date?

12 A The template is automatically set to enter in
13 this current date that you're viewing the document. So
14 it automatically updates the second you open it.

15 Q And that's the template in the AHCA document?

16 A That is our template, yeah.

17 Q And when was this GAPMS report created?

18 A This GAPMS was originally created in 2016.

19 Q Thank you. You discussed with my friend the
20 variance and waiver process. Do you recall that
21 testimony?

22 A Yes.

23 Q You testified that the variance and waiver
24 process is individualized. Do you recall that
25 testimony?

1 A Yes, I do.

2 Q Once a variance and waiver request comes in,
3 it goes to the clerk is what you testified to, if my
4 understanding is correct?

5 A Yes.

6 Q And then the clerk routes it to whom?

7 A The clerk gathers information and it has to be
8 routed up to the secretary.

9 Q Is it routed directly to the Secretary or is
10 there any other office that it goes through first?

11 A I'd have to take a look at the variances
12 again. It might be -- I think it probably have to route
13 through General Counsel before it goes to the Secretary.

14 Q Okay. And is the General Counsel's office
15 responsible for the formulating the Agency's position on
16 legal issues?

17 A Yes.

18 Q Does that include the variance and waiver
19 process?

20 A Yes.

21 MR. JAZIL: I have no further questions.

22 FURTHER EXAMINATION

23 BY MS. DEBRIERE::

24 Q Just one redirect. Very brief. On Exhibit 3,
25 which is the GAPMS memo dated May 20th, 2022, that was

1 the date it was printed out. It also appears changes
2 were made on that date, is that correct?

3 A Based on the comments in the edits, yeah, it
4 looks like somebody had made changes to that document on
5 that date.

6 Q But you don't know who that person is?

7 A SG, I'm -- I can't speak to who SG is.

8 Q But you will find that information out for us?

9 A We can -- we can figure out who, but we
10 would -- probably want to verify with IT.

11 MS. DEBRIERE: Okay. That's all.

12 MR. JAZIL: So, counsel, while we're still on
13 the record, he's still under oath, so I'm not going
14 to obviously talk to him about any issues that
15 might come up, but with your consent, I'd like to
16 at least work with him to gather the additional
17 information that's being sought. Is that
18 appropriate?

19 MS. DEBRIERE: I mean, I would assume that
20 would be your process.

21 MR. JAZIL: He is under oath, and so I'm
22 obviously not going to try to, you know --

23 MS. DEBRIERE: I see. I see.

24 MR. JAZIL: -- work with him while -- work with
25 him on his testimony, I say, as I try to gather

1 additional information, so I'll make that clear on
2 the record.

3 VIDEOGRAPHER: Anyone else? Anybody by Zoom?

4 MS. DEBRIERE: No.

5 VIDEOGRAPHER: Okay. This concludes the
6 February 8th, 2023 portion of the video-recorded
7 deposition of Corporate Representative for Agency
8 for Health Care Administration. The time is 4:40
9 p.m.

10 COURT REPORTER: Are you going to be ordering
11 this?

12 MS. DEBRIERE: Yes.

13 COURT REPORTER: All right. And Mo has
14 requested a rough draft. I told him I could get it
15 to him tomorrow. Do you guys -- would you guys
16 like one, as well?

17 MS. DEBRIERE: Yes, please.

18 (Whereupon, the deposition was concluded at
19 4:40 p.m., and the witness did not waive reading
20 and signing.)
21
22
23
24
25

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF LEON)

I, the undersigned authority, certify that the
above-named witness personally appeared before me and
was duly sworn.

WITNESS my hand and official seal this 21st
day of February, 2023.



DANA W. REEVES

NOTARY PUBLIC

COMMISSION #GG970595

EXPIRES MARCH 22, 2024

CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF LEON)

I, DANA W. REEVES, Professional Court Reporter, certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages, numbered 128 through 257, are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 21st day of February, 2023.



DANA W. REEVES

NOTARY PUBLIC

COMMISSION #GG970595

EXPIRES MARCH 22, 2024

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

3 February 21, 2023

4
5 RE: August Dekker, et al. vs. Jason Weida, et al.
6 February 8, 2023/Matthew Brackett/5696545
7

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

21 Yours,

22 Veritext Legal Solutions

23 *Federal Civil Procedure Rule 30(e)/Florida Civil
24 Procedure Rule 1.310(e).
25

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

2 February 8, 2023/Matthew Brackett

3 E R R A T A S H E E T

4 PAGE_____ LINE_____ CHANGE_____

5 _____

6 REASON_____

7 PAGE_____ LINE_____ CHANGE_____

8 _____

9 REASON_____

10 PAGE_____ LINE_____ CHANGE_____

11 _____

12 REASON_____

13 PAGE_____ LINE_____ CHANGE_____

14 _____

15 REASON_____

16 PAGE_____ LINE_____ CHANGE_____

17 _____

18 REASON_____

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

22 _____

23 _____

24 Matthew Brackett

25 DATE

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.,

Plaintiffs,

V.

Case No. 4:22-cv-00325-RH-MAF

JASON WEIDA, et al.,

Defendants.

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DEPOSITION OF: MATTHEW BRACKETT

DATE: WEDNESDAY, MARCH 8TH, 2023

TIME: 10:00 A.M. - 11:44 A.M.

PLACE: REMOTE PROCEEDINGS

STENOGRAPHICALLY

REPORTED BY: LAWANDA MERCER

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S T I P U L A T I O N S

It is hereby stipulated and agreed by and between the counsel for the respective parties and the deponent that the reading and signing of the deposition transcript be reserved.

P R O C E E D I N G S

THE VIDEOGRAPHER: This is the continued video-recorded deposition of Matthew Brackett in the matter of August Dekker, et al. v. Jason Weida, et al, Case No.: 4:22-cv-00325-RH-MAF. This deposition is being held at 2727 Mahan Drive in Tallahassee, Florida. Today's date is March 8th, 2023, and the time is 10:09 a.m. The court reporter is Lawanda Mercer. My name is R.L. Minnich, I'm the videographer.

Would counsel please introduce themselves and then the court reporter please swear in the witness.

MS. DEBRIERE: Yes. Katy DeBriere, counsel for Plaintiffs.

MS. CHRISS: Simone Chriss, counsel for Plaintiffs.

MR. PERKO: Gary Perko, Counsel for Defendants.

MS. DEBRIERE: And on the line, we have several counsel for Plaintiffs, including Jennifer Altman, Catherine McKee, Shani Rivaux and Chelsea Dunn.

MR. SHEERAN: And Andrew Sheeran of the Agency is on the phone.

COURT REPORTER: Sir, please raise your right hand.

1 Do you solemnly swear, or affirm, the testimony
2 you're about to give today is the truth, the whole
3 truth and nothing but the truth?

4 THE WITNESS: I do.

5 COURT REPORTER: Thank you.

6 MATTHEW BRACKETT,
7 having been produced and first duly sworn as a witness,
8 testified as follows:

9 DIRECT EXAMINATION

10 BY MS. DEBRIERE:

11 Q. Okay, Mr. Brackett. So, on March 6th, 2023,
12 your counsel provided us a copy of written responses to
13 our questions. And that was in -- in follow-up to
14 your -- the first part of this deposition on
15 February 8th. I'm going to mark those responses as
16 Exhibit 24 and hand you this.

17 (Thereupon, Plaintiff's Exhibit No. 24 was
18 marked for identification.)

19 BY MS. DEBRIERE:

20 Q. Do you recognize this document?

21 A. Yes, I do.

22 Q. And are these your responses?

23 A. Yes, they are.

24 Q. Okay. And we talked about this a little bit
25 before --

1 MS. DEBRIERE: Here you go, Gary.

2 MR. PERKO: Oh, thank you.

3 BY MS. DEBRIERE:

4 Q. Just a little bit before the deposition
5 started. But in the second question, I just wanted to
6 correct one thing that was my mistake. The hyperlink we
7 provided for the drug criteria in our question No. 2, it
8 did not work. I wanted to go back to the web page now
9 and show it to you and then read off the URL in the
10 transcript. And that way we can just agree that's the
11 one that contains the exhaustive list. Is that okay
12 with you?

13 A. That's okay, yeah.

14 Q. Okay. So is the exhaustive list of drug
15 criteria contained in this document titled "Preferred
16 Drug List"? Oh, no.

17 A. No.

18 Q. That's not it. Sorry. My fault here. Give me
19 one second.

20 COURT REPORTER: For the record, which attorney
21 is speaking?

22 MS. DEBRIERE: Katy DeBriere for the
23 plaintiffs.

24 COURT REPORTER: Thank you.

25 MS. DEBRIERE: Okay.

1 BY MS. DEBRIERE:

2 Q. Okay. So is this the web page that contains
3 the exhaustive list of drug criteria --

4 A. That is the web page.

5 Q. -- for AHCA? Okay.

6 A. Yes.

7 Q. And just to -- for the clarification of the
8 record, that URL is AHCA, a-h-c-a.
9 http://ahca.myflorida.com/medicaid/prescribed_drug/drug_
10 [criteria.shtml](http://ahca.myflorida.com/medicaid/prescribed_drug/drug_criteria.shtml).

11 Okay. Thank you. All right. Turning to the
12 auto PA that you link in the response to your first
13 question. We appreciate that written explanation.
14 Quick set of follow-ups: If a drug is denied on the
15 basis of auto PA, does the beneficiary receive
16 notice of that denial?

17 A. So it would automatically go to a PA. The
18 recipient would learn at the pharmacy that it was being
19 auto PA'd, yes.

20 Q. -- Okay. Do they receive notice of the denial?

21 A. It's for, like, a NABD?

22 Q. Yes. Or a pharmacy notice of some sort?

23 A. Well, the pharmacy would definitely verbally
24 tell them. I don't believe they would receive a written
25 notice just because their drug is being auto PA'd

1 because it's not officially a denial. It's being kicked
2 to auto prior authorization process.

3 Q. Okay. So it's your understanding they do not
4 receive a written -- a written denial?

5 A. That's my understanding.

6 Q. Okay. Could the -- they, or in this instance
7 the prescribing drug pro -- the provider who's
8 prescribing the drug, could they resubmit their request
9 for a prior authorization using the clinical PA process,
10 if denied on auto PA?

11 A. So the prescriber would have to go through and
12 refill the prescription if --

13 Q. Refill the prescription or re --

14 A. Or re -- reissue the prescription if it's --
15 goes through auto PA.

16 Q. Okay. Would the person then have the -- the --
17 would the Medicaid beneficiary then have the opportunity
18 to take that new prescription and submit it for clinical
19 prior authorization, if it was denied on auto PI -- PA?

20 A. They can. It would --

21 Q. Okay.

22 A. It would go to the pharmacy.

23 Q. Okay. How -- if -- so, if that's the case, how
24 does AHCA then determine if the prior authorization is
25 approved? What criteria do they use?

1 A. So that would, of course, be a case-by-case
2 basis. And it would be in accordance with our medical
3 necessity guidelines, yeah.

4 Q. Would you also use the drug criteria at the URL
5 we just read off?

6 A. Yes, we would.

7 Q. Okay. Would it -- would you also compare it
8 against the auto PA list, if it was already denied for
9 auto PA? Would you do a manual review, I guess, I'm
10 asking, of the auto PA list?

11 A. Prior -- prior authorizations are manual
12 reviews.

13 Q. Auto prior authorization is not a manual
14 review, correct, it's automatic?

15 A. It pretty much means that it's automatically
16 referred to prior authorization.

17 Q. Is there someone who's physically reviewing the
18 criteria for prior auth -- authorization under auto PA?

19 A. So --

20 Q. Or it's the computer program?

21 A. -- the prior authorizations, those, of course,
22 are reviewed by Magellan. Those are reviewed manually.

23 Q. Okay. Is that a -- what I'm trying to
24 understand is when Magellan is doing the review
25 manually, is that only for clinical PAs or is that also

1 for auto PAs?

2 A. That would be for the clinical PA.

3 Q. Okay. But not for the auto PA?

4 A. The auto PA would be, of course, automatic.

5 Q. Great. Okay. Okay. I just want to give you a
6 hypothetical real quick, looking at the auto PA list.
7 So looking at Page 27 here of the auto PA -- A list, and
8 this is the auto PA list that you provided to us linked
9 in your written responses. For Lupron Depot, let's
10 imagine a pro -- a provider has prescribed Lupron
11 Depot-PED to treat a condition not listed in list B here
12 on Page 27. Let's also assume the condition that it's
13 prescribed for is not gender dysphoria. If the prior
14 authorization request is denied through auto PA, could a
15 provider submit the clinical P -- PA process and show
16 that the coverage is nevertheless required under EPSDT?

17 A. They can do that.

18 Q. Okay. All right. On February 8th, you
19 testified that AHCA's Medicaid Program Integrity Unit
20 undertakes a rest -- retrospective claims review. Do
21 you remember that?

22 A. Yes, I do.

23 Q. Okay. And that retrospective claims review is
24 of whether prescribed drugs that don't require prior --
25 any prior authorization were prescribed for a medically

1 necessary reason. Do you recall that testimony?

2 A. I do recall that.

3 Q. Okay. So I just have some follow-up questions
4 about that retrospective review process. The point is
5 to ensure that Medicaid dollars in that retro --
6 retrospective review process, the point is to ensure
7 that Medicaid dollars aren't being used fraudulently,
8 correct?

9 A. Correct.

10 Q. Okay. Does AHCA do that retrospective review
11 for every single claim paid?

12 A. It does not.

13 Q. Okay. When it does do the review on -- so
14 it -- it only does a retrospective review on select
15 drugs; is that correct?

16 A. It does retrospective reviews when the
17 situation calls for it. So if there's suspected fraud,
18 it could do a retrospective review. If there's
19 suspicion of overpayments through humans might be not
20 needed. It's basically on an ad hoc basis as needed.

21 Q. Okay. Okay. Sorry. So when it's doing that
22 retrospective review, what criteria does AHCA use to
23 determine if the claim should not have been paid?

24 A. So if -- of course, it would look at the
25 recipient, look at their diagnosis codes, look at their

1 his -- medical history, and look -- and they would
2 evaluate to determine whether those services that are
3 being delivered and claims reimbursed for are necessary
4 for the needs of that specific recipient.

5 Q. And if you find that the drug was prescribed
6 for in -- in this ad hoc retrospective review process,
7 if you find that the drug was prescribed for something
8 that was not medically necessary, what is the
9 consequence to the pharmacy, if any?

10 A. To the pharmacy, since the pharmacy just
11 dispenses the drugs, I don't think we would have any
12 consequences to the pharmacy. It would be on the pro --
13 on the prescriber.

14 Q. Okay. So you wouldn't take Medicaid dollars
15 back from the pharmacy who is reimbursed for dispensing
16 the drug?

17 A. I don't believe we would.

18 Q. Okay. Just going back to my hypo real quick.
19 On the Lupron Depot, you said that if the PA request is
20 denied through auto PA, the provider could submit
21 through the clinical PA process and show that the
22 coverage is nevertheless required under EPSDT. Is that
23 correct?

24 A. Yes.

25 Q. Okay. In that instance, is there the

1 possibility that the drug could be covered under EPSDT?

2 A. Any FDA-approved drug could, potentially, be
3 covered under EPSDT, that's correct.

4 Q. Okay. In that clinical PA review process?

5 A. Yes.

6 Q. Okay. What percentage of prescription drugs
7 claims paid undergo retrospective review turning back
8 (inaudible)?

9 A. We don't have that information offhand.

10 Q. Okay. Is that information you could get us?

11 A. I don't know if we could, actually, get that
12 information.

13 Q. But again, your understanding is it's not every
14 drug that's dispensed, without the need for a prior
15 authorization is then subject to a retrospective review?

16 A. Retrospective reviews don't happen in -- in
17 the -- in the cases of most claims.

18 Q. Okay. Okay. Could I look at what was
19 previously marked as Plaintiff's Exhibit 19? And these
20 are e-mail exchanges between AHCA and Magellan dated
21 April 20th, 2022, to June 3rd, 2022. Looking back at
22 your written responses -- so thank you for telling us
23 what CCM stands for. What does Change Control Memo
24 mean?

25 A. So a change control memo, it's -- works like

1 a -- a file maintenance for our CPT Codes, is that when
2 we need Magellan to make an update into its system, as
3 far as processing claims go, the analyst would create a
4 Change Control Memo and send it to Magellan. And they
5 would use that as the basis to update their system. So
6 if maybe, like, a new NDC needs to be added. Things
7 like that.

8 Q. Okay. Have we been provided a copy of the
9 particular CCM or Change Control Memo that's being
10 referenced in this e-mail?

11 A. I don't know if that document has been provided
12 to you.

13 Q. Okay.

14 MS. DEBRIERE: Gary, can we find that out?

15 MR. PERKO: We'll -- we'll find it.

16 MS. DEBRIERE: Thank you. And if you do find
17 it, you'll provide it to us?

18 MR. PERKO: Yes.

19 MS. DEBRIERE: Thank you.

20 BY MS. DEBRIERE:

21 Q. Okay. Who provided the internal gender die --
22 dysphoria criteria to Magellan for use, when reviewing
23 prior authorization requests for GN -- GnRH (inaudible)?

24 A. So, at the time, that would have been the
25 Bureau of Medicaid Policy.

1 Q. Okay. Why wasn't that criteria clo -- publicly
2 posted?

3 A. That -- of course, since that was almost seven
4 years ago, the -- and the staff who were -- made that
5 determination are no longer with us. The agency
6 doesn't -- cannot recall why that occurred.

7 Q. Okay. But all drug criteria should be publicly
8 available?

9 A. No, they don't absolutely have to be.

10 Q. Okay. As you earlier testified just now what
11 was previously marked as Plaintiff's Exhibit 4, the
12 exhaustive list of --

13 A. Uh-huh.

14 Q. -- internal -- I'm sorry. Scratch that.
15 What was previously marked as Plaintiff's
16 Exhibit 4, which is the GnRH -- hold on, Mr. Brackett,
17 I'll get you a copy of it. The Special Services
18 Criteria For Pubertal Suppression with GnRH Analog.

19 A. Okay.

20 Q. This represents the internal criteria AHCA
21 provided to Magellan; is that correct? -- that's being
22 referenced in this e-mail?

23 A. Uh-huh. That's correct.

24 Q. Okay. Should this criteria have been publicly
25 posted?

1 A. It does not have to necessarily be publicly
2 posted. Just because what we have on our list currently
3 is exhaustive, doesn't preclude us from not necessarily
4 publicly posting one.

5 Q. Okay. But just to be clear, the drug criteria
6 that's posted at the website we read earlier, that is
7 the exhaustive list, right?

8 A. That's currently exhaustive, yes.

9 Q. Turning back to the e-mails. In 2017, why did
10 AHCA direct the removal of all gender codes from
11 programming?

12 A. Can you give me -- tell me the date again?

13 Q. Yep. Yep. So it's 2017.

14 A. Uh-huh.

15 Q. Specifically, Elicia King-Wilson from Magellan
16 writes to Susan Williams and others to ah -- from AHCA,
17 "As a reminder, all gender codes were removed from"
18 program -- "programming as directed by the Agency in
19 2017."

20 A. So the gender codes prim -- what that means is
21 that drugs can apply to either male or female. So it --
22 removed those and just it can apply to both genders.

23 Q. And that was the change made in 2017?

24 A. That was the change made in 2017.

25 Q. Okay. So that resulted in all products within

1 the database being coded as

2 MEDICAID_STATE_VALID_SEX_CD=B-Both.

3 A. Correct.

4 Q. (Inaudible). Okay. In June 22nd, 2022, why
5 did Arlene Elliott at AHCA direct Magellan to remove the
6 Gender Code B-Both from all the NDCs that had it hard
7 coded? And I can point you to the specific language, if
8 helpful, in the e-mail.

9 A. Yes.

10 Q. So on the first page -- oh, I see. I
11 apologize. I misspoke. That was not in June, 2022,
12 that they were directed to remove the gender code. It
13 was on August 21st of 2017; is that correct?

14 A. That would be correct, yes.

15 Q. Okay. And that was done, again, to result in
16 all products having the Gender Code of B for Both; is
17 that correct?

18 A. That's correct.

19 Q. Okay. Were there any changes to that made in
20 2022?

21 A. Well, following the promulgation of the
22 challenge exclusion --

23 Q. Uh-huh.

24 A. -- yes. Those codes would have been updated to
25 reflect the changes that would make it align with the

1 challenge exclusion.

2 Q. Okay. And is that what the Change Control Memo
3 directed Magellan to do?

4 A. We would use a Change Control Memo to have
5 Magellan update its symptoms.

6 Q. Okay. On -- okay. When did AHCA direct
7 Magellan to remove the Gender Code equals B-Both to
8 implement the adoption of the categorical exclusion?

9 A. That change would be intended to take effect on
10 the date the rule went into effect.

11 Q. Okay. So you direct -- and -- and that date
12 was August 21st, 2017?

13 A. I recollect that's correct.

14 Q. So at the -- what date would -- what date did
15 AHCA direct Magellan to make that change?

16 A. It would have been a date preceding August 21st
17 since Magellan would need advanced notice. We don't
18 have the date offhand.

19 Q. Okay. Could you get us that date?

20 A. We -- we can look into it.

21 Q. Okay. Is this an e-mail directing Magellan to
22 make the change? Is this e-mail referencing -- scratch
23 that.

24 Is Exhibit 19, is this an e-mail from AHCA to
25 Magellan asking them to make the change?

1 A. Let me take a look --

2 Q. Yeah.

3 A. -- at it again. This does not appear to be
4 that e-mail.

5 Q. Okay. Would there have been another e-mail
6 from AHCA to Magellan directing them to make that
7 change?

8 A. It may have, potentially, been a verbal
9 request.

10 Q. Okay. Can you verify that it was -- whether it
11 was an e-mail request or a verbal request for us, at
12 some point? Is that a follow-up that you can do?

13 MR. PERKO: I don't know if he can do it or
14 not.

15 THE WITNESS: I'm -- Im not sure because
16 Ashley Peterson, who used to have that role, is no
17 longer with us.

18 BY MS. DEBRIERE:

19 Q. But you could search Ashley Peterson's e-mails?

20 A. We can -- yeah. If there is an e-mail -- if
21 there was an e-mail for it, with all the searches we've
22 done for e-mails, it's probably been pulled up in that.

23 Q. Okay. When Elicia from Magellan -- so turning
24 back to the e-mail -- when Elicia from Magellan states
25 that all requests for GN -- and she's referencing GN --

1 GnRH Analogs use to delay puberty in the treatment of
2 gender dysphoria, were required to be vetted by AHCA
3 before a final determination is made. What did she mean
4 by that?

5 MR. PERKO: Can you point to the specific
6 language?

7 MS. DEBRIERE: Absolutely.

8 BY MS. DEBRIERE:

9 Q. So, looking at the e-mail from
10 Elicia King-Wilson dated April 20th, 2022, to Susan
11 Williams and others at AHCA, she states, "This internal
12 document serves for GnRH Analogs use to delay puberty in
13 adolescence with Gender Dysphoria, but it does not speak
14 to the use of hormone therapy. This document was
15 provided by the Agency due to a fair hearing request for
16 Lupron for recipients with this diagnosis. All requests
17 required vetting by AHCA before a final determination is
18 made and MMA will continue to do so as instructed."

19 A. Well, vetting by AHCA would -- could be
20 interpreted as meaning that once Magellan has made its
21 determination, it would be sent to AHCA to be reviewed
22 and then returned to Magellan with a yes or no.

23 Q. Okay. So AHCA was making a -- a determination
24 on all requests sent to Magellan, as to whether or not
25 GnH -- GnRH Analog for the treatment of gender dysphoria

1 was medically necessary?

2 A. Yes.

3 Q. Okay. And do you know if AHCA ever said yes in
4 that situation?

5 A. We don't have a running list of when we would
6 say yes or no.

7 Q. So you don't know?

8 A. We don't know.

9 Q. Okay. So these decisions would not have been
10 documented somewhere?

11 A. Not on any shared files, no.

12 Q. What other type of files would there be?

13 A. If a -- potentially if an -- an employee --
14 potentially, if an employee kept a personal file or that
15 would -- that would be it.

16 Q. Okay. Were there -- are there any particular
17 employees who might keep those personal files that you
18 can think of?

19 A. One of our pharmacists, potentially, may have
20 kept one.

21 Q. Okay.

22 A. But given that the pharmacists often share work
23 between them, and I don't think that they would have
24 because there's -- there's no way that mid -- could --
25 you get to determine whether or not that's a complete

1 list, and other pharmacists may have vetted one, and it
2 may not have been recorded.

3 Q. Who is the pharmacist you had in mind who might
4 have it?

5 A. It's potentially, since this is historic,
6 Susan Williams and Kelly Rubin, who were at the time --
7 who were here at the time and -- and Susan Williams was
8 on the e-mail chain. They are still employed with the
9 agency.

10 Q. Is Susan Williams still employed with the
11 agency?

12 A. Susan Williams is still employed --

13 Q. Okay.

14 A. -- with the agency.

15 Q. So can you ask her if she has any of those
16 decisions documented somewhere?

17 A. We can ask her.

18 Q. Okay. And -- and then get -- provide us the
19 answer?

20 A. Okay.

21 Q. Okay. When AHCA was making these
22 determinations, what criteria were they using?

23 A. So when AHCA was making its determinations, of
24 course, it's going to be in line with our internal GnRH
25 Analog for Gender Dysphoria Criteria.

1 Q. And that's what was previously marked as
2 Plaintiff's Exhibit 4?

3 A. That's correct.

4 Q. Okay. When Elicia references MMA, does MMA
5 stand for Managed Medical Assistance?

6 A. That's correct.

7 Q. Okay. And Managed Medical Assistance is AHCA's
8 Managed Care Program for Florida Medicaid, correct?

9 A. It's one of our Managed Care Programs, that's
10 correct.

11 Q. So it's referencing -- when she says MMA, she's
12 referencing all Managed Care Plans, excluding Long-Term
13 Care Plans; is that correct?

14 A. She's referencing all plans that have an MMA
15 contract, yes.

16 Q. Okay. And all plans that have an MMA contract,
17 that's publicly available on AHCA's website, correct?

18 A. This would have been actually with our first
19 contract period. So at the time --

20 Q. Uh-huh.

21 A. -- because we did a re-procurement in 2018 --

22 Q. Uh-huh.

23 A. -- and we had a new contract period, these
24 contracts would be historical. That's not available on
25 our web pages right now.

1 Q. So what plans had MMA contracts at the time?

2 A. Staywell, Sunshine, Molina, Prestige. That's
3 just the ones I can think of off the top of my head.

4 Q. Humana?

5 A. Humana was one. Aetna.

6 Q. And that -- Sunshine and Staywell, that would
7 include any of the specialty plans they operated as
8 well?

9 A. This would apply to the specialty plans as
10 well.

11 Q. Okay. Including Children's Medical Services?

12 A. That's correct. But that wasn't a Managed Care
13 during this contract period.

14 Q. 2017. So that was operated by at the time?

15 A. At -- Department of Health operated Children's
16 Medical Services. It didn't get -- get -- it wasn't
17 until the second contract period. That was when CMS --
18 that's when Staywell took over CMS.

19 Q. But this criteria -- or this requirement that
20 we've been discussing that AHCA vet every request for
21 use of GnA -- GnRH antagonist by an adolescent for the
22 treatment of gender dysphoria, they would also apply to
23 use CMS, correct?

24 A. Yes.

25 Q. Okay. Okay. So turning to the AHCA Summary of

1 Public Comments in Response to the GAPMS at issue in
2 this case.

3 MS. DEBRIERE: We'll mark that as Exhibit 25.
4 (Thereupon, Plaintiff's Exhibit No. 25 was
5 marked for identification.)

6 BY MS. DEBRIERE:

7 Q. Who wrote this memo?

8 A. I wrote it.

9 Q. Okay. Why?

10 A. So, at the direction of our general counsel's
11 office, following the rule hearing on July 8th, we
12 decided to go ahead and do a written comment summary in
13 response to some of the written comments that we
14 received. And also to summarize some of the verbal
15 comments that were provided during the -- during the
16 hearing. And -- and also because we did see Plaintiffs'
17 attorneys at the hearing. So we figured litigation was
18 imminent.

19 Q. So then what -- what was the purpose that this
20 document was supposed to serve?

21 A. So we re -- did receive substantial written
22 comments, particularly from three clinical
23 organizations. And -- which, of course, these documents
24 were not just sent to us, they were also publicly
25 released and became publicly available. Because they

1 make substantial claims about the validity of our GAPMS
2 memo, we needed to create an internal document that
3 would, of course, explain and -- any potential issues or
4 ex -- respond to any criticisms that, of course, those
5 that weren't intimately familiar with the process might
6 be aware of.

7 Q. And so the three organizations that you did
8 responses to, comments on, were Yale University,
9 Endocrine Society -- I'm sorry. There's four -- no, no,
10 no, three. Yale University, Endocrine Society and the
11 American Academy of Pediatrics. Is that correct?

12 A. That's correct.

13 Q. Why did you pick those three?

14 A. So those are the three that sent us the
15 substantial comments that had particular criticisms
16 towards our GAPMS report.

17 Q. Why didn't you respond to any of the other
18 public comments that were provided or create a written
19 detailed response like you did with these three?

20 A. The other comments were usually very brief,
21 made very general statements. Some of them made
22 expletive-laden statements, because those comments
23 didn't -- weren't looking at the legality of our rule.
24 It wasn't looking at the -- the credibility of the basis
25 for that rule. We didn't do written summaries of those

1 comments.

2 Q. Which one of the comments looked at the --
3 criticized the legality of your role?

4 A. Yale University's did.

5 Q. Okay. And then the Endocrine Society, and AAP
6 along with Yale also criticized the basis for your
7 decision; is that correct?

8 A. Their criticisms were more limited to the GAPMS
9 memo.

10 Q. And they disagreed with that conclusion?

11 A. They disagreed with it.

12 Q. Why was it sent to the experts?

13 A. Because we also wanted them to see the comments
14 that were submitted via these institutions. And we
15 wanted to make sure that our response were as complete
16 as possible.

17 Q. Were you intending to release the com -- the --
18 this report at some point? I guess, I'm still just not
19 understanding the use of the report.

20 A. So the re -- the use of the report was to have
21 an internal memo for those involved in the GAPMS
22 process. And those, of course, would be involved in the
23 imminent litigation of what was said about our report
24 and what our responses were. Now only a small handful
25 of us in the agency were intimately involved in the

1 development of the GAPMS memo. So we needed to share
2 that information with other agency staff.

3 Q. So this report wasn't created to assess the
4 validity or -- this report was not created for use --
5 for AHCA's use in determining whether or not it should
6 adopt the rule?

7 A. That's correct.

8 Q. Okay. Why not look at and respond to all
9 comments that question the validity or credibility of
10 the GAPMS report?

11 A. Because while a lot of comments hurled
12 criticisms at us, they weren't substantiated criticisms.
13 They just were saying we're wrong or --

14 Q. So that --

15 A. -- things like that. Just very general
16 statements that didn't actually provide a -- a reasoned
17 case as to why we should not go forward with the rule,
18 these comments did.

19 Q. Okay. So -- okay. Was this document ever
20 intended to become public at some point?

21 A. No.

22 Q. Is this the only document AHCA prepared
23 summarizing or responding to public comment, provided in
24 response to the adoption of 59G-1.050(7)?

25 A. That's the only document.

1 Q. Including these, did any of the public --
2 including the comments from AAP, Yale and the Endocrine
3 Society, did any of the public comments submitted lead
4 AHCA to reconsider the credentials of the consultants it
5 chose to prepare and submit reports in support of the
6 GAPMS memo?

7 A. They did not.

8 Q. Why?

9 A. None of the comments provided any reasoning or
10 evidence that would force us to redetermine the
11 decisions we'd already made.

12 Q. But you did think that the comments,
13 particularly from Yale, AAP and the Endocrine Society,
14 were substantiated and -- and reasoned through?

15 A. They -- Yale put together 47 pages, and they
16 make some pretty sensationalist claims about our report.
17 They published that report. They -- they did a press
18 release around that report. We needed to go through and
19 analyze it, to make sure that their claims were just
20 sensationalist and nothing more.

21 Q. Okay. Because you'd previously described
22 them -- the -- the reason that you gave me for why you
23 considered their comments and created a detailed summary
24 report of them was because they were reasoned and
25 substantiated, unlike the other public comments

1 provided.

2 A. They provided some fact-based arguments, if
3 that's what you're meaning. But these were still
4 sensationalist in nature. They were poorly-reasoned
5 arguments.

6 Q. What criteria did you use to determine whether
7 they were poorly reasoned?

8 A. Just the standard critical thinking procedures
9 that you would apply to research and analysis.

10 Q. Okay. So it's your position that the comments
11 provided by Yale, the Endocrine Society and AAP, were
12 poorly-reasoned criticisms of the GAPMS report?

13 A. That's my personal opinion, yes.

14 Q. What's the Agency's opinion?

15 A. The Agency's opinion was that they were flawed
16 arguments, and that they weren't sufficient to warrant
17 overturning the GAPMS report or decision to move forward
18 with the rule promulgation.

19 Q. And were you the only person who determined
20 whether the report -- the comments of Yale, the
21 Endocrine Society and AAP, were comments that AHCA would
22 disregard in adopting the opinions set forth in GAPMS?

23 MR. PERKO: Object to form.

24 THE WITNESS: I was the only author of that
25 document, but I was not the only person who read

1 those comments. As I said, we did mail copies to
2 their experts and, of course, we had other internal
3 staff look and review the comments and the rebuttal.

4 BY MS. DEBRIERE:

5 Q. And what internal staff at AHCA agreed with
6 your position about the organization's comments?

7 A. That'd have been my immediate supervisor,
8 Devona Pickle.

9 Q. Anybody else?

10 A. She was -- she -- she had reviewed them as well
11 and reviewed my work.

12 Q. Uh-huh.

13 A. That was pretty much the extent of it. Then
14 we, of course, presented our responses to leadership.

15 Q. And who's leadership?

16 A. That would have been Secretary Marstiller and
17 General Counsel Josefina Tamayo.

18 Q. Okay. And did they agree with what is
19 contained in this report?

20 A. They agreed with our findings.

21 Q. Okay. I understand that you were the only one
22 who wrote the report. Did anybody make any edits in the
23 report?

24 A. As far as any edits, no. Nobody else worked on
25 that document. We did get a suggestion from Dr. VanMol

1 to include information about Western European countries,
2 in a response to Yale. That was it.

3 Q. Okay. I'm sorry, Mr. Brackett. Say that
4 again. You asked Dr. VanMol to include --

5 A. No, Dr. VanMol said that we should mention
6 he -- we should consider including information from the
7 Western European countries.

8 Q. Okay. And so you had not previously thought
9 about that. That was Dr. VanMol's suggestion?

10 A. For this -- for the rebuttal, yes. We were, of
11 course, aware of it. But that was his suggestion to
12 make it more complete.

13 Q. Okay. So taking each comment individually,
14 starting with Yale, what was the basis for determining
15 whether it was poorly reasoned?

16 A. So the basis was that no other argument's
17 valid. What is the -- what is the basis for their
18 arguments? Do they make a case? Or when -- when you
19 apply scrutiny, which, in other words questioning, when
20 you start applying those standard analytical methods, do
21 they hold up. And they didn't. We found that they were
22 making comparisons to drugs, et cetera, making analogies
23 that just didn't apply.

24 Q. So the reason it was poorly reasoned was simply
25 because they were making analogies that didn't apply?

1 MR. PERKO: Object to form.

2 THE WITNESS: That's an example.

3 BY MS. DEBRIERE:

4 Q. Okay. Can you give me other examples?

5 A. I can. But those are also explained in the --
6 in the rebuttal.

7 Q. When you say it's not valid criteria, what
8 are -- valid reasoning, what makes something valid?

9 A. What would make something valid is that it's a
10 point, you -- you can't really take argument with it.
11 And it make -- would make you walk back from your
12 position, knowing that that's an argument that you
13 cannot overcome. In other words, it's well thought,
14 it's logical, it's supported by evidence.

15 Q. So it's your position that nothing in the Yale
16 comment was supported by -- that the thrust of the Yale
17 comment was not supported by evidence?

18 A. There was -- it could be explained that way.
19 They provide some evidence for their arguments but their
20 arguments were nonapplicable. Their arguments danced
21 around our main points.

22 Q. Okay. What about the basis for determining
23 that AAP's comment was poorly reasoned?

24 A. The same basis.

25 Q. So they didn't have any evidence for their

1 comments?

2 A. Correct.

3 Q. Okay. And they missed --

4 A. Well, let me rephrase that. They did not have
5 what we'd consider credible evidence, to support their
6 arguments.

7 Q. Okay. So what does it mean to be credible?

8 A. Well, we do explain that in our GAPMS
9 memo. We explain that in our rebuttal.

10 Q. And did the -- like the -- the Yale comment,
11 did the AAP comment miss AHCA's point?

12 A. The AAP comm -- comment was obfuscating the
13 fact that they -- that there was no standard of care
14 available for these services. The AAP comment
15 frequently referred to one. There was no standard of
16 care available for these.

17 Q. So it's AHCA's position there is no standard of
18 care?

19 A. That's not our pos -- that's not our position.
20 That's just the reality of the situation.

21 Q. Okay. So what was the basis for determining
22 whether the Endocrine Society's comment was poorly
23 reasoned?

24 A. Similar basis as to Yale's. There's was the
25 briefest of the three.

1 Q. Okay. So they didn't present evidence to
2 support their comment?

3 A. Correct.

4 Q. Okay. And they --

5 A. Or they didn't provide credible evidence to
6 support their comment.

7 Q. And did they -- like the Yale report, did they
8 miss the point that AHCA was trying to make?

9 A. I don't think they missed it. But their --
10 their -- their responses didn't fit -- sufficiently --
11 sufficiently refute that.

12 Q. Okay. And what was the point that AHCA was
13 trying to make?

14 A. The point that we made was in our GAPMS, that
15 the evidence was too low quality to constitute -- um,
16 alignment with GAPMS.

17 Q. Was there anything in any of the three comments
18 that AHCA did agree with?

19 A. Are we talking about, like, any last thing or
20 are we talking --

21 Q. Yeah.

22 A. That, of course, I think the -- probably the
23 only thing that we could agree on is, that kids who are
24 having issues and having gender dysphoria are worthy of
25 receiving some help of some kind.

1 Q. Okay. That's the only thing that you could
2 agree on with them?

3 A. I'd have to review their comments to
4 redetermine whether or not there's anything we agree --
5 could agree on. But at -- at large, we are -- I think
6 we do agree that kids who experience gender dysphoria do
7 need evidence-based treatment. We disagree on what we
8 consider to be sufficiently evidence-based treatment.

9 Q. Okay. So the purpose of the report was to
10 review those comments and then summarize your opinion
11 about those comments, right?

12 A. I wouldn't say my opinion. I would say mostly
13 more my counter-arguments.

14 Q. Okay. So then when you were preparing this
15 report, the point was to refute what Yale, the AAP and
16 the Endocrine Society were saying?

17 A. Just to point out the flaws of what they were
18 saying, and to, of course, pose counter-arguments,
19 correct.

20 Q. Okay. Why start from a position where the
21 point is to refute?

22 MR. PERKO: Object to form.

23 THE WITNESS: I'll defer to my previous
24 testimony. They make comments. They use hyperbolic
25 language. This was all released nationally in the

1 media. Internally, we needed to make sure of the
2 substance behind their statements, we needed to
3 analyze that to make sure that hey, is there
4 something in there that would be a fatal flaw or
5 not.

6 BY MS. DEBRIERE:

7 Q. Well, analyzing whether something was in there
8 that would either support or not support your conclusion
9 under GAPMS is different from starting from a position
10 where you're writing a report to refute what they're
11 saying; is that right?

12 MR. PERKO: Object to form.

13 THE WITNESS: I'm having trouble following what
14 you're saying.

15 BY MS. DEBRIERE:

16 Q. Yeah. So your previous testimony was you wrote
17 this report to refute what the AAP, the Endocrine
18 Society and Yale were saying; is that correct?

19 A. Since they were making arguments and criticisms
20 towards our GAPMS, that were not well founded the --
21 the -- yes, we were refuting their counter-arguments.

22 Q. At what point did you determine that they were
23 not well-found -- founded comments?

24 A. Shortly after I read them.

25 Q. When you were reviewing them did you go and

1 look into any of the research that they cite?

2 A. I did.

3 Q. At the time that you were reading the comments
4 you did?

5 A. I did.

6 Q. Okay. So, when you say pretty shortly after
7 reading them, what do you mean?

8 A. Well, after I read them. I mean, or -- and --
9 and as I was reading them, since Yale went
10 point-by-point, as you read something. And, of course,
11 you being an attorney, you start analyzing the language
12 as you read it.

13 Q. Okay.

14 A. So either you realize, like, oh, they have a
15 point there, or you shake your head and be, like, no,
16 they don't.

17 Q. Okay. So after -- directly after -- once you
18 finished reading the comments, you had decided that they
19 were wrong?

20 A. I had decided that they were -- yeah. That
21 they were flawed, yes.

22 Q. Okay. Did anyone at AHCA disagree with the
23 contents of this report?

24 A. You mean, anyone who was in -- who had read
25 it -- read it and received the information on it?

1 Q. I mean, anyone.

2 A. Anyone? I can't speak to every employee. Not
3 every employee was made aware of that document either.

4 Q. Are you of -- aware of anyone at AHCA who
5 disagreed with this report?

6 A. With the GAPMS memo or the comment summary?

7 Q. Well, let's start with the comment summary.

8 A. I'm not aware of any employee who disagreed
9 with the comment summary.

10 Q. Are you aware of any employee who disagreed
11 with the GAPMS?

12 A. I'm aware of one.

13 Q. Who?

14 A. Jeffrey English.

15 Q. Only Jeffrey English?

16 A. He's the only one that I'm aware of.

17 Q. Okay. Did anybody within leadership direct you
18 to make changes to your summary, after you drafted it?

19 A. No.

20 Q. Okay. So it's perfectly written as is? No one
21 edited it?

22 MR. PERKO: Object to form.

23 THE WITNESS: It is -- it is purely my work
24 product. So we got the one suggestion from

25 Dr. VanMol, but I added that in myself.

1 BY MS. DEBRIERE:

2 Q. So what -- no one made any changes to this
3 document. It's just purely your work product?

4 A. Yeah.

5 Q. Okay. Okay. So the General Counsel's office
6 never made any edits to this report?

7 A. No, they did not.

8 Q. Okay. They directed you to create the report,
9 but they did not tell you what content to put in it; is
10 that correct?

11 A. We were instructed to look at the comments,
12 review them and provide analyses of them. Of course,
13 that would be maintained internally.

14 Q. Okay. Other than the comment from Dr. VanMol,
15 were there any other -- was there any other feedback
16 from the experts?

17 A. No.

18 Q. So did they tell you anything after they read
19 the report?

20 A. No.

21 Q. Okay. So you sent them the report, and then
22 they didn't make any mention of it after that?

23 MR. PERKO: Asked and answered.

24 THE WITNESS: I'd already said that they
25 didn't.

1 BY MS. DEBRIERE:

2 Q. Okay. Who did you send this document to before
3 finalizing?

4 A. So we sent that to Dr's., VanMol, VanMeter, and
5 Grossman (phonetic).

6 Q. Okay. Did you send it to anyone internally to
7 AHCA, before finalizing?

8 A. Well, I mean, we did provide copies to
9 Secretary Marstiller, General Counsel. So they did have
10 it to review.

11 Q. Okay. And they provided you feedback to make
12 changes?

13 A. They did not request any changes.

14 Q. Okay. And they being General Counsel's Office,
15 but also AHCA leadership?

16 A. Correct.

17 Q. Okay. Okay. So the GAPMS memo -- I'm sorry.
18 The GAPMS regulation presumes that services either meet
19 the GAPMS requirement or they do not. And if they do
20 not, then those services are experimental, correct?

21 A. That's what we determined, yes.

22 Q. In the 2022 GAPMS process, you determined that
23 the services listed in 59G-1.050 subpart (7) are
24 experimental, correct?

25 A. That's what is written in the GAPMS memo, yes.

1 Q. And, therefore, AHCA adopted the categorical
2 exclusion for the treatment of gender dysphoria from
3 Medicaid coverage; is that correct?

4 A. That's correct.

5 Q. Okay.

6 MS. DEBRIERE: So can I have the Errata sheet?
7 (Thereupon, Plaintiff's Exhibit No. 26 was
8 marked for identification.)

9 BY MS. DEBRIERE:

10 Q. So this is marked as Exhibit 26, it's the
11 Errata sheet that you sent to us yesterday. So, on this
12 Errata sheet, you're saying that there are potentially
13 situations where an individual can prove that the
14 treatment -- the services listed at 59G-1.050(7) to
15 treat gender dysphoria can not be experimental; is that
16 correct?

17 A. No. That's not how that's to be -- to be
18 interpreted.

19 Q. Okay. So I'm looking at this Errata sheet, and
20 it says that you can use the variance and waiver
21 process -- "An individual can use the variance and
22 waiver process to have an individual determination as to
23 whether one of the services listed at 59G-0 --
24 1.050(7) -- subpart seven is not experimental to treat
25 their gender dysphoria."

1 A. That text means that they are entitled to
2 review under the legal process.

3 Q. Are there any circumstances in which that
4 request would be granted?

5 A. We don't know. That'd be speculation.

6 Q. Well, if it was granted, then the person would
7 have proven that the service was not experimental as to
8 them, correct?

9 A. In a very hypothetical situation, if a variance
10 is approved for coverage of these services, it would be
11 strictly on that individual basis and that individual's
12 basis alone.

13 Q. But that individual would have to prove that
14 the treatment for gender dysphoria listed at 59G-1.050
15 subpart(7) was not experimental as to them, correct?

16 A. Hypothetically speaking, if it was to be
17 approved, they would have to satisfy proof, that it
18 wouldn't be experimental, as to them.

19 Q. So AHCA believes there are situations in which
20 the services listed at 59G-1.050 subpart(7) to treat
21 gender dysphoria can not be experimental?

22 MR. PERKO: Object to form.

23 THE WITNESS: That is not what we are saying
24 here. The variance of the process is a legal
25 process because of -- of the Agency's rulemaking

1 authorities. And then, of course, every agency can
2 allow for variances, no matter what the rule says,
3 regardless of whether it applies to health care,
4 environment, business, commerce, et cetera. This is
5 a legal process.

6 BY MS. DEBRIERE:

7 Q. I understand that anybody can access the legal
8 process.

9 A. Uh-huh.

10 Q. But under what situations would AHCA grant that
11 specific variance request?

12 MR. PERKO: Object to form.

13 THE WITNESS: We would be speculating.

14 BY MS. DEBRIERE:

15 Q. The individual would have to prove that the
16 services are not experimental as to them, correct?

17 MR. PERKO: Asked and answered.

18 THE WITNESS: The burden of proof is on the
19 recipient.

20 BY MS. DEBRIERE:

21 Q. To prove that the service is not experimental?

22 MR. PERKO: Objection to form.

23 THE WITNESS: The burden of proof is on the
24 recipient.

25 BY MS. DEBRIERE:

1 Q. What do they have to prove?

2 A. They have to prove your -- for -- they've --
3 they have to prove substantial hardship because of
4 the -- of the rule. That's what the grounds under which
5 a variance is granted.

6 Q. Would they have to prove that the services are
7 not experimental, as to them?

8 A. They would have to prove substantial hardship.

9 Q. Substantial hardship to receive services that
10 AHCA has determined are experimental?

11 MR. PERKO: Object to form.

12 THE WITNESS: The GAPMS memo is -- serves as
13 the basis to say, that they're experimental and
14 investigational. If -- if -- and if a recipient
15 feels that -- that their -- that rule is causing
16 them substantial hardship, they are welcome to try
17 to request a variance and have it undergo the review
18 process.

19 BY MS. DEBRIERE:

20 Q. I understand that an individual -- I understand
21 that an in -- any individual can access the waiver --
22 the variance and waiver process. What I'm asking is, in
23 order for AHCA to approve that variance request, what
24 does the individual have to establish?

25 MR. PERKO: Object to form. Asked and

1 answered.

2 BY MS. DEBRIERE:

3 Q. Let's scratch that.

4 Looking at the Erat -- the Errata sheet, you
5 say, add the line, that AHCA decides whether a -- a
6 service is experimental as to the requester.

7 A. And --

8 Q. Is that the testimony?

9 A. Yes.

10 Q. Okay. So in order to have a variance approved,
11 the individual has to -- AHCA decides whether a service
12 is experimental, as to the requester?

13 A. It could be interpreted that way.

14 Q. I'm trying to understand what AHCA's policy is,
15 as it relates to a request for a variance or waiver, for
16 someone who is seeking treatment -- seeking a service in
17 59G-1.050 subpart(7) to treat gender dysphoria.

18 A. So --

19 MR. PERKO: Object to form.

20 THE WITNESS: -- we previously did explain the
21 variance review process. It's very individualized.
22 Because it's very individualized, we really can't
23 speak to what we would exactly request because of
24 the individualized nature of the variance process.
25 It would be speculation.

1 BY MS. DEBRIERE:

2 Q. So you cannot sit here today and tell me one
3 example of an individual who would be granted a variance
4 from 59G-1.050 subpart(7)?

5 A. No, it's all hypotheticals.

6 Q. I'm not asking for a hypothetical. I'm asking
7 for an example. Can you give me one example?

8 MR. PERKO: Asked and answered.

9 THE WITNESS: Any examples we would give would
10 be hypothetical.

11 BY MS. DEBRIERE:

12 Q. Mr. Brackett, you have written here that it is
13 AHCA's position that when someone requests a variance or
14 waiver from this rule then it is AHCA's rule to
15 determine whether the service is experimental, as to the
16 requester. Is that correct?

17 A. Those are the words I wrote, yes.

18 Q. In what situations could AHCA decide whether a
19 service is -- is not experimental as to the requester?

20 MR. PERKO: Object to form.

21 BY MS. DEBRIERE:

22 Q. If you have decided that these service are
23 always experimental, they're either experimental or
24 they're not.

25 MR. PERKO: Object form.

1 BY MS. DEBRIERE:

2 Q. Is that correct?

3 A. I defer to the conclusions we drew -- drew in
4 the GAPMS memo.

5 Q. The services are either experimental or they're
6 not, correct? So -- excuse me. Under the GAPMS memo,
7 you determine that all the services are experimental,
8 correct?

9 A. When --

10 Q. As to everyone?

11 A. When used for those clinical indications,
12 correct.

13 Q. When used for the treatment of gender
14 dysphoria?

15 A. Correct.

16 Q. So all situations, where one of those services
17 is being used to treat gender dysphoria, in all
18 situations, the services are experimental, correct?

19 A. Based on our GAPMS memo determination, yes.

20 Q. Okay.

21 MS. DEBRIERE: Okay. Let's -- let's take a
22 five-minute break.

23 THE VIDEOGRAPHER: Okay. This concludes Video
24 One of the continued video-recorded deposition of
25 Matthew Brackett. The time is 11:07 a.m.

1 (Discussion held off the record.)

2 THE VIDEOGRAPHER: This is the beginning of
3 Video Two of the continued video-recorded deposition
4 of Matthew Brackett. The time is 11:17 a.m.

5 BY MS. DEBRIERE:

6 Q. All right. Mr. Brackett, turning back to your
7 Errata sheet. It -- reviewing it yesterday, I noticed
8 that there are just a lot of places where you delete
9 entire lines, and then substitute a few words. And the
10 reason behind that is, because your position it's a more
11 accurate description of agency policy. Um, how did you
12 learn about those more accurate descriptions of agency
13 policy?

14 A. Those came from our General Counsel's Office.

15 Q. Um, so did you review your deposition with the
16 General's Counsel's Office, and they directed you to
17 include these in that Errata sheet?

18 A. Yes. And (inaudible) outside counsel to make
19 sure it was as accurate as possible.

20 Q. Is outside counsel aware of accurate -- more
21 accurate agency policy?

22 A. Yes.

23 Q. How?

24 A. Via our General Counsel's Office.

25 Q. So General Counsel's Office gave outside

1 counsel a more accurate description of agency policy,
2 and then outside counsel directed you to fill out this
3 Errata sheet?

4 A. It was a team effort, yes.

5 Q. Are these policies kept anywhere?

6 A. I mean, these policies are -- these statements
7 are more in line -- aligned with the statutes, as
8 written, when it comes to requesting variances and
9 rulemaking.

10 Q. Okay. But your reason is that you are
11 providing a more accurate description of agency policy.
12 So they're not policies that are written; is that
13 correct?

14 A. If you're talking about promulgated policies
15 that go through the rulemaking process --

16 Q. I'm not. I'm talking about internal policies
17 or formally-adopted policies.

18 A. This would be more reflective of -- of our
19 internal processes, yes.

20 Q. Okay. And are those internal processes written
21 anywhere?

22 A. Can't speak to that at this time.

23 Q. Okay. So you don't know?

24 A. Don't know.

25 Q. Okay. So can you find that out for me, please?

1 A. We can check to see if there is a -- if the
2 General Counsel's Office has a written process for
3 variances.

4 Q. As to the treatment of gender dysphoria?

5 A. As to the treatment of gender dysphoria?

6 Q. Uh-huh.

7 A. There isn't one.

8 Q. Okay. How did you learn that your initial
9 responses were not accurate?

10 A. We just reviewed the transcript.

11 Q. But as it stands, what's in the Errata sheet is
12 your testimony, correct?

13 A. This is my testimony, correct.

14 Q. Okay. Would you agree that there are
15 individuals for whom their gender dysphoria cannot be
16 resolved with only psychotherapy?

17 A. That is a statement that, of course, is going
18 to be made by individual clinicians. That's not --
19 that's not a statement -- the Agency's not in a position
20 to discuss the effectiveness of medical treatments, when
21 it comes down to individuals such as -- such as you're
22 describing.

23 Q. Okay. But the agency isn't in a position -- is
24 in a position to determine whether or not services are
25 experimental, as to the provision to Medicaid

1 (inaudible)?

2 A. That's a different question. That's a
3 different scene -- scenario.

4 Q. Okay. So in what scenario -- I'm sorry. So
5 then would the --

6 A. So can you please repeat that question?

7 Q. Yes. Would you agree that there are
8 individuals, for whom their gender dysphoria cannot be
9 resolved with only psychotherapy?

10 A. So just because one treatment may not
11 necessarily be effective, doesn't mean that a treatment
12 that we've deemed to be experimental and investigational
13 is going to be effective.

14 Q. Okay. So it is not the Agency's position that
15 individuals who are suffering from gender dysphoria, the
16 only method of treatment that is appropriate is
17 psychotherapy?

18 A. We can't speak to that because that's kind of
19 an absolute statement. We do deem psychotherapy as
20 being an appropriate treatment. But in regards to the
21 other treatments, such as those discussed in the GAPMS
22 memo, those are experimental/investigational.

23 Q. Okay. I -- but that's not quite my question,
24 though. I mean, my question is, is it the Agency's
25 position that there are medical circumstances, in which

1 a Medicaid beneficiary who's suffering from gender
2 dysphoria needs treatment other than psychotherapy?

3 MR. PERKO: Object to form.

4 THE WITNESS: We're talking only about
5 psychotherapy, correct?

6 BY MS. DEBRIERE:

7 Q. Yes.

8 A. We could probably say yes.

9 Q. Okay.

10 MS. DEBRIERE: Are there any other questions
11 that I've missed, Simone?

12 Okay. All right. That's it for Plaintiff's
13 side.

14 MR. PERKO: I got no questions.

15 THE VIDEOGRAPHER: Anybody via Zoom?

16 MS. DEBRIERE: We're good, but thank you.

17 THE VIDEOGRAPHER: Okay. This concludes the
18 video-recorded deposition of Matthew Brackett. The
19 time is 11:23 a.m.

20 (Discussion held off the record.)

21 COURT REPORTER: Is anyone requesting a copy of
22 this deposition at this time?

23 MS. DEBRIERE: Yes, we will.

24 MR. PERKO: And we will take a copy.

25 (Discussion held off the record.)

1 MS. DEBRIERE: Ms. Mercer, can you send it to
2 the person who initially organized your services?

3 (Discussion held off the record.)

4 COURT REPORTER: Bill it to Jennifer Altman?

5 MS. DEBRIERE: Yes, please.

6 (Deposition concluded at 11:23 a.m.)

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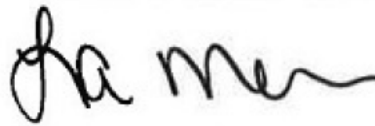
CERTIFICATE OF OATH

STATE OF FLORIDA:

COUNTY OF DUVAL:

I, LAWANDA MERCER, Florida Professional Reporter,
Notary Public, State of Florida, do hereby certify that
MATTHEW BRACKETT personally appeared before me on
11th day of March, 2023, and was duly sworn and produced
Florida driver's license as identification.

Signed this 23rd day of MARCH, 2023.

A handwritten signature in black ink, appearing to read 'La mer', is positioned above the printed name of the notary.

LAWANDA MERCER

Florida Professional Reporter

Notary Public, State of Florida

My Commission No.: HH 285925

Expires: July 25th, 2026

CERTIFICATE OF REPORTER

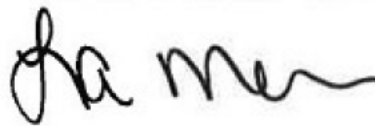
STATE OF FLORIDA:

COUNTY OF DUVAL:

I, LAWANDA MERCER, Florida Professional Reporter,
Notary Public, State of Florida, certify that I was
authorized to and did stenographically report the
deposition of MATTHEW BRACKETT; that a review of the
transcript was requested; and that the foregoing
transcript, pages 5 through 53, is a true and accurate
record of my stenographic notes.

I further certify that I am not a relative,
employee, or attorney, or counsel of any of the parties,
nor am I a relative or employee of any of the parties'
attorneys or counsel connected with the action, nor am I
financially interested in the action.

DATED this 23rd day of March, 2023.

A handwritten signature in black ink, appearing to read 'Lawanda Mercer', is written over a light gray rectangular background.

LAWANDA MERCER

Florida Professional Reporter

ERRATA SHEET

DO NOT WRITE ON TRANSCRIPT-ENTER CHANGES HERE

IN RE: AUGUST DEKKER ET AL. VS. JASON
WEIDA, ET AL.,

CASE NO: 4:22-CV-00325-RH-MAF

DATE: MARCH 8TH, 2023

DEPONENT: MATTHEW BRACKETT

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

DATE

MATTHEW BRACKETT

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March 23rd, 2023

MATTHEW BRACKETT
C/o Gary Vergil Perko
Gperko@holtzmanvogel.com

In Re: March 8th, 2023, Deposition of MATTHEW BRACKETT
Job# 5801255

Dear MATTHEW BRACKETT:

This letter is to advise that the transcript for the above-referenced deposition has been completed and is available for review. Please read the transcript, make any changes and sign the errata sheet provided, then email completed errata to transcripts-fl@veritext.com and to all ordering parties.

It is suggested that the review of this transcript be completed within 30 days of your receipt of this letter, as considered reasonable under Federal Rules*; however, there is no Florida Statute to this regard.

The original of this transcript has been forwarded to the ordering party and your errata, once received, will be forwarded to all ordering parties for inclusion in the transcript.

Sincerely,

Veritext Legal Solutions

cc: Katherine Jean Ann DeBriere, Esquire
Gary Vergil Perko, Esquire

Waiver:

I, _____, hereby waive the reading and signing of my deposition transcript.

Deponent Signature

Date

*Federal Civil Procedure Rule 30(e)/Florida Civil Procedure Rule 1.310(e)

[& - aetna]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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.

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA

TALLAHASSEE DIVISION

CASE NO.: 4:22-cv-00325-RH-MAF

AUGUST DEKKER, et al.,

Plaintiffs,

vs.

JASON WEIDA,

Defendant.

DEPOSITION OF: ANN DALTON

DATE: TUESDAY, JANUARY 24, 2023

TIME: 10:04 A.M. - 6:05 P.M.

PLACE: AGENCY FOR HEALTH CARE
ADMINISTRATION
2727 MAHAN DRIVE
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I N D E X

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S T I P U L A T I O N S

It is hereby stipulated and agreed by and between the counsel for the respective parties and the deponent that the reading and signing of the deposition transcript be reserved.

1 P R O C E E D I N G S

2 THE COURT REPORTER: Do you swear or affirm
3 that the testimony you are about to give will be the
4 truth, the whole truth, and nothing but the truth?

5 THE WITNESS: Yes.

6 ANN DALTON,
7 having first been duly sworn, was examined and
8 testified as follows:

9 DIRECT EXAMINATION

10 BY MS. DEBRIERE:

11 Q. Ms. Dalton, have you ever had your deposition
12 taken before?

13 A. Yes.

14 Q. Okay. So I'm just going to walk through some
15 preliminary issues and go over some basic instructions
16 that you've probably heard a million times, and then
17 I'll get started with the questioning.

18 A. Okay.

19 MS. DUNN: Sorry. Before we start, can we
20 introduce everybody who is on the phone.

21 MS. DEBRIERE: Absolutely. Thank you, Chelsea.
22 Before we start, we want to introduces folks on
23 the phone.

24 MS. DUNN: I think there's one person who is
25 currently muted. Someone just joined.

1 Shani, are you there?

2 MS. RIVAUX: Good morning. This is Shani
3 Rivaux.

4 MS. DEBRIERE: Anyone else, Chelsea?

5 MS. DUNN: There is one person. I just don't
6 know who it is.

7 MS. DEBRIERE: Is anybody else there?

8 MS. DUNN: It's a 305 number. So it's Miami.

9 MS. CHRISS: That's Jennifer.

10 MS. DEBRIERE: Okay. Jennifer Altman is the
11 other person.

12 MS. DUNN: If folks on the line could mute
13 their phones just so we don't have any background
14 noise, that would be helpful. Thanks.

15 MS. DEBRIERE: So we're just going to mark
16 exhibits as they're discussed. I'll be showing you
17 papers to read off, and we'll just mark them as we
18 move through. As I mark those exhibits, I'm going
19 to read something called a Bates number; that just
20 helps us track what pages we're on when we discuss
21 things. If there's a Bates number, it's probably
22 going to start with "DEF," then underscore, then the
23 Bates number.

24 I'd like to go ahead and mark the notice of
25 deposition as Exhibit 1. There's no Bates number on

1 that one.

2 MS. DUNN: And Catherine McKee just joined the
3 line as well.

4 MS. DEBRIERE: It's just the notice that brings
5 you here today.

6 (Plaintiff's Exhibit No. 1 was marked for
7 identification.)

8 BY MS. DEBRIERE:

9 Q. So I'm going to be using the acronym GAPMS
10 quite a bit. Do you know what that stands for?

11 A. Yes.

12 MS. DEBRIERE: And, Court Reporter, it's
13 G-A-P-M-S.

14 BY MS. DEBRIERE:

15 Q. And it stands for generally accepted
16 professional medical standards; which is set forth in
17 59G-1.035. You probably don't have that memorized.
18 That's okay.

19 I will use the term "gender dysphoria," which
20 is defined as discomfort or distress that is caused by a
21 discrepancy between a person's gender identity and that
22 person's sex assigned at birth and the associated gender
23 role and/or primary and secondary sex characteristics.
24 When I use that term, can we just agree that's the
25 definition I'm using?

1 A. Okay.

2 Q. I'm also going to be using the phrase
3 "categorical exclusion of gender affirming care." And
4 that's just the exclusion set out in 59G-1.050, Subpart
5 7. That's why we're here for today, for that exclusion
6 of gender affirming care. Do you understand what I mean
7 when I say that?

8 MR. PERKO: I'm going to object to the form.

9 You can answer.

10 THE WITNESS: Yes.

11 BY MS. DEBRIERE:

12 Q. Well, I do want to make sure you understand
13 what I'm talking about. Would you like to see a copy of
14 the rule before we can agree on use of that phrase?
15 Because as I use it, I do want to make sure we're
16 talking the same thing.

17 A. Yeah.

18 MS. DEBRIERE: So we'll mark this as Exhibit 2.

19 It's a copy of 59G-1.050.

20 (Plaintiff's Exhibit No. 2 was marked for
21 identification.)

22 BY MS. DEBRIERE:

23 Q. If you scroll down to Subpart 7 -- scroll down;
24 you're not a computer. If you follow down to Subpart
25 7 --

1 MR. PERKO: It's on the back of the page.

2 BY MS. DEBRIERE:

3 Q. So when I'm using the phrase "categorical
4 exclusion of gender affirming care," I'm referring to
5 that Subpart 7. Can we agree that that's the phrase
6 that encompasses that portion of the rule?

7 MR. PERKO: I'm going to object to form.

8 But you can answer.

9 MS. DEBRIERE: Well, I think we do need --
10 Gary, I understand where you're coming from. But I
11 think we just need to figure out a way to
12 shorthand --

13 MR. PERKO: That's fine.

14 MS. DEBRIERE: -- that reference.

15 MR. PERKO: I'm just objecting to the use of
16 "gender affirming care."

17 MS. DEBRIERE: Okay. How about "treatment for
18 just gender dysphoria"? Would you --

19 MR. PERKO: That's fine.

20 BY MS. DEBRIERE:

21 Q. So we're going to use "categorical exclusion of
22 treatment for gender dysphoria." And when I use that
23 phrase -- categorical exclusion of treatment for gender
24 dysphoria -- I'm referring to that Subpart 7. Can we
25 agree to that?

1 A. Okay.

2 Q. I'm also going to use the term "EPSDT
3 services"; which is an acronym for early and periodic
4 screening, diagnostic, and treatment services. When I
5 say "EPSDT," do you know what I mean when I say that?

6 A. Yes.

7 Q. So my name is Katy DeBriere. And I represent
8 the plaintiffs August Dekker, Brit Rothstein, and Susan
9 Doe and K.F.

10 I know you've been deposed before. I'm just
11 going to go over some very brief instructions, just as a
12 refresher.

13 If I ask a question ask and you don't
14 understand it, don't try to, you know, understand what
15 I'm saying and try to answer the question. Instead,
16 just stop me and tell me to rephrase so that you
17 understand the question. That's no problem at all.

18 A. Yes.

19 Q. And speaking one at a time -- I have a horrible
20 habit of speaking over people. But we need to try and
21 do our best to speak one at a time, so the court
22 reporter can get down everything we say. I don't think
23 you're going to have that problem, but I will. So
24 please just let me finish my question before you answer.
25 And I will do my best to do the same when you're

1 providing an answer back to me; okay?

2 A. Yes.

3 Q. Verbal answers -- again, it's clear that you
4 understand. But as we move through, the court reporter
5 can't record things like "uh-huh," or "huh-uh." So if
6 you could just use "yes," or "no," or words whenever you
7 are responding to a question; okay?

8 A. Yes.

9 Q. If you need to take a break for any reason,
10 please feel free to ask me. Stop me; tell me you need
11 to take a break. That's not going to be a problem at
12 all. The only thing I ask is that you finish answering
13 your question before we do.

14 A. Yes.

15 Q. Okay. Are you on any medications or other
16 substances that can impact your memory today?

17 A. No.

18 Q. Can you state your name.

19 A. Ann Dalton.

20 Q. And, Ms. Dalton, what did you do to prepare for
21 today?

22 A. I met with my attorneys.

23 Q. Okay. And how long did you meet with them for?

24 A. 45 minutes.

25 Q. Okay. Did you review any documents?

1 A. No.

2 Q. Okay. Can you describe your educational
3 background for me.

4 A. I have master's degree in music from Florida
5 State University and a bachelor's degree in music from
6 Northern Kentucky University.

7 Q. What's your current position at the Agency for
8 Health Care Administration?

9 MS. DEBRIERE: And, Court Reporter, probably
10 throughout the deposition we'll be using "AHCA";
11 which is the acronym -- AHCA. Or I might reference
12 "the agency" at times. And when I reference "the
13 agency," I mean the Agency for Health Care
14 Administration.

15 BY MS. DEBRIERE:

16 Q. So what is your current position at AHCA?

17 A. I'm the bureau chief of the Bureau of Medicaid
18 Policy.

19 Q. How long have you worked in that role?

20 A. Since -- officially, since August 2021.

21 Q. Okay. What did you do prior to that role?

22 A. I was an AHCA administrator in the Bureau of
23 Medicaid Policy.

24 Q. What does that mean to be an AHCA
25 administrator?

1 A. I was a manager of a team -- the Program
2 Authority Section in the Bureau of Medicaid Policy.

3 Q. What kind of responsibilities does that entail?

4 A. The Program Authorities Section was responsible
5 for submitting and maintaining the Medicaid waivers, the
6 Medicaid state plan with the federal partners at CMS;
7 the promulgation of administrative rules; and the PACE
8 program.

9 Q. And how long were you in that role for?

10 A. Since August 2018.

11 Q. What did you do prior to that?

12 A. I was a program administrator over a section in
13 the Bureau of Medicaid Policy.

14 Q. And what responsibilities does that entail?

15 A. That section was titled Program Policy. And it
16 was responsible for the Children's Health Insurance
17 Program or CHIP Program; the provider enrollment policy;
18 the eligibility rule; and a few other rule areas that I
19 can't remember.

20 Q. What do you mean by eligibility rule? What's
21 that?

22 A. The -- I don't remember the exact rule number.
23 But it is the rule that outlines the eligibility
24 criteria for recipients in the Medicaid program.

25 Q. Okay. Is that related to what category of

1 Medicaid someone would fall under in order to be
2 eligible for Medicaid?

3 A. I believe so.

4 Q. Okay. And how long were you in that position
5 for?

6 A. From January 2018 to August of 2018.

7 Q. And what did you do prior to that?

8 A. I worked at the Department of Elder Affairs as
9 a senior management analyst in the Long Term Services
10 and Supports Bureau.

11 Q. And how long were you in that role for?

12 A. From August 2017 to January 2018.

13 Q. Did that role require any knowledge about
14 Medicaid?

15 A. Yes.

16 Q. And did that role require any knowledge about
17 rulemaking?

18 A. Not the promulgation process itself, per
19 Chapter 120; but the development of rule language, yes.

20 Q. Okay. And when did you start at DOEA?

21 A. June 2012.

22 Q. Okay. And so what other positions did you hold
23 there between June 2012 and when you became the senior
24 program management analyst?

25 A. I held various analyst positions within the

1 same unit.

2 Q. Okay. And did those other positions require
3 knowledge of Medicaid?

4 A. Yes.

5 Q. And did those other positions require knowledge
6 about rule promulgation?

7 A. The same as the senior management analyst would
8 have.

9 Q. In your current role at AHCA, who is your
10 direct supervisor?

11 A. Currently Brian Meyer is my direct supervisor.

12 Q. And who is that person's supervisor?

13 A. Jason Weida.

14 Q. And what is Brian Meyer's position at the
15 agency?

16 A. These changes are recent. And I'm not sure of
17 the exact title of his position.

18 Q. How is his position in relation to Tom Wallace?
19 Or I should ask: What is Tom Wallace's position at the
20 agency?

21 A. He's a deputy secretary at the agency.

22 Q. Does Brian Meyer supervise him?

23 A. No, I believe they're the same position.

24 Q. Okay.

25 A. But, again, these are recent changes, and I'm

1 not quite sure of the exact title.

2 Q. What was Brian Meyer's role before he changed
3 into the role he currently is in?

4 A. He was assistant deputy secretary of
5 operations.

6 Q. Okay. Is Brian within the Bureau of Medicaid
7 Policy?

8 A. No.

9 Q. Okay. Is he within any specific bureau at the
10 agency?

11 A. No.

12 Q. Describe your current role at the agency for
13 me. What are the responsibilities?

14 A. I oversee the Bureau of Medicaid Policy. The
15 Bureau of Medicaid Policy is responsible for the federal
16 authorities; which are the contracts between us and the
17 federal government that manage the Medicaid program in
18 Florida. Promulgates -- we oversee the promulgation of
19 all the rules and rule class 59G; which are the Medicaid
20 rules. Oversee the coverage policy development; those
21 coverage policies are promulgated in administrative
22 rule, but outline the specific services and the criteria
23 for reimbursement.

24 The administration of the CHIP program is also
25 part of the bureau's responsibility. And the managed

1 care plan contracts -- the drafting of those contracts
2 and policy actions related to the managed care program.

3 Q. What are coverage policies?

4 A. Coverage policies are documents that contain
5 the information needed by providers and recipients that
6 describes the service and also provides the information
7 that they would need to be reimbursed -- providers would
8 need to be reimbursed for a service. It describes who
9 can provide the service, who can receive the service,
10 and then any service criteria or details around that
11 service.

12 Q. What do you mean "service criteria"? Can you
13 explain that further.

14 A. A description of the service and then any
15 exclusions, if there are any, pertaining to that
16 service. It's different for each coverage policy.

17 Q. Okay. And what are coverage handbooks?

18 A. "Handbooks" is a term that we used to use at
19 the agency. A lot of the coverage policies were -- they
20 are now separate coverage policies, but they were
21 contained in bigger handbooks that have since been kind
22 of broken down to be more service specific. And so the
23 term that we use now to describe the information that
24 was previously contained in the handbooks is "coverage
25 policy."

1 Q. Are the handbooks promulgated into rule?

2 A. Yes.

3 Q. And does the agency still rely on those
4 handbooks in determining service eligibility?

5 A. If the information from a handbook was moved to
6 a coverage policy, the coverage policy would be
7 promulgated in the rule and the handbook would no longer
8 be part of that rule.

9 Q. Can you give a recent example of the handbook
10 information moving into a coverage policy rule.

11 A. It's not that recent, but it's the first one
12 that comes to my mind -- is the Home Health Handbook was
13 broken down into three coverage policies, I believe,
14 around 2016. And those three policies are the Home
15 Health Services Coverage Policy, Personal Care Services
16 Coverage Policy, and the Private Duty Nursing Services
17 Coverage Policy.

18 Q. Okay. And this will seem like a simple
19 question. But where do those coverage policies -- can
20 the public access those coverage policies?

21 A. Yes.

22 Q. And where would they access those coverage
23 policies?

24 A. The agency has an external web page specific to
25 all the coverage policies, fee schedules, reimbursement

1 policies.

2 Q. And the policies that are on that public facing
3 website, are they all inclusive of the policies on which
4 the agency relies for determining coverage? Strike that
5 question.

6 Is it an exhaustive -- is what is contained on
7 the agency's website, is it an exhaustive list of
8 Medicaid coverage policies?

9 A. All the policies promulgated in class 59G. And
10 the rules or links to the FAR notice are on our website,
11 yes.

12 Q. Are there any coverage policies not on the
13 website on which AHCA relies to determine coverage of
14 Medicaid services?

15 A. Not that I'm aware of.

16 Q. What is a fee schedule?

17 A. A fee schedule is the document that provides
18 information on billing codes, the description associated
19 with a code, and the amount that Medicaid will reimburse
20 for fee for service.

21 Q. What is fee for service?

22 A. Fee for service is a delivery system where the
23 State pays providers directly -- reimburses them
24 directly for the service provided.

25 Q. Is that in contrast to managed care?

1 A. It's a different delivery model.

2 Q. If a Medicaid service is listed on the fee
3 schedule, does that mean Medicaid covers it?

4 I'll strike that. I think I can ask a question
5 that will help here.

6 If a Medicaid service is on the fee schedule,
7 does that mean Medicaid does not categorically exclude
8 it?

9 MR. PERKO: Object to form.

10 MS. DEBRIERE: You can go ahead and answer if
11 you understand. If you don't understand, please
12 feel free to ask me to rephrase.

13 THE WITNESS: I don't think I understand.

14 BY MS. DEBRIERE:

15 Q. If a Medicaid service is listed on a fee
16 schedule, does that mean that Medicaid is willing to pay
17 for it if the recipient meets all eligibility criteria
18 for that service?

19 A. So the fee schedules have to be used in
20 conjunction with the coverage policy. So, like I said,
21 the fee schedule contains the coding that the provider
22 needs to use in order to get reimbursed, and, in most
23 cases, the amount and description. But the parameters
24 of who can receive the service -- what kind of providers
25 can get reimbursed for the service -- that's in the

1 coverage policy.

2 Q. Okay. What would it mean if a Medicaid service
3 was not on the fee schedule?

4 A. So the fee schedule document and the term as we
5 would use "fee schedule" does not include all of the
6 services. Some of those are going to be found in the
7 reimbursement methodology rules, if there's not a
8 specific fee equated to a specific code. So there's
9 also reimbursement methodology rules and documents as
10 well.

11 Q. Are there services -- Medicaid services on the
12 fee schedule that AHCA will not cover?

13 A. I don't know if there's any. But it would
14 be -- any information about how the services covered
15 would be included -- either on the fee schedule or in
16 the coverage policy.

17 Q. Okay. Do your responsibilities currently
18 include developing coverage policies for the Florida
19 Medicaid program?

20 A. I oversee the teams that are responsible for
21 that, yes.

22 Q. And who are those individuals? Or let's start
23 with: Who are the teams?

24 A. The team primarily responsible for the majority
25 of the coverage policies is the team managed by Jesse

1 Bottcher; he's the AHCA administrator. And he has three
2 program administrators who report directly to him.

3 Q. And who are those people?

4 A. Christine Polacheck [phonetic], and she
5 oversees the specialized services section. John Matson,
6 he's the manager over at the primary and preventative
7 services section. And then Tim Beaner is the manager
8 over the behavioral health and behavioral analysis
9 section.

10 Q. Are those the only teams over which you manage?
11 Or are there other teams?

12 A. I have five AHCA administrator direct reports.

13 Q. Okay.

14 A. And then one program administrator direct
15 report. So I have six direct management team reports.

16 Q. So who are the other ones?

17 A. Catherine McGrath is the AHCA administrator
18 over the program authority section. Ashley Peterson is
19 the AHCA administrator over at the pharmacy policy
20 section. One of them is vacant -- the managed care
21 contract AHCA administrator position. Devona Pickle,
22 she is the AHCA administrator over the Canadian
23 Prescription Drug Importation team. And Jesse Bottcher.
24 And then Lakeva Campbell [phonetic] is a program
25 administrator over the administrative unit who does the

1 administrative functions of the bureau.

2 Q. Who works under Jesse Bottcher?

3 A. That was Christine Polacheck, John Matson, and
4 Tim Beaner.

5 Q. And do you know who Mr. Jeff English is?

6 A. Yes.

7 Q. And who is his supervisor?

8 A. His current supervisor is Cole Giering.

9 Q. Who is Mr. Giering's supervisor?

10 A. Catherine Mcgrath.

11 Q. And Mr. Bottcher -- does he supervise the
12 person who undertakes GAPMS analysis?

13 A. The position that is designated to do the GAPMS
14 is under Jesse Bottcher.

15 Q. Okay. And who does Ms. Peterson supervise?

16 A. The pharmacy policy team, which consists mostly
17 of pharmacists within the bureau.

18 Q. How many pharmacists are there?

19 A. In Ashley's section, there are currently three.

20 Q. Do you know the names of any of those people?

21 A. Yes. Jessica Forbes, Kelly Rubin, Susan
22 Williams.

23 Q. Are you familiar with a person named Nai Chen?

24 A. Yes.

25 Q. And who is his supervisor?

1 A. D.D. Pickle.

2 Q. And was Mr. Chen ever involved in the pharmacy
3 policy? Did Mr. Chen ever work for the pharmacy policy
4 unit?

5 A. No.

6 Q. How long has Mr. Chen been in that position?

7 A. I don't remember.

8 Q. More than a year?

9 A. Yes.

10 Q. More than two years?

11 A. I'm not sure.

12 Q. Okay. Does Mr. Chen in his position have any
13 responsibilities over pharmacy coverage policies?

14 A. None that are currently promulgated.

15 Q. What about policies that are not promulgated?

16 A. I don't know if there's going to be the need
17 for a coverage policy or what types of administrative
18 rule we're going to need to implement the Canadian
19 Prescription Drug Importation Program once that's
20 federally approved -- which is why I answered how I did.

21 Q. Are there any other pharmacy related activities
22 that Mr. Chen engaged in the past year?

23 A. Yes.

24 Q. What are those?

25 A. His -- he's part of the Canadian Prescription

1 Drug Importation Program team. And there has been
2 pharmacy related activity regarding the SIP approval.

3 Q. What does SIP stand for? Or you can just
4 describe it if that's easier.

5 A. It's the proposal or the importation program
6 plan that the federal government authorized states to
7 submit or request approval of in order to develop an
8 importation program. And this was submitted to the FDA.

9 Q. What does the Canadian Prescription Drug
10 Importation unit do?

11 A. Their primary responsibility is to implement
12 the Canadian Prescription Drug Importation Program that
13 was statutorily authorized -- and I think it was in
14 2019 -- which includes seeking that federal approval
15 from the FDA and any implementation activities in
16 managing the contract with LifeScience Logistics -- the
17 agency's vendor who assists with that program.

18 Q. And did Mr. Chen over the past year have any
19 responsibilities related to pharmacy activities that did
20 not involve the Canadian Prescription Drug Importation
21 Program?

22 A. Yes.

23 Q. And what were those?

24 A. I can't recall all the specific assignments.
25 But he has helped with several research projects. I

1 think he has assisted Ashley's team with some questions
2 or answering questions. And he's been available to
3 assist with just different research projects.

4 Q. Was he involved at all with the categorical
5 exclusion of treatment for gender dysphoria in
6 developing the pharmacy coverage decisions related to
7 that?

8 A. So when you ask that, you're specifically
9 talking about the rule?

10 Q. I'm talking about the rule and the ways in
11 which AHCA is implementing the rule.

12 A. I don't know to the extent -- I know that he
13 assisted with research for the GAPMS report.

14 Q. Okay. And by GAPMS report, is that the report
15 that is related to the categorical exclusion for
16 treatment of gender dysphoria?

17 A. Yes.

18 Q. Why did Mr. Chen assist the pharmacy unit with
19 the GAPMS report instead of the other pharmacists in the
20 pharmacy policy unit? I'll strike that.

21 Why did Mr. Chen -- does the Canadian
22 Prescription Drug Importation unit focus on pharmacy
23 policies unrelated to the Canadian Prescription Drug
24 Importation Program typically?

25 A. Since there's been such a long delay with the

1 federal approval of the Canadian Prescription Drug
2 Importation Program, that team has assisted with various
3 other projects within the bureau.

4 Q. Okay. Is that why Mr. Chen assisted with the
5 GAPMS report for the exclusion of the treatment for
6 gender dysphoria?

7 A. Yes.

8 Q. What types of services does AHCA develop
9 coverage policies for? Actually -- I'm sorry; strike
10 that. I apologize.

11 What does the Pharmacy Policy unit do?

12 A. Their job entails a lot of duties. Primarily
13 they host and oversee the PNT and DUR meetings -- public
14 meetings and the boards associated with that. They
15 oversee the coverage policies specific to pharmacy.
16 They assist with any contract language for the managed
17 care contracts for pharmacy. They oversee the contract
18 for our PBM contractor Magellan. Those are the primary
19 duties.

20 Q. What does PBM stand for?

21 A. Pharmacy benefits manager.

22 Q. And what is that?

23 A. PBMs can have various duties. But the contract
24 that I'm referring to is our rebate negotiation
25 contract.

1 Q. Okay. And you said that PBM contract is with
2 Magellan; is that correct?

3 A. Yes.

4 Q. Okay. What's DUR?

5 A. Drug Utilization Review Board.

6 Q. And I think you used one other acronym when you
7 were discussing the public facing pharmacy meetings.

8 A. PNT.

9 Q. And what does that stand for?

10 A. I believe it's pharmaceuticals and
11 therapeutics.

12 Q. Okay. And what is that?

13 A. All the responsibilities of that board are
14 outlined in statute.

15 Q. Okay.

16 A. I can't think off the top of my head. But they
17 meet quarterly. And we host those meetings and schedule
18 them.

19 Q. Okay. A few more questions about Mr. Chen.

20 Is Mr. Chen a pharmacist?

21 A. I believe so.

22 Q. And is he the only pharmacist in the Canadian
23 Prescription Drug Importation Program unit?

24 A. None of the other members of that team are
25 pharmacists.

1 Q. So Mr. Chen is the only one?

2 A. Yes.

3 Q. Okay. Did any other pharmacist assist with the
4 2022 GAPMS relating to exclusion of treatment for gender
5 dysphoria?

6 A. I don't know.

7 Q. What types of services does AHCA develop
8 coverage policies for?

9 A. The coverage policies are -- outline the
10 services that the State covers through the state plan --
11 Medicaid state plan or Medicaid waivers. So those are
12 just any Medicaid related service.

13 Q. Does AHCA develop coverage policies for
14 surgeries?

15 A. Yes.

16 Q. How about for prescription drugs?

17 A. Yes.

18 Q. Does AHCA develop coverage policies for every
19 Medicaid service?

20 A. I don't know.

21 Q. Have you ever had a situation where a Medicaid
22 recipient requests coverage for a service and there is
23 no policy?

24 A. I personally have not, no.

25 Q. Okay. And what process does AHCA use to decide

1 whether to provide coverage of a Medicaid service?

2 A. That really depends on the specifics of what
3 that service is.

4 Q. Does every service have a different process?

5 A. The process could vary based on what the
6 service is that we are determining coverage for.

7 Q. Do you use the same process for developing
8 pharmacy policy coverage?

9 A. I can't speak to the process or approach of the
10 analysts. The process of promulgating the coverage
11 policies into rule is always going to be in accordance
12 with Chapter 120.

13 Q. During your time at AHCA, have you developed --
14 have you been involved in developing or has your team --
15 those you supervise -- been involved in developing new
16 coverage policies to cover services?

17 A. Yes.

18 Q. Can you remember a specific service that you
19 did that for?

20 A. Yes. We are currently in the process with
21 promulgating the iBudget Waiver handbook. And as part
22 of the updates to the handbook, one of those is to
23 develop a new life skills development for Level 4
24 service. As part of that process, we also worked with
25 our federal partners at CMS to get a waiver amendment

1 approved. That's a very recent example of a new service
2 being developed.

3 Q. Do you have an example of a state plan service
4 that you developed coverage for that's under current
5 development?

6 A. Yes. We recently added some Puro Meno products
7 to the DME fee schedule.

8 Q. And so in that instance, did you establish a
9 coverage policy for those specific items of DME?

10 A. We did a coverage determination to determine if
11 and how they could be included as a covered service as
12 part of the DME service.

13 Q. And what is DME?

14 A. Durable medical equipment.

15 Q. And that includes medical supplies?

16 A. Yes.

17 Q. And Puro Meno would be a medical supply?

18 A. Yes.

19 Q. And you, to cover that service, incorporated it
20 onto the fee schedule?

21 A. Yes.

22 Q. Did you do --

23 Okay. How did you assess whether to decide to
24 incorporate Puro Meno into the fee schedule?

25 A. So I can't speak to all the steps that the

1 analyst -- the specific steps that they took. But just
2 speaking overall, determined if we had the legislative
3 and state plan authority to cover it; determined if it
4 was -- if there would be a fiscal impact.

5 And we approach coverage like that example to,
6 you know, try and make sure it's budget neutral since we
7 are -- our coverage is driven by our general
8 appropriations and our state general appropriations act.
9 And then determined if and what types of updates would
10 be needed to any of the Medicaid rules. That's the
11 general process for determining that kind of coverage.

12 Q. So to make a coverage determination you look at
13 your legislative authority -- authority under the state
14 plan -- and you do a fiscal analysis and hope for budget
15 neutrality. You check to see if there's any updates to
16 Medicaid rules. Anything else?

17 A. Making sure that it's an allowable service
18 under Medicaid, as well; which would entail that it
19 meets all federal, state rules and regulations for
20 coverage. But, like I said, all the details of the
21 research that the team does -- I can't speak to exactly
22 everything that they read or looked at.

23 Q. And if in that coverage determination you
24 decide to cover that service, do you then incorporate it
25 into the fee schedule?

1 A. In the example I gave, that's what we did, yes.

2 Q. Are there any situations where you would not
3 incorporate it into the fee schedule?

4 A. Yes.

5 Q. What are those circumstances?

6 A. That would vary depending on what the actual
7 request or coverage benefit is that we're looking.

8 Q. Can you think of an example?

9 A. Yes. Last legislative session, I believe it
10 was, there was a specific language regarding the
11 coverage of human donor milk and milk derivatives for
12 inpatient use. Because it was under inpatient, that is
13 a -- the reimbursement for that is different and isn't
14 included in a fee schedule.

15 Q. Okay. That makes sense.

16 Once this coverage determination is made, do
17 your responsibilities include reviewing that to
18 determine whether to approve the decision?

19 A. Yes.

20 Q. And how do you go about doing that?

21 A. We usually meet with the team. We do a
22 walkthrough, have discussions around the proposal and
23 the recommendation. And then we put together --
24 depending on what the change is, put together a document
25 to get approval from management -- upper management.

1 Q. Does that document have a specific title -- the
2 same title every time?

3 A. No.

4 Q. How would you identify that document?

5 A. So if a fee schedule change was needed, there
6 is a formal routing process for the rule promulgation
7 process that would be routed through management and
8 signed off on.

9 Q. Okay. Are there other documents that would be
10 routed through management to be signed off on?

11 A. Yes.

12 Q. And what are the titles of those documents?

13 A. It depends on the situation. For example, we
14 also have a steering committee at the agency for the
15 division of Medicaid. And we call that a decision point
16 that would be to the steering committee.

17 Q. Okay.

18 A. And the Medicaid director or agency leadership
19 is part of that committee. And so that is also a way
20 for us to get approval.

21 Q. For those coverage determinations that you
22 reviewed and put together in a document for
23 administrative review, who in the administration reviews
24 that document?

25 A. Depends on what that is. So for administrative

1 rule -- that needs to be signed off by several agency
2 leadership; including the general counsel, the agency
3 secretary for a proposed rule. So it would depend on
4 what the final document is who the final signatory would
5 be.

6 Q. Distinct from implementation of the coverage
7 determination, is there a review by the administration
8 of just whether to cover the Medicaid service?

9 A. It depends on what the specific circumstances
10 are.

11 Q. Okay. Can you think of an example of the
12 administration reviewing a determination of whether to
13 cover a service?

14 A. Can you be more specific? So the waiver
15 example I used a while back would be signed to submit
16 the waiver -- the iBudget waiver -- with the changes.
17 That would have been signed by the Medicaid director
18 prior to submission to federal CMS.

19 Q. How long have you been involved in the process
20 of doing coverage determination?

21 A. Since my time at AHCA.

22 Q. Okay. So since -- I'm trying to take notes
23 here. So since August of 2018?

24 A. January of 2018.

25 Q. January of 2018. Thank you.

1 And when you're making coverage determinations,
2 you coordinate with AHCA rules unit if a rule change is
3 needed; is that right?

4 A. Yes.

5 Q. Okay. Under what bureau does the AHCA rules
6 unit fall?

7 A. Under the Bureau of Medicaid Policy.

8 Q. Okay. So under your unit?

9 A. In the bureau.

10 Q. I'm sorry. Under you're bureau?

11 A. Yes.

12 Q. And you coordinate with AHCA's pharmacy policy
13 unit; which falls under your -- the pharmacy policy unit
14 falls under your bureau as well; is that right?

15 A. Yes.

16 Q. Okay. Do you coordinate with other bureaus in
17 developing coverage determinations?

18 A. Yes.

19 Q. Which ones?

20 A. All the bureaus in the division work closely
21 together. And there have been some recent changes with
22 that structure. But speaking prior to those changes,
23 the Bureau of Medicaid Program Finance would be probably
24 be the primary bureau; because they assist with
25 determining or setting our fee schedules and our rates

1 and the methodologies and doing fiscal impact
2 analyses -- data analytics -- Medicaid data analytics.

3 As part of the whole development package, we
4 talk to all the bureaus because plan management
5 operations can be affected if there is an update to the
6 contracts. The Bureau of Medicaid Quality who monitors
7 and oversees the provision of services through those
8 contracts -- and they have various other duties. But
9 depending on what the change is, we would communicate
10 with most of the bureaus within the division.

11 Q. Okay. You just mentioned some recent changes
12 in terms of that structure. What are those recent
13 changes?

14 A. The Bureau of Medicaid Finance and Medicaid
15 Data Analytics are reporting directly to Tom. And Plan
16 Management Operations, Quality, and Policy are reporting
17 directly to Brian Meyer.

18 Q. And why is that a change?

19 A. Previously I had been reporting directly to Tom
20 Wallace.

21 Q. Is Brian Meyer's position a new one?

22 A. I don't know all the details of those changes.

23 Q. Okay. Who made the decision to make those
24 changes?

25 A. I don't know.

1 Q. Okay. Who oversees the rules unit?

2 A. Cole Giering is program administrator of the
3 rules unit.

4 Q. How long has he been in that position?

5 A. I'm not sure exactly. But it was since I've
6 been bureau chief.

7 Q. Okay. So --

8 A. August of 2021.

9 Q. Thank you.

10 Do you coordinate -- in making coverage
11 determinations, do you coordinate with the chief medical
12 officer for AHCA?

13 A. Yes.

14 Q. Who is that?

15 A. Dr. Christopher Cogal.

16 Q. Can you describe how you coordinate with him,
17 what that process looks like.

18 A. Again, it really depends on the specific
19 question or policy we're reviewing. But it would
20 consist of meetings or discussions.

21 Q. What types of things would you discuss?

22 A. So, for example -- I'm going to go back to the
23 two examples of recent activity. So he wasn't involved
24 in the iBudget Waiver changes at all. But for the human
25 donor milk, he assisted when we had originally done the

1 legislative bill analysis when the legislation was first
2 proposed. And so for the development of how to
3 implement the changes, he was consulted. I don't know
4 the specific conversation, but I do know that he was
5 involved in that process.

6 Q. On what kind of expertise do you rely on him
7 for? What kind of input does he provide in the process?
8 Is it medical in nature?

9 A. I don't know.

10 Q. Okay.

11 A. To the extent -- I know he's an available
12 resource for the team. But I don't know to the extent
13 that -- of his involvement.

14 Q. When he gets involved, is it through a formal
15 process? Or is it just a decision to reach out and ask
16 him for advice? How would you characterize it?

17 A. From my experience at the bureau level, it's
18 been more informal. I know that there have been -- he's
19 been formally asked to review bill analysis or -- but
20 how that process works, I don't know.

21 Q. Okay. Are there people under you who are more
22 likely to communicate with Dr. Cogal?

23 A. I believe there's staff that communicate with
24 him more than others, yes.

25 Q. What staff are those?

1 A. Ashley Peterson has been meeting with him on
2 some projects lately. Again, it really depends on the
3 project. But we are working with him on continuous
4 glucose monitoring -- questions around coverage there.
5 And Jesse Bottcher and his team.

6 Q. When you say Jesse Bottcher and his team, would
7 that include the GAPMS process?

8 A. His team is responsible for it.

9 Q. In coordinating with Dr. Cogal -- in the
10 coordination between Mr. Bottcher's team and Dr. Cogal,
11 would that include the GAPMS process?

12 A. I don't know the extent to which he is involved
13 in that.

14 Q. Okay. To your knowledge, has he ever been
15 involved in that?

16 A. I don't know specifically.

17 Q. Have you and Dr. Cogal and anyone from
18 Mr. Bottcher's team ever met to discuss the GAPMS
19 process?

20 A. The process, yes. When I first took the role,
21 we had met to talk through the process. But I can't
22 remember the specific conversation.

23 Q. Okay. Switching gears a bit. When I use the
24 term "Florida Medicaid managed care plan," do you know
25 what it means?

1 A. Yes.

2 Q. What does that term mean?

3 A. Those are the managed care plans that the
4 agency contracts with to provide the services through
5 the managed care delivery model.

6 Q. Do Medicaid managed care plans have their own
7 coverage policies?

8 A. The agency's coverage policies are incorporated
9 into the managed care plan contracts by reference. And
10 there are requirements outlined in the contract with how
11 the managed care plans have to provide services.

12 Q. Are you aware of managed care plans having
13 their own policies that incorporate Florida Medicaid's
14 policies?

15 A. I don't know.

16 Q. Have you ever seen a copy of a Florida Medicare
17 managed care plan document that discusses the coverage
18 of a Florida Medicaid service?

19 A. I reviewed the plans' member handbooks or
20 enrollee handbooks. And I've seen their resources
21 available on their websites that weigh out what they
22 cover. I can't remember if I've ever seen an official
23 document titled "Coverage Policy."

24 Q. So my question is: Have you ever seen a
25 document from a Medicaid managed care plan -- formal or

1 informal, it doesn't matter -- with information that
2 contains the criteria used to determine if Florida
3 Medicaid will cover a service?

4 A. I believe that information is in the handbooks.
5 But I can't recall any specific documents drafted by the
6 plans.

7 Q. What unit would be responsible for
8 communicating with managed care plans about their
9 coverage of Florida Medicaid services?

10 A. That would depend if they had a question for
11 the agency on the agency's coverage of a covered service
12 or a contractually required service. Those most likely
13 would be sent to Medicaid policy.

14 Q. Okay.

15 A. To review.

16 MS. DEBRIERE: Okay. Yes. Definitely. Just a
17 couple more questions, if that's okay.

18 BY MS. DEBRIERE:

19 Q. Are you okay Ms. Dalton?

20 A. Yes.

21 Q. Who would review those questions? Who
22 specific -- like, what specific individuals?

23 A. It would depend on what the question was.

24 Q. Okay. If the managed care plan doesn't have a
25 question, is there any process that exists that just

1 involves overseeing whether a Medicaid managed care plan
2 is covering a Florida Medicaid service?

3 A. The Bureau of Plan Management Operations is the
4 bureau that oversees the adherence to the contract. All
5 the contract managers for the individual plans are
6 housed there. So if it was a compliance question on if
7 the managed care plan was following the requirements in
8 the contract, that would be Plan Management Operations
9 most likely who would be the first point of contact for
10 the plans.

11 Q. Okay. Can MCOs create their own guidelines for
12 implementing AHCA coverage policies?

13 A. I don't know.

14 Q. Who would know that?

15 A. It would be in the contracts.

16 Q. Okay.

17 A. The parameters around what their materials are
18 allowed to contain and if the materials have to be
19 reviewed and approved by the agency.

20 Q. Okay. And that would be the Bureau of Planned
21 Management Operations who does that -- takes on that
22 role? And if not, then who?

23 A. I believe it would depend on what the materials
24 being reviewed are. Just like with reporting -- there
25 are different report owners in different bureaus within

1 the division of Medicaid that review compliance with
2 the -- the plan's compliance with the contracts. But
3 the first point of contact for submitting those
4 materials and making sure that they're submitted would
5 be through Plan Management Operations.

6 Q. And who is that bureau chief? Remind me.

7 A. Pam Hall.

8 Q. Okay. One last question. Are you aware that
9 MCOs have their own guidelines for specific types of
10 Medicaid services?

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

12 Q. Do you know who would know?

13 A. Are you asking if it's a required -- or if
14 they're allowed to --

15 Q. No. I'm just asking if you're aware. So are
16 you aware that they have their own --

17 MR. PERKO: Asked and answered.

18 MS. DEBRIERE: -- criteria guidelines?

19 THE WITNESS: I would have to review the
20 contract.

21 BY MS. DEBRIERE:

22 Q. Okay. So is that a no, you are not aware as we
23 sit here today without having anything in front of you?

24 A. Correct. I don't know without seeing a
25 specific example or reviewing the contract.

1 Q. Okay. Do you want to take a break?

2 A. Yes.

3 (Brief recess.)

4 BY MS. DEBRIERE:

5 Q. Ms. Dalton, just briefly -- when we took a
6 break, did you discuss this deposition with anyone?

7 A. No.

8 Q. Did you discuss it with your attorneys?

9 A. Just briefly.

10 Q. Okay. When I use the term "quality improvement
11 organizations" or QIOs, do you know what I mean?

12 A. Yes.

13 Q. What does that term mean?

14 A. Quality improvement organization.

15 Q. Yeah. Is eQHealth a QIO?

16 A. Yes.

17 Q. And what do they do?

18 A. I don't know the whole scope. But their main
19 function in their contract with the agency is the -- to
20 do prior authorization for fee for service services.

21 Q. Okay. What does prior authorization mean?

22 A. It's a utilization management tool to ensure
23 that the services are in their scope, authorized, and
24 appropriate.

25 Q. By "appropriate," what do you mean?

1 A. That the service that's being requested is
2 allowable and delivered within the parameters of the
3 Medicaid program.

4 Q. Who makes the request for prior authorization?

5 A. I don't know the details of how the process
6 works.

7 Q. Okay. By parameters, do you mean the
8 parameters set by AHCA's coverage policies?

9 A. Yes. And administrative rule.

10 Q. Okay. Is administrative rule distinct from a
11 coverage policy?

12 A. Yes. Not all of the administrative rules
13 incorporate a coverage policy by reference.

14 Q. Okay. So an example of that would be the
15 definition of medical necessity -- would be an
16 administrative rule that sets out the parameters for
17 coverage but does not include a specific coverage
18 policy?

19 A. The definition of medical necessity is actually
20 in the definitions policy -- which is a document
21 incorporated by reference into the text of the
22 administrative rule.

23 Q. Okay. Do QIOs like eQHealth -- do they have
24 their own coverage criteria they rely on?

25 A. Yes.

1 Q. Do you coordinate with QIOs regarding those
2 coverage criteria?

3 A. I personally do not.

4 Q. Does anybody on your team?

5 A. The eQHealth contract is housed in the Bureau
6 of Medicaid Quality.

7 Q. Okay.

8 A. So they would be a lead in managing of that
9 contract and communicating with the vendor. But I do
10 know that we have communicated with them in the past --
11 the Bureau of Medicaid Policy has.

12 Q. What types of things have you communicated
13 about in the past?

14 A. The first example that comes to mind is
15 recently the agency opened the definitions rule policy
16 and did communicate that that rule was being opened with
17 eQHealth.

18 Q. Okay. Are MCOs and QIOs bound by AHCA's
19 coverage policies?

20 MR. PERKO: I'm going to object to form.
21 You can answer.

22 THE WITNESS: As I stated before, the contract
23 for the managed care plans incorporates the coverage
24 policies by reference. And the plans are not
25 allowed to be more restrictive than the coverage

1 policies. I don't know the specific language off
2 the top of my head with the requirements of how they
3 adhere to the policies. But that is in the
4 contract.

5 BY MS. DEBRIERE:

6 Q. Okay. So the MCO's obligation to adhere to
7 AHCA's coverage policies is set forth in the contract?

8 A. Yes.

9 Q. Okay. What about QIOs?

10 A. I don't know the specific language off the top
11 of my head. But that information is also in the
12 contracts on how the managed care plans' contracted QIO
13 vendors are expected to operate.

14 Q. Okay. Is there a formal approval process for
15 the QIO's coverage criteria?

16 A. I don't know.

17 Q. Is Magellan a QIO?

18 A. I don't know.

19 Q. Okay. Does Magellan conduct prior
20 authorization of Florida Medicaid services?

21 A. I don't know.

22 Q. Does Magellan review the request of a Medicaid
23 recipient to authorize prescription drug services in the
24 Fee for Service program?

25 A. I don't know.

1 Q. Do you know what -- do you know if Magellan
2 plays any role in determining coverage of pharmacy
3 services under Florida Medicaid?

4 A. I believe the agency has a contract with them
5 to adjudicate the claims. But I don't know the scope of
6 that contract.

7 Q. What do you mean by adjudicate the claims?

8 A. I don't know the whole scope of that process or
9 the contract.

10 Q. When you just use that phrase, what did you
11 mean by that?

12 A. That they're involved in the reimbursement
13 process.

14 Q. Okay. And would the reimbursement process
15 involve determining the eligibility for the service
16 itself?

17 A. I don't know the extent of that process.

18 Q. Would anybody at AHCA know or be able to answer
19 that question?

20 A. I don't know.

21 Q. Moving back to coverage determinations
22 undertaken by your bureau, who is the final
23 decisionmaker as to whether AHCA will adopt that
24 coverage determination?

25 A. Can you repeat the question.

1 Q. So earlier we were talking about your bureau
2 undertaking coverage determinations of Florida Medicaid
3 services; correct?

4 A. Yes.

5 Q. Who is -- before AHCA or anyone at AHCA can act
6 on that determination, who is the final decisionmaker?

7 A. Again, it depends on the circumstances. And I
8 can only speak to the signatory of who needs to be -- to
9 officially sign off. But the example I used before for
10 a federal authority submission, that would be whoever
11 was designated from the agency as the Medicaid director
12 or the Medicaid state plan approver.

13 Q. Okay.

14 A. And then administrative rule to actually
15 complete the promulgation process. That's actually
16 signed off by the head of the agency, which here would
17 be our secretary.

18 Q. Okay. When coverage policies are promulgated,
19 are there multiple drafts of those policies? Are there
20 ever multiple drafts of those policies?

21 A. Can you repeat the question.

22 Q. When you're developing a coverage policy, are
23 there multiple drafts?

24 A. It would it depend on what the change was.

25 Q. So there are times when coverage policies have

1 multiple drafts?

2 A. Yes.

3 Q. And how do you track any changes to those
4 policies during the drafting process?

5 A. So specific to the coverage policy, we
6 typically use a document called a revisions template;
7 which tracks the changes being proposed.

8 Q. Okay. Is there a limit to the people who can
9 make changes to the revisions document?

10 I'm sorry; the revision just tracks who has
11 made the changes; is that right?

12 A. So it tracks what the old policy said, what the
13 new changes are, if there's a reason for the change.
14 I'm not sure if it includes who the requester of the
15 change is.

16 Q. Okay. Does it record who is making the change?

17 A. I can't recall if that's on the template.

18 Q. Is anybody at AHCA allowed to make a change?

19 A. So for most of the coverage policies, there's a
20 subject matter expert assigned to that program area who
21 any changes would filter through. And then they have to
22 work with the rules unit who is actually making the
23 changes to the coverage policy and promulgating that
24 through the rulemaking process.

25 Q. Okay. Just switching quickly to some specific

1 Medicaid services. Are coverage policies regarding
2 surgery adopted into rule?

3 A. Yes.

4 Q. And are they in handbooks or a handbook?

5 A. I don't believe it's one specific handbook.

6 Q. Do you remember the names of any of the
7 handbooks they are contained in?

8 A. We have a transplant services coverage policy.

9 Q. Okay.

10 A. Which I would consider inclusive of surgical.
11 We have an inpatient services coverage policy. Without
12 seeing the list of policies, I can't recall off the top
13 of my head.

14 Q. Give me one second.

15 Would coverage policies about surgeries be in
16 the Ambulatory and Surgical Center Services Policy?

17 A. I don't know the content of that policy off the
18 top of my head.

19 Q. Okay. You said inpatient hospital services
20 would contain surgery policies?

21 A. I don't know all the content in the policy
22 without looking at it. But it...

23 Q. If it mentions surgery in the handbook, is it
24 going to have a coverage policy related to it?

25 How would you know if a handbook covered

1 surgery or contained a surgery coverage policy in it?

2 A. I would have to read the handbook. Depending
3 on what the specific question was, what type of surgery.

4 Q. Okay. What about prescription drug coverage
5 policies? Are those adopted into rule?

6 A. I believe there is a rule specific to pharmacy
7 policies and prescription drugs, yes.

8 Q. Okay. And then I'm just going to flip my
9 computer around here and go to this page. We're looking
10 at what's titled Agency for Health Care Administration
11 Drug Criteria.

12 AHCA.myFlorida.com/Medicaid/prescribed_drug_criteria.
13 shtml.

14 And I assume, Ms. Dalton, I'm seeing here --
15 are you just seeing a list of drug criteria?

16 A. Yes.

17 Q. Is this an exhaustive list of the drug criteria
18 that AHCA relies on?

19 A. I don't know.

20 Q. Who would know that?

21 A. Ashley Peterson and her team may be able to
22 confirm.

23 Q. Okay. And why wouldn't this be an exhaustive
24 list?

25 MR. PERKO: Object to form.

1 THE WITNESS: I'm not personally very familiar
2 with this page.

3 MR. PERKO: Counsel, for the record, can we
4 read the URL.

5 MS. DEBRIERE: Absolutely. Well, I think I --
6 Gary, do I not know what a URL is?

7 MR. PERKO: The website address.

8 MS. DEBRIERE: So I think we read most of it.
9 But I can start with
10 [https://AHCA.myFlorida.com/Medicaid/prescribed_drug/](https://AHCA.myFlorida.com/Medicaid/prescribed_drug/drug_criteria.shtml)
11 [drug_criteria.shtml](https://AHCA.myFlorida.com/Medicaid/prescribed_drug/drug_criteria.shtml).

12 MR. PERKO: Thank you.

13 MS. DEBRIERE: Absolutely.

14 BY MS. DEBRIERE:

15 Q. Do you know what categorical exclusion means?

16 MR. PERKO: I'm going to object to form. I
17 guess I'm a bit confused, Counsel. You already
18 defined what categorical exclusion means at the
19 beginning of this deposition.

20 MS. DEBRIERE: Well, that's categorical
21 exclusion -- you're right, Counsel. It contained
22 the statement "categorical exclusion"; just
23 categorical exclusion of a very specific set of
24 services. The treatment for --

25 MR. PERKO: That wasn't the definition at the

1 beginning. But go ahead.

2 BY MS. DEBRIERE:

3 Q. How about this, Ms. Dalton: Can you provide an
4 example of a categorical exclusion under Medicaid?

5 A. I can't think of an example. I'm familiar with
6 the term. I cannot think of an example.

7 Q. Okay. I'm trying to think of one too.
8 Does AHCA -- does Florida Medicaid cover
9 private duty nursing service for individuals over the
10 age of 21?

11 A. Not through the state plan.

12 Q. Okay. Do they cover it through home and
13 community based services with a Medicaid waiver?

14 A. Yes.

15 Q. Okay. And if Florida Medicaid does not cover
16 private duty nursing services for individuals over 21
17 under the Medicaid state plan, is that a categorical
18 exclusion?

19 A. Yes.

20 Q. And does the agency categorically exclude any
21 Medicaid service for beneficiaries under the age of 21?

22 A. Can you repeat the question.

23 Q. I'm sorry. Bear with me one second,
24 Ms. Dalton. I'll come back to that.

25 Do your responsibilities include ensuring that

1 coverage policies meet the standards under EPSDT?

2 A. The Bureau of Medicaid Policy doesn't oversee
3 the monitoring of the adherence to the policies or the
4 provision of services. In terms of ensuring that the
5 policy language complies with the federal EPSDT
6 requirements, yes.

7 Q. And how do you ensure that compliance when
8 developing coverage policies?

9 A. It depends on the specific coverage policy.
10 But the majority of the service specific coverage
11 policies include language incorporating EPSDT by
12 reference and language from the federal regulation.

13 Q. Generally speaking, what is that EPSDT
14 requirement?

15 A. That the State must provide all medically
16 necessary services to children ages under 21.

17 Q. Does the State have to provide a service under
18 EPSDT to a Medicaid recipient under 21 if that service
19 is experimental?

20 MR. PERKO: Object to form.

21 BY MS. DEBRIERE:

22 Q. Do you know what I mean when I say
23 experimental?

24 A. Yes.

25 Q. So same question. Does the State have to

1 provide coverage to children under age 21 if that health
2 service is considered experimental?

3 MR. PERKO: Object to form.

4 THE WITNESS: The State is allowed to develop
5 its own definition of medically necessary or medical
6 necessity; which Florida has done and promulgated in
7 administrative rule. And part of that definition
8 does include the parameters by which a service would
9 not be determined medically necessary; and,
10 therefore, not required under the EPSDT.

11 BY MS. DEBRIERE:

12 Q. Okay. And that definition of medical necessity
13 includes the requirement that the service not be
14 experimental; correct?

15 A. I cannot recall the exact definition off the
16 top of my head. But that is in -- promulgated in the
17 definition coverage policy.

18 Q. When you say that is --

19 A. The definition of medical necessity.

20 MS. DEBRIERE: Okay. We can mark -- I have a
21 copy of the rule so you can reference it. We can
22 mark that as Exhibit 3. And that's 59G-1.010.

23 We might have forgotten to put a copy in. If
24 we did, it's my fault.

25 MS. DUNN: I have a copy right here.

1 (Plaintiff's Exhibit No. 3 was marked for
2 identification.)

3 MS. DUNN: Yeah. It's right there. Last
4 definition on that page.

5 THE WITNESS: It doesn't seem to be the
6 whole --

7 MS. DUNN: It's not.

8 MS. DEBRIERE: It's not. We ended it at "N,"
9 because it's a very large coverage policy and we are
10 trying to save some trees.

11 BY MS. DEBRIERE:

12 Q. So if you look at the definition of "medically
13 necessary" or "medical necessity," does that contain a
14 requirement that the service not be experimental?

15 A. Yes.

16 Q. And so under EPSDT, can the agency deny a
17 medical service to a child under 21 if they deem it to
18 be experimental?

19 A. Yes.

20 Q. Okay. Who is responsible for compliance with
21 EPSDT? Is it a specific person?

22 A. I don't know who is responsible.

23 Q. Is it someone within your bureau regarding
24 EPSDT as it relates to the development of coverage
25 policies?

1 A. There isn't a specific person in my bureau, no.

2 Q. Are there any written guidelines about ensuring
3 compliance with EPSDT with developing coverage policies?

4 A. Can you repeat.

5 Q. Are there any written guidelines relied on to
6 determine whether a coverage policy complies with EPSDT,
7 other than that contained in the Federal Medicaid Act?

8 A. I don't know specific -- all the specific
9 documents that the analysts rely on when developing the
10 coverage policy. But as part of that process, the
11 expectation is to review the federal guidelines and
12 statute and other rules and regulations of governing the
13 Medicaid program to ensure that the coverage policy
14 adheres to the Medicaid program federally and state.

15 Q. And that's an expectation of the staff within
16 your bureau?

17 A. Yes. It's the common practice when approaching
18 research regarding changes to the policy -- a policy.

19 Q. Okay. When I use the term "comparability," do
20 you know what I mean as it's laid out in regulations
21 implemented in the Federal Medicaid Act?

22 A. You may have to give me some more context.

23 Q. So under the Federal Medicaid Act, there is a
24 requirement that state agencies who administer Medicaid
25 do so in a way that all Medicaid recipients receive

1 comparable services. Are you familiar with that
2 requirement?

3 A. Vaguely sounds familiar.

4 Q. Is your bureau required to be familiar with
5 that requirement in developing coverage policies?

6 A. I can't speak to that without more information.

7 Q. Okay. Is there anyone who can speak to the
8 requirement -- is there anyone who can speak to ensuring
9 that the policy comply with comparability under the
10 Federal Medicaid Act?

11 A. So, again, I think it really would depend on
12 what the specific question is regarding or which
13 specific coverage policy. As I said before, a lot of
14 the coverage policies have a specific subject matter
15 expert with knowledge of that service area. So it just
16 really would depend.

17 Q. Okay. I'm just going to make myself a note.
18 What is the purpose -- turning back to Exhibit
19 3 and the definition of medical necessity -- what's the
20 purpose of AHCA's medical necessity standard?

21 MR. PERKO: Object to form.

22 BY MS. DEBRIERE:

23 Q. Does AHCA's medical necessity standard have a
24 purpose?

25 MR. PERKO: Object to form.

1 THE WITNESS: I don't know what you mean.

2 BY MS. DEBRIERE:

3 Q. What is the purpose of the definition of
4 medical necessity?

5 MR. PERKO: Object to form.

6 BY MS. DEBRIERE:

7 Q. What do you use it for?

8 A. The definition is relied on a lot. Most of the
9 service specific coverage policies refer and incorporate
10 by reference the definitions policy and make a statement
11 that the service must be medically necessary as part of
12 the requirement for reimbursement.

13 Q. If a Medicaid recipient makes a request for a
14 Medicaid service, in order for that service to be
15 authorized, does it have to be medically necessary?

16 A. Yes.

17 Q. Do managed care plans rely on AHCA's medical
18 necessity standard in their prior authorization process?

19 A. I can't recall the exact contract language.
20 But, yes.

21 Q. And what about QIOs?

22 A. I don't know.

23 Q. Regardless of the method in which Medicaid is
24 delivering the service -- fee for service or managed
25 care -- in order for that service to be authorized, does

1 it have to be medically necessary?

2 A. I don't know the details of the actual
3 authorization process. I do know that the expectation
4 from policy prospective is that the services have to be
5 provided in accordance with the agency's coverage
6 policies and administrative rules.

7 Q. And that includes the definition of medical
8 necessity?

9 A. Yes.

10 Q. If AHCA finds that a Medicaid service is
11 experimental, would AHCA or a contractor or managed care
12 plan still review whether service meets other portions
13 of AHCA's medical necessity definition?

14 A. I don't know the extent of their review.

15 Q. What about your review at AHCA for fee service?

16 A. Again, I don't know eQHealth or QIO vendors'
17 process.

18 Q. Do all Florida Medicaid services require prior
19 authorization?

20 A. I don't know. I don't believe so.

21 MS. DEBRIERE: Okay. Can I have what we'll
22 mark as Exhibit 4, which is the GAPMS Report on
23 Cross-Sex Hormone Therapy, dated May -- I believe we
24 did the May version.

25 So what I'm showing you is Bates stamped

1 beginning at Defendant 00126105. I should pull out
2 my own copy.

3 And that continues through, Court Reporter --
4 this one is not Bates stamped. It's weird. This
5 one doesn't have a copy. This copy is not Bates
6 stamped. But it is entitled Cross-Sex Hormone
7 Therapy GAPMS Determination Report With
8 Recommendation.

9 That's very odd. Very odd. I don't think it's
10 a huge deal.

11 (Plaintiff's Exhibit No. 4 was marked for
12 identification.)

13 BY MS. DEBRIERE:

14 Q. So on the last two pages, Ms. Dalton, starting
15 at "Coverage policy" -- and it starts, "Federal
16 regulations."

17 "Federal regulations for Medicaid..." and
18 continues on through the definition of medical
19 necessity --

20 MR. PERKO: Can you give a page number.

21 MS. DEBRIERE: Oh, yes. Thank you, Gary.

22 So page 8, 9, and a tiny bit of the top of 10.

23 THE WITNESS: I'm there.

24 BY MS. DEBRIERE:

25 Q. Take all the time you need to read it. And

1 afterwards, if you can tell me if this is an accurate
2 portrayal of the standard used to determine Florida
3 Medicaid coverage for prescription drugs.

4 MR. PERKO: Do you have another copy?

5 Thank you.

6 BY MS. DEBRIERE:

7 Q. I think it starts at the top of page 8 --
8 middle of page 8. So reviewing that standard, is that
9 what's used to determine whether Florida Medicaid will
10 cover a prescription drug?

11 A. Can you direct me more to where you're
12 referring. I read both pages 8 and 9, and I don't think
13 I can speak to the specifics of all this information.

14 Q. Okay. When reviewing whether to cover a
15 prescription drug, does AHCA look at -- here on page 8
16 it says AHCA is -- "The program is required to asses
17 data on drug use against predetermined standards
18 consistent with the following compendia." And then it
19 lists three types of compendia and the peer reviewed
20 medical literature. Is that an accurate statement of
21 AHCA policy?

22 A. I don't know.

23 Q. Who would know that?

24 A. I don't know if I can speak for them. But I
25 would ask one of the pharmacists.

1 Q. Would you ask Ashley Peterson? Or would you
2 ask one of the pharmacists that works under her?

3 A. I specifically would go to Ashley, as she's my
4 direct report. And then she would research the question
5 for me.

6 Q. Okay. Would research involve asking one of her
7 pharmacists?

8 A. I don't know. I can't speak for her process.

9 Q. So going to page 9, top of the page says, "In
10 order to be reimbursed by Medicaid, a drug must be
11 medically necessary."

12 Is that the same as the definition contained in
13 the 59G-1.010 that we just reviewed -- Exhibit 3?

14 A. I don't understand what you mean by the same.

15 Q. Does medically necessary mean the same as the
16 definition in the definitions policy?

17 A. I would think so.

18 Q. Okay. And it is, "Either prescribed for
19 medically accepted indications and dosages found in the
20 drug labeling or drug compendia in the Medicaid Act or
21 prior authorized by a qualified clinical specialist
22 approved by that agency."

23 Is this an accurate recitation of the standard
24 AHCA uses to authorize prescription drug coverage?

25 A. I don't know.

1 Q. Would Ashley Peterson know that information --
2 her or her team?

3 A. I would think so, yes.

4 Q. Okay. The next thing it says, "The criteria
5 that are utilized under the Florida Medicaid program in
6 the authorization of drugs for off-label purposes are as
7 follows." And then it lists three criteria.

8 Reading over that statement, are these
9 currently the criteria AHCA uses in authorizing drugs
10 for off label purposes?

11 A. Again, I don't know.

12 Q. Would Ashley Peterson know the answer to that
13 question?

14 A. I would think her team would, yes.

15 Q. Is this the type of information -- looking at
16 this, is this the type of information that would be
17 contained in a coverage policy adopted in rule?

18 A. I'm not sure.

19 Q. Why aren't you sure? What's throwing you about
20 it?

21 A. I don't know the content of the rules off the
22 top of my head.

23 Q. But I think my question is a little different.
24 So does this appear to be the type of information that
25 would be contained in a coverage policy adopted into

1 rule?

2 A. I can't speak to that. I don't know because of
3 the reason I stated. I will say the coverage policies
4 traditionally do not repeat regulation or requirements
5 or information that are found elsewhere; for example, in
6 Florida statute or in federal regulation. And each
7 coverage policy is structured somewhat similarly, but
8 does contain very different information. So I don't
9 know if this is information that's found off the top of
10 my head in one of our policies.

11 Q. Okay. I think you -- do all prescription drugs
12 require prior authorization to be reimbursed by
13 Medicaid?

14 A. I don't know.

15 Q. Who would know that?

16 A. I would think Ashley Peterson and her team. Or
17 it might be available on the information on our website
18 regarding pharmacy policy and authorization criteria.

19 Q. Okay. So Ms. Peterson would be familiar with
20 authorization criteria for prescription drugs?

21 A. Yes. Or she would know where to look.

22 Q. Okay. Specifically related to pharmacy
23 coverage policies, how are they developed?

24 A. The coverage of the pharmacy services is a
25 little different than the other coverage policies. I

1 don't know all the details that go from the analysts
2 into the developments. But because there is different
3 statutory requirements -- Florida statutory requirements
4 around pharmacy services, including the PNT and DUR
5 board -- the process for overseeing the coverage of
6 pharmacy services is a little different.

7 Q. In reviewing whether a prescription drug
8 requires a coverage policy -- strike that.

9 Do you use the GAPMS process to determine
10 pharmacy coverage -- to determine whether coverage of a
11 prescription drug is experimental?

12 A. I don't know specifically for determining if a
13 prescription drug is experimental. I don't know.

14 Q. When you develop coverage policies in your
15 bureau, does that include a determination as to whether
16 a service is experimental?

17 A. So the coverage policies are drafted specific
18 to the covered services that we've been approved to
19 provide.

20 Q. Okay.

21 A. By the federal government. So that is the
22 driving factor on how we would initially approach the
23 coverage and organize or draft a coverage policy
24 asserting a service that we are authorized to provide.

25 Q. So separate and apart from developing coverage

1 policies, the responsibilities of your bureau also
2 include determining whether a service is experimental;
3 is that correct?

4 A. So that would be part of the GAPMS process that
5 is outlined in administrative rule.

6 Q. Okay. Do you use the GAPMS process for
7 prescription drugs?

8 A. Without researching or consulting others on the
9 team for a specific example, I don't know the interplay
10 between the different authorities and how that works.

11 Q. Which team is responsible for the GAPMS
12 process?

13 A. That position is within the Medicaid -- Bureau
14 of Medicaid Policy.

15 Q. Earlier speaking about teams under the bureau,
16 which teams is responsible for the GAPMS process?

17 A. Jesse Bottcher is the manager over the position
18 that is primarily responsible for the GAPMS process.

19 Q. Are there any other teams that are primarily
20 responsible for the GAPMS process? Or is it only
21 Jesse's team?

22 A. So in terms of listing that as a primary
23 responsibility on a job description, that would be
24 Jesse's team.

25 Q. Should the people on Jesse's team be aware of

1 every GAPMS process that's undertaken?

2 MR. PERKO: I'm going to object to form.

3 You can answer.

4 THE WITNESS: So as the bureau chief of Policy,
5 I do try to keep staff within the bureau aware of
6 everything that's happening within the bureau --
7 especially when a determination has been made.
8 Jesse's team would definitely need to be aware,
9 because there could be potential impacts with a
10 specific service coverage policy. But I do think
11 every circumstance is different. So I can't say
12 just in a general statement to your question.

13 BY MS. DEBRIERE:

14 Q. Would it be typical for Jesse's team to not be
15 aware of a GAPMS report being developed?

16 A. I can't say if it would be typical. I have not
17 overseen very many GAPMS in my time as bureau chief.

18 Q. So as the bureau chief with Jesse's team being
19 primarily responsible for GAPMS, would you as that chief
20 endeavor to ensure that Jesse's team was aware of all
21 GAPMS reports being written?

22 A. Yes. We meet the managers on -- my direct
23 reports and I meet regularly at least twice a week for
24 an hour and discuss projects that are going on with each
25 team and provide updates. So the ongoing bureau

1 activities are regularly discussed with the management
2 team.

3 Q. Okay. Do you know what a drug compendium is?

4 A. I recognize the term, but don't think I can
5 define it.

6 Q. Do you know which compendia are listed in the
7 Federal Medicaid Act?

8 A. No.

9 Q. I'm just going to screen share again. I'm
10 showing right now on my screen -- the URL is
11 [https://AHCA.myFlorida.com/Medicaid/prescribed_drug/
12 pharm_thera/pdf/PDL.pdf](https://AHCA.myFlorida.com/Medicaid/prescribed_drug/pharm_thera/pdf/PDL.pdf). The title of this document is
13 Preferred Drug List, Effective January 21st, 2023.

14 Do you know what the preferred drug list is?

15 A. Yes.

16 Q. What is it?

17 A. It's list of drugs developed that the managed
18 care plans must adhere to. And it has to do with rebate
19 negotiations and is recommended by the PMT committee.

20 Q. Perhaps you just answered this. But who
21 develops the PDL?

22 A. The agency.

23 Q. What is the PMT committee's role in it?

24 A. Per statute, they make recommendations to the
25 agency.

1 Q. Okay. Does the DUR have any role in developing
2 the PDL?

3 A. I don't know. I don't believe so.

4 Q. And this PDL applies to managed care plans; is
5 that correct?

6 A. And fee for service.

7 Q. Okay. So on here -- I'm going to have to do
8 Control+F. Pardon; one second.

9 It's very small. So tell me if you need to
10 make it any bigger.

11 Okay. On here you will see the drug
12 estradiol -- e-s-t-r-a-d-i-o-l -- listed. And there is
13 many versions here starting at it looks like this line
14 continuing all the way down until we hit norethindrone
15 AC. So the fact that estradiol is listed on the PDL, does
16 that mean Florida Medicaid will cover it if the
17 eligibility criteria are met? Excuse me. Scratch that.

18 Since estradiol is listed on this PDL, does it
19 mean that Florida Medicare will cover it?

20 MR. PERKO: Object to form.

21 THE WITNESS: I don't know.

22 BY MS. DEBRIERE:

23 Q. If any drug is listed on the PDL, does that
24 mean Florida Medicaid will cover it?

25 A. I don't know the interplay between the PDL and

1 the other rules and regulations covering pharmacy
2 services.

3 Q. Okay. Over in this column at the top of page,
4 it reads "Clinical PA required." And it also has a
5 column for a minimum and a maximum age. What does
6 clinical PA required mean?

7 A. Operationally, I don't know.

8 Q. Do you know it in any other version?

9 A. I understand the words. But I don't know in
10 the context of the program or the PA process what that
11 means.

12 Q. What does "PA" stand for?

13 A. Prior authorization.

14 Q. Okay. Is it possible that clinical PA -- so if
15 we scroll down to estradiol -- this version with a
16 minimum of an age of zero, maximum age of 999 -- and it
17 says "no" under the column of clinical PA required, do
18 you know what that means?

19 A. No.

20 Q. Who would know that?

21 A. Ashley Peterson and her team are lead on this.

22 Q. Do you know what it means to have a minimum age
23 column? Why that's significant or why it's on there?

24 A. Specific to this document, no.

25 Q. Same with maximum age?

1 A. No, I don't know the reason why it's on there.

2 Q. Since you've been at the agency -- January

3 2018?

4 A. Yes.

5 Q. How many GAPMS processes have you been involved
6 in?

7 A. Two completed. And maybe one or two
8 discussions.

9 Q. How many pending?

10 A. I don't know.

11 Q. Do you know currently how many GAPMS are
12 pending?

13 A. Clarify "pending."

14 Q. Why don't you tell me what you meant by
15 completed.

16 A. Two that have been signed by agency leadership.

17 Q. Okay. And how many reports are in the stage of
18 being written and not yet signed?

19 A. I don't know.

20 Q. To be clear, though, as bureau chief you meet
21 weekly with Jesse Bottcher and his team who are
22 primarily responsible for GAPMS.

23 A. I meet weekly with Jesse Bottcher and my team.

24 Q. Okay.

25 A. I don't regularly meet with the individual

1 teams, but with the managers.

2 Q. When you meet with Jesse, do you discuss GAPMS?

3 A. Not routinely. We have before.

4 Q. What are the other responsibilities of Jesse's
5 team?

6 A. The three managers under Jesse each have units
7 that are responsible for the developments of the service
8 specific coverage policies. His team also oversees the
9 eligibility policy and the provider enrollment policy,
10 updates all the fee schedules -- so works closely with
11 fiscal agent operations to ensure updates are made to
12 the MMIS system and with Medicaid program financing the
13 development of fee schedules. And that's the bulk of
14 their responsibilities.

15 Q. So when you're meeting with Jesse weekly, what
16 are you discussing about his team?

17 A. It depends on what -- the highest priority
18 assignments are usually up first; things that are due
19 that week.

20 Q. Okay. So you do not routinely discuss GAPMS --
21 that was your testimony just a second ago?

22 A. Yes. I wouldn't say that it's a subject that
23 we discuss at every meeting or routinely at our
24 individual meetings, no.

25 Q. And you organize what you discuss based on what

1 has the highest priority?

2 A. Yes, typically.

3 Q. Okay. How familiar with you with the GAPMS
4 process?

5 A. In terms of all the research and everything
6 that goes into developing, I'm not as familiar. But I
7 am familiar with the routing process, the rule, the
8 authority for that process.

9 Q. Okay. So just generally, what does AHCA use
10 the GAPMS process for?

11 A. So if the agency receives a request for
12 coverage -- typically that's how the process would be
13 initiated. If the coverage was determined to not be
14 something that the agency could proceed with -- possibly
15 adding to the fee schedule or incorporating into a
16 service definition -- then the GAPMS process would be
17 used.

18 Q. Okay. How is the GAPMS process initiated?

19 A. I believe it's a rule how to.

20 Q. Would it be helpful if you had the rule in
21 front of you?

22 A. Yes.

23 MS. DEBRIERE: Okay. Let's mark that as
24 Exhibit 5. That's Rule 59G-1.035.

25 (Plaintiff's Exhibit No. 5 was marked for

1 identification.)

2 BY MS. DEBRIERE:

3 Q. So how is GAPMS initiated?

4 A. A request is submitted to the health services
5 research inbox in the Medicaid Policy Bureau.

6 Q. Who can submit a request to that inbox?

7 MR. PERKO: Object to form.

8 THE WITNESS: I believe anyone can.

9 BY MS. DEBRIERE:

10 Q. Okay. Is that the only way that a request is
11 submitted for AHCA to undertake a GAPMS?

12 A. No.

13 Q. What are other ways?

14 A. So in the contracts with the plans, there's
15 also language on how a managed care plan can submit a
16 request to the agency for review -- not necessarily
17 through the health services inbox. I can't recall the
18 exact direction. But there's also the opportunity for
19 the clients to request a review.

20 Q. When that review is requested, is it -- is the
21 standard process used? Is the standard GAPMS process
22 used?

23 A. I'm not sure. I believe it may be expedited.
24 But I'm not sure to the specifics of the process.

25 Q. Who would be most familiar with that process?

1 A. Either Jesse Bottcher or Jeffrey English.

2 Q. Okay. So you mentioned managed care plans can
3 submit a request -- or anyone can submit a request
4 through the health services inbox. Are there any other
5 ways that a request can be submitted to the agency to
6 undertake a GAPMS?

7 A. Yes.

8 Q. And what are those ways?

9 A. I don't know all the ways. But I can't think
10 of us not approaching the process if we received a
11 request outside of getting it specifically through the
12 health services research inbox.

13 Q. How often --

14 A. Which is -- I'm hesitating because I couldn't
15 see us not -- like, refusing to complete the process if
16 it was received another way.

17 Q. How often does that happen?

18 A. So, like I said before, in my time as bureau
19 chief, there haven't very many finalized GAPMS. Or that
20 process has not been a part of my day-to-day work. So
21 I'm not sure.

22 Q. Okay. So you cannot recall another way that a
23 GAPMS request came to the agency, other than through a
24 managed care plan or the health services inbox?

25 A. So for the most recent GAPMS report, that was a

1 request from -- I believe it was the secretary. But I
2 don't know if it went through the inbox specifically or
3 not.

4 Q. Okay. So that's another way that the GAPMS
5 process can be requested -- is through the secretary?

6 A. That's the way that it has been.

7 Q. Okay. How many times?

8 A. I don't know.

9 Q. And when you say the most recent GAPMS report,
10 do you mean the GAPMS report related to gender
11 dysphoria?

12 A. Yes.

13 Q. When that request came in through the
14 secretary, did the secretary identify why she was making
15 that request?

16 And, I'm sorry, do you mean Secretary
17 Marstiller?

18 A. Yes.

19 Q. Okay. Did she identify why she was making that
20 request?

21 A. I can't recall the contents of the specific
22 request.

23 Q. Did the request come -- who did the request
24 from Marstiller go to?

25 A. I don't know.

1 Q. How did you find out about it?

2 A. I just can't remember if I was sent the letter
3 in an email. But it was then discussed by my manager.

4 Q. And that manager was? Is?

5 A. At the time was Jason Weida, who is the
6 assistant deputy secretary.

7 Q. And did you receive the letter from Secretary
8 Marstiller before that discussion occurred?

9 A. Yes.

10 Q. And how long between receiving the letter and
11 having -- how long past between receiving that letter
12 and having that conversation with Mr. Weida?

13 A. I don't remember.

14 Q. Was it, like, hours? A day? Several days?
15 Within the same week?

16 A. I don't remember.

17 Q. Okay. Was that discussion just between you and
18 Mr. Weida? Or were there other people?

19 A. I don't remember in the initial conversation if
20 there was anybody with me.

21 Q. Okay. Was it -- where did it take place?

22 A. I believe it was in Jason's office.

23 Q. Okay. Did Jason ask you to come to his office
24 to have the conversation? How were you notified of the
25 meeting?

1 A. I don't remember. We had standing meetings in
2 his office; he was my -- or I was his direct report. So
3 I don't remember if it was part of that when we were
4 talking about assignments and priorities or separate. I
5 can't remember.

6 Q. What was Mr. Weida's position at the time at
7 the agency?

8 A. He was the assistant deputy secretary for
9 Medicaid policy and quality.

10 Q. And then who is in that position prior to him?

11 A. I think Shevaun Harris.

12 Q. Okay.

13 A. There was a gap in between. But I think she
14 was the last person.

15 Q. Okay. And who took that position after
16 Mr. Weida?

17 A. That position is currently vacant.

18 Q. Okay. And has Brian Meyer ever held that
19 position?

20 A. No.

21 Q. Okay. Prior to your meeting with Mr. Weida but
22 after you received the request from Secretary
23 Marstiller, did you communicate with anybody else about
24 the request?

25 A. Can you repeat the question.

1 Q. Between the time that you received the request
2 from Secretary Marstiller -- the letter -- and meeting
3 with Mr. Weida, did you have a conversation with anyone
4 else about the request?

5 A. I don't believe so.

6 Q. Okay. Were you surprised to see the request?

7 A. No.

8 Q. Why not?

9 A. Medicaid Policy -- I think we're unique in that
10 bureau because no one day is exactly the same. There's
11 always something new coming out from the federal
12 government, from legislative action, from leadership.
13 So I think that's kind of part of the job of being the
14 bureau chief of Medicaid policy.

15 Q. Okay. What was -- when you met with Mr. Weida,
16 did you develop a plan about how to honor the
17 Secretary's request?

18 A. Yes.

19 Q. And what was that plan?

20 A. The team that was going to work on it was the
21 Canadian Prescription Drug Importation Plan team;
22 following the regular GAPMS process in terms of research
23 and report and development.

24 Q. Did you identify who was going to be on that
25 team?

1 A. Yes.

2 Q. And who did you identify?

3 A. Matt Brackett, Nai Chen, and D.D. Pickle.

4 Q. As part of that plan -- and to be clear, the
5 secretary's request was specifically a request to
6 undertake a GAPMS investigation?

7 A. Yes; to review through that process.

8 Q. Okay. And the team identified was Brackett,
9 Chen -- and I forgot the --

10 A. Their manager, D.D. Pickle.

11 Q. D.D. Pickle. Thank you.

12 So you previously testified that the team
13 primarily responsible for GAPMS was led by Jesse
14 Bottcher. Why was Jesse Bottcher not part of the team
15 to undertake this GAPMS?

16 A. So there was several factors considered. Matt
17 Brackett has worked with the bureau a long time and
18 previously had the position responsible for -- primarily
19 responsible for the GAPMS. D.D. Pickle has also been
20 with the bureau and agency a very long time. So I would
21 say that the historical knowledge, the bandwidth --
22 having bandwidth to focus on completing the GAPMS --
23 were probably the two biggest factors.

24 Q. When you say bandwidth, what do you mean?

25 A. So that team -- their primary responsibility is

1 the Canadian Prescription Drug Importation Program,
2 which is not approved federally. So our ability to move
3 forward with the day-to-day operations and
4 implementation of that program is stalled. Due to that,
5 that team has been available to assist in other areas
6 within the bureau when needed.

7 Q. Was the team that's primarily responsible for
8 GAPMS -- were they overwhelmed with doing GAPMS at the
9 time?

10 A. I don't know.

11 Q. But you used the fact that Mr. Brackett and
12 D.D.'s team generally would have a lot of time to work
13 on GAPMS as a deciding factor to pick the team for this
14 report; is that right?

15 A. Yes.

16 Q. But you didn't first check whether the team
17 that's primarily responsible for GAPMS would have the
18 time to do the report?

19 A. No.

20 Q. Okay. How long has Mr. Chen been with the
21 agency?

22 A. I don't remember.

23 Q. Would you classify him -- as you did Ms. Pickle
24 and Mr. Brackett -- as being with the agency for a long
25 time?

1 A. No.

2 Q. So he did not have that historical knowledge
3 that Mr. Brackett and Ms. Pickle have with the agency?

4 A. No.

5 Q. And that was a deciding factor in picking the
6 team?

7 A. Yes.

8 Q. When you met with Mr. Weida to pick this team,
9 did Mr. Weida suggest the names or did you?

10 A. I believe I did.

11 Q. Okay. Other than the length of time at the
12 agency and bandwidth, what criteria -- did Mr. Weida
13 give you any criteria in terms of picking the team?

14 A. I don't think so, no.

15 Q. Did you use any other factors other than the
16 length of time at the agency and bandwidth to select
17 this team?

18 A. I think it's still the same as historical
19 knowledge. But I have worked very closely with D.D.
20 and Matt in my various positions. I knew Matt had some
21 knowledge of previous similar requests, as well
22 extensive knowledge of the standard GAPMS process. And
23 it was a team of three that was available. So I think
24 that still kind of historical knowledge and bandwidth
25 were really the biggest factors.

1 Q. You said Mr. Brackett had experience with
2 previous similar requests. What were those previous
3 similar requests?

4 A. I believe there was a GAPMS request in the past
5 before my time with the agency that had to do with
6 hormone treatment.

7 Q. Would it be -- and it was hormone treatment.
8 When you say a similar request, was it for GAPMS?

9 A. Yes.

10 Q. Would it have been the cross-sex hormone
11 therapy GAPMS that is Exhibit 4?

12 A. No.

13 Q. How do you know?

14 A. The date on this. The one I was thinking of
15 was much earlier before my time.

16 Q. Before your time -- do you have any sense of
17 when that might be?

18 A. Maybe 2016 or 2017.

19 Q. Do you know who the Governor of Florida was in
20 2016 or 2017? I'm sorry. It's not a test, I promise.

21 Was it Rick Scott?

22 A. Yes.

23 Q. Okay. And was the interim secretary at the
24 time at AHCA, was it Justin Senior?

25 A. Yes.

1 Q. And was Beth Kidder there at that time at AHCA?

2 A. Yes.

3 Q. And all of those people are listed on this
4 Exhibit 4 --

5 A. So my document has Beth Kidder crossed out and
6 looks to be a draft document from May 20th, 2022.

7 Q. Is there a name that replaced Beth Kidder on
8 that?

9 A. Ashley Peterson.

10 Q. Okay. Do you know when Ashley Peterson joined
11 AHCA?

12 A. I believe it was 2021.

13 Q. Okay. And is it --

14 MR. PERKO: Counsel, it's 1:30. Are we going
15 to stop for lunch?

16 MS. DEBRIERE: We can if you want to.

17 MR. PERKO: Do you want to? It's up to you.

18 THE WITNESS: At some point.

19 MS. DEBRIERE: That's fine. Can I just finish
20 up here real quick.

21 BY MS. DEBRIERE:

22 Q. So is it possible that this document was
23 created in 2017?

24 A. I'm looking at a document that has track
25 changes that appear to be since then. But I don't know.

1 Q. Why do those track changes appear to be since
2 then?

3 A. Since the date was updated to May 20th, 2022.

4 Q. Okay. There's some editing in the column.
5 It's very faint. Can you see it?

6 A. Yes.

7 Q. And the initials of editor appear to be GS.

8 A. Yes.

9 Q. Do you have any idea who that would be?

10 A. No.

11 Q. Do you know anybody here with the initials GS?

12 A. I'm sure somebody here has those initials, but
13 I don't know off the top of my head.

14 Q. So Mr. Brackett was involved with a GAPMS
15 related to cross-sex hormone therapy, but it wasn't
16 necessarily this one; is that right?

17 A. I don't know the level of his involvement, but
18 I know that he had some knowledge or knew about it.

19 Q. Okay. Did he do any other GAPMS related to the
20 treatment of gender dysphoria?

21 A. I don't know.

22 Q. Mr. Chen -- did he have any previous experience
23 with GAPMS?

24 A. I don't know.

25 Q. Ms. Pickle -- has she had any previous

1 experience with GAPMS?

2 A. I don't know.

3 Q. And you've explained why Mr. Brackett,
4 Ms. Pickle, and Mr. Chen were selected for the team.
5 Why was Mr. Bottcher not selected?

6 A. I can't recall all the details of the decision.
7 But Jesse Bottcher's team is one of the busiest in the
8 bureau, and has a lot of time sensitive work that they
9 are constantly working on. So I think that had
10 something to do with it, since he is the manager of an
11 entire section.

12 Q. I think you had previously testified there
13 weren't a lot of GAPMS pending at the time this request
14 come through; is that right?

15 A. I didn't know the bandwidth or the workload.

16 Q. Okay. You didn't know the bandwidth. So you
17 didn't know if, for example, Mr. English had the
18 bandwidth to handle the GAPMS report?

19 A. No.

20 Q. Do you want to take a break?

21 A. Yes.

22 (Brief recess.)

23 BY MS. DEBRIERE:

24 Q. Previously before break we were talking about
25 the selection of Mr. Brackett to be on the GAPMS report

1 team for gender dysphoria. And you mentioned that he
2 had drafted previous similar GAPMS in the past. And I
3 believe you used the example of cross-sex hormones.

4 Were there any other similar requests that he
5 drafted related to gender dysphoria in the past?

6 MR. PERKO: Object to form.

7 THE WITNESS: Just to clarify, I'm not sure if
8 he drafted it.

9 MS. DEBRIERE: I'm sorry; yes.

10 THE WITNESS: I know he had some historical
11 knowledge of previous GAPMS.

12 MS. DEBRIERE: Okay.

13 THE WITNESS: So can you repeat your question.

14 BY MS. DEBRIERE:

15 Q. Did he have hysterical knowledge of previous
16 GAPMS related to gender dysphoria?

17 A. Outside of the one that I referred to earlier?

18 Q. No, including that one.

19 A. Yes, I believe he had some historical knowledge
20 of previous GAPMS.

21 Q. Other than the one you referenced earlier, are
22 you aware of any other GAPMS that he was involved in
23 related to gender dysphoria?

24 A. I don't know the extent of all the GAPMS he was
25 involved in.

1 Q. Also earlier when you were discussing your
2 responsibilities under GAPMS, you mentioned routing.

3 A. Yes.

4 Q. Can you describe that a little bit.

5 A. As the bureau chief of Bureau of Medicaid
6 Policy, any official documents that leave the bureau are
7 usually reviewed by me. And so routing process is the
8 hierarchy of reviewers through wherever the final
9 reviewer or signatory or approver. That's what I was
10 referring to by routing process.

11 Q. Okay. Does every GAPMS report have a routing
12 process?

13 A. Yes.

14 MS. DEBRIERE: Okay. Can I have the 2016 GAPMS
15 routing form. And we'll mark it as Exhibit 6.

16 MS. DUNN: I can tell from this exhibit that
17 when we printed these the Bates numbering got cut
18 off. So I will look it up and read --

19 MS. DEBRIERE: That's a bummer.

20 MS. DUNN: I know.

21 (Plaintiff's Exhibit No. 6 was marked for
22 identification.)

23 BY MS. DEBRIERE:

24 Q. Okay. So do you recognize this document?

25 A. Not this specific document. But this appears

1 to be a policy routing and tracking form.

2 Q. And is that form the same as the form you
3 currently use to track -- to route and track?

4 A. Sometimes.

5 Q. What other forms do you use?

6 A. Prior to the pandemic, we used this form
7 primarily. Since returning to the office there have
8 been different variations of routing and tracking forms
9 developed for different teams or documents -- types of
10 documents.

11 Q. Do you use the same routing and tracking form
12 for GAPMS?

13 A. So I've only approved two GAPMS in my time.
14 And I can't remember if this was the -- this format was
15 what was used to route it to me.

16 Q. Okay. But there was a form used to route it to
17 you when you approved -- when you approved your two
18 GAPMS?

19 A. I believe so.

20 Q. Okay. And on this GAPMS form, it says prepared
21 by Monique Johnson. What does it mean to be prepared
22 by? Was the form prepared by Ms. Johnson? Or was the
23 GAPMS report prepared by Ms. Johnson?

24 A. I don't know.

25 MS. DEBRIERE: Okay. Could I see the 2022

1 GAPMS. This will be Exhibit 7.

2 (Plaintiff's Exhibit No. 7 was marked for
3 identification.)

4 BY MS. DEBRIERE:

5 Q. So I'm handing you -- and Gary will want to
6 take a look at it too -- again, the first page of the
7 document is entitled "Medicaid Policy Routing and
8 Tracking Form." If you go through the entire document,
9 it should also include the June 20, 2022, GAPMS report
10 on treatment of gender dysphoria.

11 MR. PERKO: I believe it was June 2nd.

12 MS. DEBRIERE: June 2nd. Excuse me.

13 BY MS. DEBRIERE:

14 Q. So looking at the document -- the first page,
15 is this the Medicaid Policy Routing and Tracking Form
16 that was associated with the GAPMS report on the
17 treatment of gender dysphoria?

18 A. Yes.

19 Q. How do you know?

20 A. These are my initials.

21 Q. Okay. So you've seen this before?

22 A. Yes.

23 Q. I do want to point out "prepared by" here.
24 What does that mean?

25 A. That Matt Brackett prepared the routing

1 package.

2 Q. Okay. Did he also prepare the GAPMS report
3 itself?

4 A. Yes.

5 Q. Do you know if the person who prepares the
6 routing and tracking form -- if they are the person who
7 also prepares the GAPMS report?

8 A. Can you repeat the question.

9 Q. The person who prepares the Medicaid Policy
10 Routing and Tracking Form, do they also prepare the
11 GAPMS report itself?

12 A. I don't know how all the team members are
13 instructed to fill out the report or -- I'm sorry --
14 fill out the tracking form.

15 Q. Is there any other way to determine who has
16 prepared a GAPMS report?

17 A. I don't know. But speaking in general
18 assignments -- these forms are used for other
19 assignments. And there are a lot of assignments that
20 are done collaboratively. So, yeah. I don't know
21 specifically how else you would know just looking at
22 documentation.

23 Q. Would that information be contained on an AHCA
24 shared drive?

25 A. It's possible.

1 Q. Okay. Is there a reason the GAPMS report
2 doesn't identify an author on the report?

3 A. I don't know.

4 Q. Okay. A couple other things. On the section
5 line here, it says Canadian Prescription Drug
6 Importation Program. But we have established this was
7 the routing and tracking form for the GAPMS report
8 related to the treatment of gender dysphoria. Are those
9 two things related?

10 A. So the Canadian Prescription Drug Importation
11 Program is the section of who developed the report. And
12 it lets us know how the hierarchy of the routing should
13 go through the management levels within the bureau and
14 outside.

15 Q. So it was the Canadian Prescription Drug
16 Importation unit who prepared the GAPMS report on the
17 treatment for gender dysphoria?

18 A. So that's what I would interpret this
19 section -- why it's listed there next to this section.
20 It's the section responsible for routing and lets us
21 know the hierarchy of the management.

22 Q. Okay. And then just looking down at the
23 "Reviewed by and Routing Timelines," the start date is
24 June 1st, 2022, for everybody except Mr. Wallace; who
25 has a date of June 2nd, 2022. And the end date is June

1 1st, 2022, except for Mr. Wallace. Does that indicate
2 that you Mr. Weida and Ms. Pickle all reviewed the
3 report and signed off on it on the same day?

4 A. That the official routing and the signature
5 occurred on the same day, yes.

6 Q. What do you mean by official routing?

7 A. So the date that this form and the final
8 routing package was ready for signature.

9 Q. And what was continued in the final routing
10 package?

11 A. I believe it was just the report.

12 Q. Okay. So the final report -- what was being
13 tracked through this routing and tracking form?

14 A. Yes.

15 Q. Were there any attachments to the final report
16 that were also reviewed?

17 A. The expert witness reports were also reviewed.
18 But I can't remember if they were included in this
19 routing package at the same time.

20 Q. Who reviewed those final expert reports?

21 A. I don't remember.

22 Q. Did you review them?

23 A. I don't remember if I reviewed them all. But I
24 had seen them -- at least some of them. I can't
25 remember if I reviewed them all formally.

1 Q. Okay. Turning just back to the general GAPMS
2 process. Is the GAPMS process ever initiated to assess
3 existing coverage of Medicaid services?

4 A. Can you repeat the question.

5 Q. Is the GAPMS process ever used to assess
6 existing coverage of Medicaid services?

7 A. I don't know specifically.

8 Q. Okay. Who would know that?

9 A. Are you asking if it ever has or ever would?

10 Q. Ever would.

11 Would Ms. Pickle know that?

12 A. So my personal experience with the GAPMS
13 process is somewhat limited. But it is such a unique
14 process. I feel it's hard to answer that without each
15 situation or each request that we would get would be
16 unique, because that process is dealing with questions
17 that fall outside of something that's easily answered
18 policy question.

19 MS. DEBRIERE: Have we entered the GAPMS rule
20 into evidence yet? Can we do that now. And that's
21 to be 59G-1.0 -- I thought we had. Oh, it's 5.
22 Okay. Sorry. That's my fault.

23 MR. PERKO: That's fine.

24 BY MS. DEBRIERE:

25 Q. So a couple questions about the language of the

1 rule. First under (1)(b), "health services" is defined
2 as diagnostic tests, therapeutic procedures, or medical
3 devices or technologies.

4 Under what category would prescription drugs
5 fall in this definition?

6 A. I don't know.

7 Q. You are familiar with the GAPMS rule, though;
8 correct?

9 A. Yes. I've read the GAPMS rule.

10 Q. Would prescription drugs fall under any of
11 these categories?

12 MR. PERKO: Object to form.

13 THE WITNESS: I don't know. I wasn't part of
14 the original drafting of this rule text. So in
15 order to interpret the policy, I would need to do
16 research.

17 BY MS. DEBRIERE:

18 Q. Who would you ask?

19 A. I would probably start with Ashley Peterson.

20 Q. Okay. And going down to 3, the second
21 sentence -- "The public may request that a health
22 service be considered for coverage under the Florida
23 Medicaid program by submitting a request."

24 What does this sentence mean to you?

25 A. There's much room for interpretation. It says

1 the public may request a public health service be
2 considered for coverage.

3 Q. Does this sentence mean that the public may
4 request that Florida Medicaid consider whether to
5 exclude a service previously covered?

6 MR. PERKO: I'm going to object to form.

7 THE WITNESS: So I think it could. Not only do
8 we update the coverage policies to include new
9 services, but we do change the scope of a service as
10 part of that process. So if there was a question
11 that was not clear within the scope of the service,
12 I can see how that might apply.

13 Or the example that you used earlier with a
14 service that's only provided to under 21. If that
15 service was -- if we received a request to make that
16 service available for over 21. So I can think of
17 examples where it wouldn't have to be a new service.

18 BY MS. DEBRIERE:

19 Q. Does this rule cover a public's request to take
20 a service away?

21 MR. PERKO: Object to form.

22 THE WITNESS: I don't know.

23 BY MS. DEBRIERE:

24 Q. Okay. Who would know?

25 A. Public -- that would be a legal interpretation

1 or policy interpretation that would need consultation
2 with the agency for me to answer.

3 Q. As the bureau chief of Medicaid Policy, you're
4 responsible for developing coverage policies; correct?

5 A. I oversee the teams that develop coverage
6 policies, yes.

7 Q. And you are responsible for overseeing the
8 teams that develop administrative rules to implement
9 those coverage policies; correct?

10 A. Yes.

11 Q. So you would be responsible for understanding
12 how rules that implement coverage policies should be
13 interpreted.

14 MR. PERKO: Object to form.

15 BY MS. DEBRIERE:

16 Q. Is it your responsibility to understand the
17 content of this rule?

18 A. Yes.

19 Q. Okay. But you can't tell me how to interpret
20 that second sentence in Subpart 3?

21 A. So if we received a request and I wasn't clear
22 on the authority, there's several steps I would take to
23 confirm that the agency's position is we have
24 authority -- which would be to review any other
25 applicable laws or regulations; would be to consult with

1 my team and with agency management and perhaps with
2 legal if I was not sure whether a specific question or
3 scenario that was received. We may not have the
4 authority to take an action.

5 Q. So when reading the second sentence in Subpart
6 3 -- "The public may request a health service be
7 considered for coverage" -- in order to understand what
8 that sentence means, would you undertake any of the
9 steps you just described?

10 A. It would depend on the exact question. If I
11 wasn't clear with what the request was and how that
12 authority applied, then I would take further steps to
13 make sure that I understood how the rule applied to the
14 request.

15 Q. Did you do that for -- okay. Okay. Let me
16 make a note.

17 In the legal consultation part, it triggered me
18 to remember just a housekeeping question. At lunch did
19 you speak with your attorneys --

20 A. No.

21 Q. -- about the deposition?

22 A. No.

23 Q. Okay. Does the GAPMS process typically look at
24 an individual service when you're undertaking analysis?

25 A. I don't know.

1 MS. DEBRIERE: Okay. Can I have either the
2 Van Mol or Van Meter ATF. It doesn't matter. And
3 we'll mark that as Exhibit 8.

4 (Plaintiff's Exhibit No. 8 was marked for
5 identification.)

6 BY MS. DEBRIERE:

7 Q. So at the top of the page you have a -- did you
8 approve this document?

9 A. Yes.

10 Q. Okay. So under "Reason for Occurrence," it
11 says, "On April 20th, 2022, the Bureau of Medicaid
12 Policy received a request for a time-sensitive analysis
13 of service coverage. While such requests are typically
14 for a single service or good --" Is that a correct
15 statement?

16 A. I don't know.

17 Q. But you wrote this?

18 A. No. I signed this.

19 Q. Okay. Were you the one making the request?

20 A. No.

21 Q. Who was making the request?

22 A. Devona Pickle.

23 Q. Okay. Before you sign something, do you have
24 to agree with the language contained therein?

25 A. Yes.

1 Q. So at the time you signed this, you agreed with
2 the statement that such requests are typically for a
3 single service or good?

4 A. Yes.

5 Q. Okay. But now you don't know if GAPMS are
6 typically used for a single service or good?

7 A. My experience with GAPMS is limited. And I
8 trust the expertise of my staff. And one of the reasons
9 I asked or had recommended that this team be responsible
10 was because of their historic knowledge of the GAPMS
11 process.

12 Q. And when you say that, that includes D.D.
13 Pickle; correct? You trust her expertise on the GAPMS
14 process?

15 A. Yes.

16 Q. Okay. Are you aware of a standard operating
17 procedure used for the GAPMS process?

18 A. I've heard mention of it. But I don't believe
19 I've ever seen it.

20 Q. Who did you hear mention of it from?

21 A. I can't remember. Either Matt or Jesse.

22 MS. DEBRIERE: Okay. Can I have what we'll
23 mark as Exhibit 9, which is the GAPMS Decision Tree
24 Checklist.

25 (Plaintiff's Exhibit No. 9 was marked for

1 identification.)

2 BY MS. DEBRIERE:

3 Q. Do you recognize this document, Ms. Dalton?

4 A. I believe I've seen this before.

5 Q. Do you know what it's used for?

6 A. I believe this was developed to determine if a
7 request just goes through the coverage determination
8 process or should be handled as a GAPMS.

9 Q. Okay. And tell me the difference between a
10 coverage determination and something that needs to go
11 through the GAPMS.

12 A. I don't know everything that goes into how that
13 decision is concluded. But in general, a coverage
14 determination is when it's very clear that the agency
15 has the authority to add a service and that it meets all
16 of the agency's rules and -- for example, an optional
17 state plan service that the agency currently doesn't
18 cover but is clearly allowed through federal CMS would
19 be a coverage determination. Where the GAPMS process is
20 driven by the rule you referenced earlier that describes
21 when it's not clearly meeting all the requirements and
22 laid out in the current coverage policies.

23 Q. So much earlier in the deposition you gave an
24 example of a coverage determination of a medical supply
25 for -- was it Amino Foods?

1 A. Puro Meno.

2 Q. Puro Meno Foods. Why didn't you use the GAPMS
3 process for that? Did you use the GAPMS process for
4 that?

5 A. No.

6 Q. Why not?

7 A. Because the agency already covered similar
8 products.

9 Q. Okay. Was that the only factor in determining
10 whether to assess it using GAPMS?

11 A. I don't remember the conversations with the
12 team when I was briefed on the recommendation.

13 Q. Was a GAPMS Decision Tree Checklist done for
14 Puro Meno Foods?

15 A. I don't believe so. I never saw one, no.

16 Q. Okay. Who undertakes the process to fill out
17 the decision tree?

18 A. I don't know.

19 MS. DEBRIERE: I apologize. Can we take just a
20 two-minute break.

21 MR. PERKO: Sure.

22 (Brief recess.)

23 BY MS. DEBRIERE:

24 Q. Do you know how to interpret the answers on a
25 decision tree checklist?

1 A. No, I don't believe I've ever seen one filled
2 out.

3 Q. Okay. There's a space here that says "GAPMS
4 Topic." What would go in that space? Do you know?

5 A. I don't know.

6 Q. Would a decision tree checklist be generated
7 for every GAPMS request that comes in?

8 A. I don't know.

9 Q. Who would know that?

10 A. I don't know. I don't know if this is still
11 the internal process. I don't know.

12 Q. Who would know whether it was still the
13 internal process?

14 A. Jesse Bottcher.

15 Q. Okay. Would the members of Jesse Bottcher's
16 team also know?

17 A. No, I don't think anyone currently on his team
18 would know.

19 Q. How about anybody previously on his team -- I'm
20 sorry; back up.

21 So no one on Jesse Bottcher's team is in charge
22 of the GAPMS process?

23 A. The GAPMS position is currently vacant.

24 Q. Would anybody who was in charge of the GAPMS
25 process at some point know whether the decision tree

1 checklist is used in the GAPMS process?

2 A. I don't know.

3 Q. And there's only one position that would know
4 that, and that is currently vacant; correct?

5 A. I believe so, yes.

6 Q. And what is that position called?

7 A. I believe it's a Government Analyst II.

8 Q. And so there's just that one position in charge
9 of knowing the GAPMS process?

10 A. As far as I know, yes.

11 Q. Okay. We touched on this a bit earlier. Does
12 AHCA use the GAPMS process for prescription drugs?

13 A. I don't know.

14 Q. When you were giving an example of similar
15 requests that Mr. Brackett handled for GAPMS, the
16 example you gave was cross hormone therapy; correct?

17 MR. PERKO: Object to form.

18 THE WITNESS: I believe that was the example I
19 gave.

20 BY MS. DEBRIERE:

21 Q. And what is cross-sex hormone? What is a
22 hormone?

23 A. I don't think I can recite the clinical
24 definition.

25 Q. Is the hormone a prescribed drug?

1 A. I believe so.

2 Q. So then you're aware of one instance in which
3 GAPMS was used for determining -- for assessing a
4 prescription drug?

5 A. Yes.

6 Q. But you don't know generally if GAPMS is used
7 to assess prescription drugs?

8 A. My knowledge of GAPMS is limited. So to speak
9 in generalities -- but I do see where in 2016 there was
10 the GAPMS on hormone suppression.

11 Q. Okay. Is GAPMS the only method AHCA relies on
12 to determine whether a Medicaid service is experimental?

13 A. I don't know. I know we have a clinical trials
14 coverage policy. So there may be circumstances where
15 it's clear that coverage would be -- that coverage
16 policy or the clinical trials rule would apply. And I
17 don't know all the details of how the QIO vendors --
18 what that process, all that entails.

19 Q. Whether the QIO vendors would determine whether
20 something is experimental?

21 A. Or if it was clear the clinical trial policy
22 would apply instead. So I don't know to the extent of
23 if there could possibly be.

24 Q. What is the clinical trials policy?

25 A. It's a rule that outlines the agency's coverage

1 for recipients participating in a clinical trial.

2 Q. And what does that type of authorization
3 entail?

4 A. I don't know the specifics.

5 Q. Is GAPMS the only method that AHCA relies on to
6 determine whether a Medicaid service is experimental and
7 therefore should be excluded?

8 A. Can you repeat the question.

9 Q. Is GAPMS the only method that AHCA relies on to
10 determine whether a Medicaid service is experimental and
11 therefore should not be covered?

12 A. I don't know the specifics. But if, for
13 example, a pharmaceutical is not FDA approved, there
14 would be perhaps, like, a different process where it
15 wouldn't have to go through the process.

16 Q. What is the significance of a drug being FDA
17 approved for the purposes of coverage?

18 A. I don't know the details.

19 Q. What do you know about it?

20 A. I believe there's federal requirements on if a
21 drug is not FDA approved -- there is certain coverage
22 requirements.

23 Q. Do you know if that relates to the compendia we
24 were earlier talking about?

25 A. I don't know.

1 Q. Okay. If AHCA is determining whether a
2 production drug is experimental, does AHCA consider
3 whether the drug is FDA approved?

4 A. I believe so.

5 Q. If a particular use for a drug has been FDA
6 approved, can AHCA deem the drug experimental for that
7 use?

8 A. Can you repeat the question.

9 Q. If a particular use for a drug has been FDA
10 approved, can AHCA deem that drug experimental for that
11 use?

12 MR. PERKO: I'm going to object to form.

13 THE WITNESS: I don't know.

14 BY MS. DEBRIERE:

15 Q. But FDA approval bears on a determination as to
16 whether AHCA will cover a drug; is that correct?

17 A. Yes, I think it's considered.

18 Q. If it's not -- if a drug is not FDA approved,
19 are there circumstances under which AHCA will still
20 cover the drug?

21 A. I don't know. But I think there is federal
22 regulations around what's allowable.

23 Q. In the Federal Medicaid Act?

24 A. I believe.

25 Q. You mentioned just a second ago, a clinical

1 trials coverage policy. Where does that policy live?

2 A. In Rule Class 59G on our website.

3 Q. If it's not there where would we find it?

4 A. In the Florida Administrative Code.

5 Q. It should be in Chapter 59G?

6 A. But it should be on our website.

7 Q. Okay. And it is adopted as a rule?

8 A. Yes.

9 Q. Okay. Once AHCA reaches a decision through the
10 GAPMS process, describe the implementation of that
11 decision.

12 A. So, again, in my experience -- I've only been
13 bureau chief for two finalized decisions that were
14 different. And I can't remember all the steps to
15 implementation. But once a determination of any
16 coverage is made, then there's a process of how to
17 notify the public. There's a process for notifying the
18 plans of changes if it affects the plans. There's a
19 process of making sure that the -- any other associated
20 rules that may be impacted are updated.

21 Q. Anything else?

22 A. If a training is needed, it depends on what it
23 is. But there could be other.

24 Q. Who would you train?

25 A. So, again, just speaking generally -- the

1 managed care plans; the public; if it's fee for service,
2 the providers; especially if it has to do with submitted
3 claims.

4 Q. What are the two final reports that you have
5 overseen as bureau chief?

6 A. So it was the GAPMS that we're discussing
7 today.

8 Q. And, again, that's the one that relates to
9 treatment of gender dysphoria?

10 A. Yes. And then the -- I can't remember the
11 exact name of the other GAPMS. But it was through a
12 managed care plan request.

13 Q. Was it an expedited GAPMS?

14 A. I don't believe so.

15 Q. Do you remember what the service was at issue?

16 A. I do not.

17 Q. Okay. And the process for an expedited GAPMS,
18 that's different from the traditional GAPMS process?

19 A. I'm not sure of the differences outside of the
20 timeframe.

21 Q. Is it different as to how you would inform the
22 public about it?

23 A. I don't know. I can't recall what steps we
24 took after notifying the plans of the final decision.

25 Q. Okay. Through the traditional GAPMS process --

1 do you have any GAPMS right now that are in the final
2 stages?

3 A. No.

4 Q. Okay. And you don't know how many requests are
5 currently pending?

6 A. I don't know.

7 Q. So the last GAPMS that was finalized was in
8 June of 2022?

9 A. Yes.

10 Q. Okay. And now we're in February of 2023. And
11 there's no GAPMS that are ready for finalization at this
12 point?

13 A. I don't know what stages of development they
14 are.

15 Q. Okay. Is there anything on your desk to
16 review?

17 A. I don't know. I don't remember if I have
18 anything pending.

19 Q. Okay. When you were meeting with Mr. Weida
20 about the June 2022 GAPMS report related to the
21 treatment for gender dysphoria, that report had not been
22 drafted; correct?

23 A. Sorry. Can you repeat that.

24 Q. Yeah. Absolutely. So earlier you spoke to
25 meeting with Mr. Weida once you received the request

1 from the secretary to undertake the GAPMS for treatment
2 of gender dysphoria; do you remember?

3 A. Yes.

4 Q. During that meeting had the GAPMS report been
5 drafted yet? I know it seems like a silly question.
6 But I'm asking at face value.

7 At the time you met with Mr. Weida, had the
8 GAPMS report been drafted yet?

9 A. The GAPMS report I was discussing with him?
10 No.

11 Q. Okay. But you have a good memory of that
12 report before it was even drafted; is that right? You
13 were able to recount details to me about discussing that
14 report about before it had been drafted; is that right?

15 A. Throughout the process there had been
16 discussions. But I don't know if I remember all the
17 details.

18 Q. What I'm wondering is just why that report
19 sticks out in your mind, but now you can't recount any
20 other GAPMS reports that are pending. Is there a reason
21 for that?

22 A. I have a lot of documents in my queue at any
23 one time. And it's really on the onus of the analyst --
24 part of their job responsibilities -- to make sure
25 assignments are completed and finalized and routed and

1 closed. So because there was discussion and updates on
2 the status and progress of the report -- and it was not
3 that long ago -- I remember having conversations about
4 the report.

5 Q. There are GAPMS reports pending right now,
6 though; right?

7 A. I don't know. I don't know what the GAPMS
8 queue is right now.

9 Q. Okay. So you don't know if there's anything in
10 the queue right now?

11 A. Correct.

12 Q. But you do remember details about the GAPMS
13 report related to treatment of gender dysphoria?

14 A. Details on the process?

15 Q. Yeah.

16 A. Yes.

17 Q. Okay. When I say "rulemaking process," do you
18 understand what I'm referring to?

19 A. Yes.

20 Q. And do your current responsibilities at AHCA
21 include the rulemaking process?

22 A. Yes.

23 Q. Can you describe those responsibilities.

24 A. I review drafts of the coverage policy and the
25 documents that go along with the rule promulgation

1 process. I sometimes participate in the public meetings
2 and review provider alerts or other notices associated
3 with the process.

4 Q. Anything else?

5 A. Not that I can think of.

6 Q. Okay. Do you ever review public comment
7 associated with the rule?

8 A. It depends.

9 Q. So you have before?

10 A. More in my old role as the AHCA administrator.

11 Q. Okay. Can you remind me the dates you were in
12 that role.

13 A. August 2018 to August 2021.

14 Q. And in your previous roles at AHCA as well as
15 DOEA, you had rulemaking responsibilities; is that
16 right?

17 A. DOEA was more of the drafting of the policy and
18 not the promulgation process.

19 Q. Okay.

20 A. And then AHCA has been more on the promulgation
21 process -- administrative process.

22 Q. So you'd say you had experience with Florida
23 agency rulemaking?

24 A. Yes.

25 Q. When I say "rule workshop," do you understand

1 what I'm referring to?

2 A. Yes.

3 Q. When I say "rule hearing," do you understand
4 what I'm referring to?

5 A. Yes.

6 Q. What is the difference?

7 A. Chapter 120 has different public meetings
8 outlined in different stages of the process. The
9 workshop as we use it here is primarily for the rule
10 development stage of the administrative process. And
11 the hearing occurs at the proposed rule stage.

12 Q. Okay. When you say the development of the
13 rule, does that mean generally the rule language itself
14 has not yet been drafted or proposed?

15 A. It depends.

16 Q. Okay. So is there a difference between
17 workshop and hearing?

18 A. They're both public meetings meant to garner
19 input from the public and make the public aware of the
20 changes. But per Chapter 120, there are differences
21 because of the different stages of the process.

22 Q. Okay. Why was there no public workshop held
23 for the rule development of the change to Rule 1.050
24 excluding the treatment for gender dysphoria?

25 A. I don't know.

1 Q. Were you here were when that happened?

2 You were?

3 A. Yes.

4 Q. Okay. While here, have you had public comment
5 on rule workshops for other rules?

6 A. Can you repeat the question.

7 Q. Since you've been here at AHCA, have you -- let
8 me ask this question: When the rule was developed to
9 exclude treatment of gender dysphoria per 1.050, were
10 the you bureau chief for Medicaid Policy?

11 A. When the rule was promulgated?

12 Q. Well, when you were having the -- when you
13 noticed the proposed rule and had the rule hearing.

14 A. For this specific rule?

15 Q. Yes.

16 A. Yes.

17 Q. Okay. In your role as bureau chief, have you
18 ever -- in your role as bureau chief, have you been
19 involved in rule workshops for other rules?

20 A. Yes.

21 Q. So why weren't you involved in the rule
22 workshop for the exclusion of treatment for gender
23 dysphoria; do you know?

24 A. I can't remember. I believe I was out of town.

25 Q. Okay. If you weren't out of town, would you

1 have been involved in it?

2 A. I don't remember the discussion around that.
3 But I'm not always involved in the workshops or rules.

4 Q. How is that determined?

5 A. It depends on the circumstances and the content
6 of the rule. But I can't remember the specific
7 conversation when that was determined.

8 Q. Was there a public workshop for the exclusion
9 of the treatment for gender dysphoria? There was only a
10 public hearing; correct?

11 A. I know there was only one public meeting. I
12 can't remember.

13 Q. Generally what's the process for planning a
14 rule hearing?

15 A. We determine a date, a location, and who will
16 be in attendance. And the date and location is included
17 in the notice.

18 Q. And when you say who will be in attendance, who
19 does that mean?

20 A. Who the subject matter experts or other agency
21 staff will conduct the public meeting.

22 Q. Okay. And what do you mean by subject matter
23 expert?

24 A. So I think I described it a little before how
25 for most of the coverage areas there is a specific

1 analyst responsible for the development of that policy.
2 So, for example, if there was a change to respiratory
3 services, whoever that suggest matter expert or analyst
4 is would typically be present at the workshop since they
5 have the in-depth knowledge on the changes being
6 proposed.

7 Q. Is that person always a person employed by the
8 agency?

9 A. The subject matter expert for all our coverage
10 policies are individuals employed with the agency.

11 Q. Okay. Are there any written protocols
12 regarding the planning of a rule hearing?

13 A. I know we've developed process maps and
14 procedures. But I don't know the details of planning a
15 hearing specifically and how detailed those documents
16 are on that process.

17 Q. What's a process map? What does that entail or
18 detail?

19 A. There's a graphic that was created before my
20 time that -- it's a real nice layout of the
21 administrative rulemaking process.

22 Q. Okay.

23 A. And so it has -- it's a graphic, and it's one
24 page. So it's easy to put on your wall.

25 Q. And your responsibilities include sometimes

1 attending rule hearings?

2 A. Yes.

3 Q. Since you've been the bureau chief, how many
4 rule hearings have you attended?

5 A. I don't think I've attended any hearings.

6 Q. As a State agency employee -- either at DOE or
7 AHCA -- how many rule hearings have you attended?

8 A. So at DOE I attended several AHCA rule
9 hearings in the audience. In my previous position with
10 the agency, I think it was only a handful.

11 Q. Does that mean five?

12 A. Yes; I'd say five or less.

13 Q. Okay. Who else from AHCA attends rule
14 hearings? Let me ask this: Are there AHCA staff who
15 attend rule hearings as part of their job description --
16 they have to be at every rule hearing?

17 A. I don't know if that's actually in the job
18 descriptions. But Cole and his team -- since they set
19 up the workshop or hearing or the public meeting --
20 their responsibilities include making sure they have the
21 speaker list, making sure that everybody is escorted
22 into the building, that the speakers can be heard. So
23 they're in attendance for all of the public meetings.

24 Q. Okay. And do you know if they have any
25 protocol off which they operate -- written protocol for

1 conducting the hearing?

2 A. I believe there's an internal process and
3 process map. But I don't know the details off the top
4 of my head what's included in that document.

5 Q. Is it the rules unit that is in possession of
6 that document?

7 A. I would think so, yes.

8 Q. Okay. In your experience, aside from the
9 agency who attends the hearing?

10 A. From the public?

11 Q. I mean, I think that would be the only other
12 option; right?

13 What types of people from the public?

14 MR. PERKO: Object to form.

15 THE WITNESS: That would really depend on what
16 the change is and who is impacted.

17 BY MS. DEBRIERE:

18 Q. In your experience attending public hearings --
19 rule hearings -- are there typically more than 25 people
20 from the public that show up at the rule hearing?

21 A. I would say yes. Especially since the hearings
22 are now -- have a virtual option. The majority of them
23 are virtual and in person.

24 Q. Are there typically more than 25 people who
25 show up in person?

1 A. So I haven't participated in all of them. In
2 the last few that I participated in, there was not 25.

3 Q. In the last one you participated in how many
4 were there?

5 A. Less than ten.

6 Q. Does AHCA ever invite specific persons from the
7 public to attend the rule hearings?

8 A. Yes.

9 Q. And how do they do that invite?

10 A. A provider alert is sent out to the providers.
11 Usually that goes along with the FAR notice that was
12 posted and the public was noticed. If it's a sister
13 agency, it might be by email. So if we believe a rule
14 might impact a sister agency, we might reach out
15 specifically.

16 Q. So other than posting the public notice and the
17 FAR provider alerts and emails to potentially impacted
18 sister agencies, is there any other way the agency
19 invites specific people to attend the hearing?

20 A. I believe we sent calendar invites before.

21 Q. To what people? How did you decide on sending
22 calendar invites?

23 A. The specific example I'm thinking of is a
24 sister agency for the iBudget handbook. We invited ADP
25 to participate and sent them a meeting invite so they

1 can block that time.

2 Q. Okay. Have you ever invited Medicaid
3 recipients other than through the public notice to
4 attend a rule hearing?

5 A. I don't know, outside of the public notice
6 process.

7 Q. In your experience?

8 A. I personally have not.

9 Q. Okay. Do any State agencies in hosting a rule
10 hearing, do they arrange for transportation for
11 individuals from the public to attend that hearing?

12 MR. PERKO: Object to form.

13 THE WITNESS: I can't speak for any other
14 agency. I don't know.

15 BY MS. DEBRIERE:

16 Q. What about at DOEA? Did that ever happen?

17 A. I don't believe I ever participated in an
18 actual public meeting hosted by DOEA.

19 Q. That's right. You said that.

20 What about AHCA? Are you aware of AHCA ever
21 arranging transportation for individuals from the public
22 to attend a hearing?

23 A. Not that I'm aware of.

24 Q. Are you aware of anyone from the public being
25 paid to attend a hearing?

1 A. No.

2 Q. Are you aware of anyone who is a subject matter
3 expert being paid to attend a hearing?

4 A. I know we've reimbursed the subject matter
5 experts. But I'm not sure if that was specifically --
6 attending the hearing was specifically included.

7 Q. And these are subject matter experts that are
8 employed with the agency?

9 A. I don't know how that process works. But
10 they're not full-time employees with the agency. I
11 believe it's like consultants.

12 Q. Okay. What's the average length of a hearing?

13 A. I don't know the average. I know our public
14 meetings typically range between 30 minutes and two
15 hours.

16 Q. Okay. On average how many comments do agencies
17 receive for a rule hearing? Is there an average?

18 MR. PERKO: Object to form.

19 THE WITNESS: I don't know.

20 BY MS. DEBRIERE:

21 Q. Do you think 100 comments is a lot of public
22 comments to receive at a hearing?

23 MR. PERKO: Same objection.

24 THE WITNESS: I really don't know.

25 BY MS. DEBRIERE:

1 Q. In your experience, does a State agency ask
2 outside legal counsel to attend and perhaps in rule
3 hearings?

4 A. Can you repeat the question.

5 Q. In your experience, does a State agency
6 normally ask that outside legal counsel attend a rule
7 hearing?

8 A. I don't know.

9 Q. When you planned this last rule hearing, did
10 you ask outside legal counsel to attend?

11 A. Can you specify which hearing.

12 Q. Yeah. There was a hearing a couple of weeks
13 ago on the change to the medical necessity definition.

14 A. Yes. The workshop.

15 Q. Workshop. Did you ask outside legal counsel to
16 attend that workshop?

17 A. I personally did not.

18 Q. Did outside legal counsel attend that workshop?

19 A. I don't believe so.

20 Q. And have you ever attended a rule hearing where
21 outside legal counsel was asked to participate in?

22 A. I can't recall if that circumstance has ever
23 happened.

24 Q. So it's not usually -- it's not the standard
25 course of things for outside legal counsel to attend?

1 A. Correct.

2 Q. All right. Turning to the exclusion for
3 treatment of gender dysphoria under Rule 59G-1.050.
4 Prior to the adoption of this exclusion, did any
5 coverage policies regarding any of the services listed
6 there -- sorry. Strike that.

7 Prior to the adoption of the exclusions set
8 forth -- I'm not sure you're looking at the right rule.
9 59G-1.050. Exhibit 2. It would help me to tell you the
10 exhibit number. And then it's Subpart 7.

11 So prior to the adoption of that rule -- that
12 Subpart 7 -- did any coverage policies exist regarding
13 the services that are now subject to that exclusion?

14 A. Can you repeat that question.

15 MS. DEBRIERE: Court Reporter, can you read
16 back that last question.

17 (The preceding question was read back by the
18 reporter.)

19 THE WITNESS: There was not a specific coverage
20 policy for services for the treatment of gender
21 dysphoria.

22 BY MS. DEBRIERE:

23 Q. Does that mean those services were never
24 covered to treat gender dysphoria by Florida Medicaid?

25 A. I don't believe there was any policy language

1 that specifically outlined coverage of the services
2 listed in this section.

3 Q. If there was no specific policy language, does
4 that then mean those services were not covered to treat
5 gender dysphoria by Florida Medicaid?

6 A. I don't know the extent to what providers were
7 reimbursed for providing the services.

8 Q. So even if there wasn't a coverage policy
9 specifically related to these services, it's possible
10 that Florida Medicaid was covering the services for the
11 treatment of gender dysphoria?

12 A. It's possible Florida Medicaid reimbursed for
13 these.

14 Q. Are there circumstances in which AHCA might not
15 have an explicit or affirmative coverage policy, but
16 would consider a request for a service on a case-by-case
17 basis?

18 A. Can you repeat the question.

19 Q. Are there circumstance in which AHCA might not
20 have an explicit coverage policy regarding those
21 services -- or any service -- but would consider a
22 request for a service on a case-by-case basis?

23 A. I don't know specifically if it's case-by-case
24 basis. But I believe that the plans -- that some of the
25 request from the managed care plans may be specific to a

1 request for a specific coverage. So when plans request
2 for a GAPMS to be provided, it could be being driven by
3 a specific case.

4 Q. Okay. So even though a coverage policy does
5 not exist regarding the coverage of a specific service,
6 there are circumstances in which AHCA might still cover
7 that service?

8 A. Yes.

9 And I apologize. On your last question I think
10 I heard you specific about GAPMS, which is what I
11 answered. So I apologize.

12 Q. That's okay. No, that's fine. You're
13 referring to not the last question, but the question
14 before that; is that right?

15 A. Yes.

16 Q. Okay. But your response on that last question,
17 you understood the question?

18 A. Yes.

19 Q. Okay. Will Florida Medicaid cover an EPSDT
20 service if that service is experimental?

21 A. So in order for an EPSDT service to be covered,
22 it has to meet the definition of medical necessity.

23 Q. And that medical necessity definition includes
24 the requirement that the service not be experimental?

25 A. Yes.

1 Q. Okay. So you received a request from Secretary
2 Marstiller via email to engage in a GAPMS regarding
3 treatment for gender dysphoria; correct?

4 A. I can't remember if it was email.

5 Q. Right. But you received the request somehow?

6 A. Yes.

7 Q. And roughly when was that; do you remember?

8 A. I don't remember.

9 Q. And then the next step was speaking with
10 Mr. Weida about the letter?

11 A. Yes.

12 Q. And developing the plan as to who was going
13 to --

14 A. Yes. Developing how the process would work.

15 Q. Were all the decisions reached in that one
16 meeting with Mr. Weida?

17 MR. PERKO: Object to form.

18 THE WITNESS: No.

19 BY MS. DEBRIERE:

20 Q. Okay. So after that meeting with Mr. Weida,
21 what happened next?

22 A. I can't remember the exact timeline of events.
23 I know we met at some point with the Canadian
24 Prescription Drug Importation team.

25 Q. And they were the ones who were put in charge

1 of doing this GAPMS?

2 A. Yes.

3 Q. Okay.

4 A. And there was several conversations following
5 that.

6 Q. Were those conversations limited to yourself,
7 Mr. Brackett, Mr. Chen, and Ms. Pickle? Or were there
8 other people involved?

9 A. I can't remember the chronology. I know after
10 the report and then into the rulemaking Cole Giering was
11 brought into the conversation. Legal counsel -- there
12 was conversations with the experts.

13 Q. Who were the experts?

14 A. I can't remember all their names. I don't know
15 if we have that list here.

16 Q. Did you ever personally speak with any of the
17 experts?

18 A. No.

19 Q. Are all the experts listed here on what would
20 be will be your Exhibit 7 on page 45?

21 A. I believe so, yes.

22 Q. Was a Dr. Von Mol ever involved as an expert?

23 A. I believe so.

24 MS. DEBRIERE: And let me just mark this as
25 Exhibit 10.

1 (Plaintiff's Exhibit No. 10 was marked for
2 identification.)

3 BY MS. DEBRIERE:

4 Q. And this is a document -- an After the Fact
5 Request Form Under 35K. This form is indicating what?

6 A. Consultant services for vendor name Andre
7 Van Mol.

8 Q. And what kind of consulting services did
9 Dr. Van Mol provide?

10 A. I don't know all the details of that -- what
11 the contractor provided. But it was as part of the
12 GAPMS process.

13 Q. Okay. Why was it time sensitive? It indicates
14 on that form it was time sensitive. Why?

15 A. I don't know why the request was time
16 sensitive.

17 Q. Who would know that?

18 A. I don't know.

19 Q. Okay. At any time throughout the process did
20 you feel like there was an urgency to the development of
21 the report and rule?

22 A. Yes. The time sensitive nature was
23 communicated.

24 Q. By?

25 A. I don't know remember if it was in the original

1 request or if it was later in conversations with
2 leadership. I can't remember exactly who. But I think
3 the expectation to follow the process but work as
4 quickly as possible was apparent.

5 Q. Okay. But you cannot provide me an explanation
6 as to why it was identified as time sensitive?

7 A. Correct.

8 Q. I believe we already marked ATF to
9 Dr. Van Meter as Exhibit 8.

10 Dr. Van Mol -- do you know if he attended the
11 rule hearing for the exclusion of treatment for gender
12 dysphoria?

13 A. I don't know.

14 Q. Okay. What does this document, Exhibit 8,
15 indicate to you?

16 A. An approval for consultant services for vendor
17 named Quintan Van Meter.

18 Q. Okay. And what kind of services did he provide
19 in exchange for that reimbursement?

20 A. Consultant services.

21 Q. Consulting on what?

22 A. As part of the GAPMS process.

23 Q. Do you know what specific stages he provided
24 consultation on?

25 A. I don't.

1 Q. Do you know whose idea it was to use him?

2 A. I don't.

3 Q. Do you know whose idea it was to retain any of
4 the outside experts?

5 A. No.

6 Q. Was it internal to AHCA, that decision? Did
7 someone at AHCA decide to retain outside experts?

8 A. I don't know.

9 Q. Who would have made that decision?

10 MR. PERKO: Asked and answered.

11 THE WITNESS: I don't know.

12 BY MS. DEBRIERE:

13 Q. Are you aware of AHCA retaining outside experts
14 for any other GAPMS report?

15 A. I don't know.

16 Q. Other than Dr. Van Meter and Dr. Van Moll --
17 I'm sorry.

18 Was there a Dr. Grossman involved in the
19 process?

20 A. Yes.

21 Q. And what was Dr. Grossman's role?

22 A. I believe it was the same -- consultant
23 services.

24 Q. For the development of the report?

25 A. Yes.

1 Q. Okay. Do you know if they were reimbursed to
2 participate in the hearing?

3 A. I don't know.

4 Q. Okay. Were any of the -- other than
5 Dr. Van Mol and Dr. Van Meter -- was
6 Dr. Brignardello-Petersen reimbursed by AHCA for
7 consultant services related to the development of the
8 exclusion of treatment for gender dysphoria?

9 A. I don't know off the top of my head.

10 Q. What about Dr. James Cantor?

11 A. I don't know off the top of my head without
12 consulting if there was an invoice.

13 Q. Is that true for all the experts?

14 A. I can't remember how exactly the contracts --
15 the contracted services were reimbursed.

16 Q. Were they reimbursed?

17 A. They were.

18 Q. Looking at Van Meter's form -- why did you sign
19 that form for a \$34,000 reimbursement if you didn't know
20 what Van Meter was doing?

21 MR. PERKO: I'm going to object to form.

22 THE WITNESS: So I know that Van Meter was
23 consulting as part of the project. I just don't
24 know throughout the process all the specific details
25 of that consultation.

1 BY MS. DEBRIERE:

2 Q. Would you assume each expert listed was
3 similarly compensated for the amount that Dr. Van Meter
4 and Van Mol were compensated?

5 A. I'm not going to assume. Just looking at the
6 two invoices, they are very different.

7 Q. In what ways?

8 A. This one has a not to exceed amount. And then
9 this one has as dollar amount.

10 Q. Okay. Is that the only way they're different?

11 A. No.

12 Q. How else are they different?

13 A. The one for Quinton Van Meter has specific
14 information regarding his MFMP registration.

15 Q. What is MFMP?

16 A. My Florida Market Place.

17 Q. Okay. Any other ways that they're different?

18 A. Some of the other language is different. The
19 dates are different. But aside from that, no.

20 Q. How often do you approve an After the Fact
21 Request Form for reimbursement of outside expertise?

22 A. Not often.

23 Q. How many times have you done it for expertise
24 not related to the treatment of gender dysphoria?

25 A. I can't recall if I actually approved the

1 invoice; but I believe there was a consultant for the
2 Canadian Prescription Drug Importation Program at one
3 point. And I just can't remember the time.

4 Q. Is that the only time you can remember?

5 A. Yes.

6 Q. Okay. So when you were approving these forms
7 that don't come across your desk often, do they strike
8 you as something that needed careful review?

9 A. The invoice itself?

10 Q. The reason for reimbursement.

11 A. Yes. But the invoice itself seems pretty
12 straightforward that a reimbursement based on services
13 provided -- that had already been provided would be
14 signed.

15 Q. Did you do a careful review of the reason for
16 reimbursement?

17 MR. PERKO: Object to form.

18 THE WITNESS: I guess I'm not sure what you
19 mean by careful review. I personally was not
20 involved in all of the consultation services
21 provided. But I did meet with the team and knew
22 that services were provided.

23 BY MS. DEBRIERE:

24 Q. Prior to you receiving this request for
25 reimbursement, did you know these experts were being

1 relied on for consultation?

2 A. Yes.

3 Q. Did you have to approve that request?

4 A. I don't know if there was a request initiating
5 the services. I don't remember.

6 Q. Was there a need to approve the decision to
7 rely on outside experts?

8 MR. PERKO: Object to form.

9 BY MS. DEBRIERE:

10 Q. Was there a requirement that consulting with
11 outside experts be approved prior to the consultation?

12 MR. PERKO: Object to form.

13 THE WITNESS: Can you repeat that question.

14 BY MS. DEBRIERE:

15 Q. Was there -- who consulted with the outside
16 experts?

17 A. Again, I don't know the extent of what the
18 consultation services were or who all was part of that.

19 Q. In order for them to -- in order for the team
20 to develop the GAPMS report -- who wrote it -- in order
21 for them to consult with outside experts, did it require
22 your approval?

23 A. I don't recall ever approving them.

24 Q. And the team relying on outside experts to
25 write the GAPMS report on gender dysphoria, did it

1 require the approval of D.D. Pickle?

2 MR. PERKO: Object to form.

3 THE WITNESS: I can't recall how the formal
4 process was initiated.

5 And I do want to say relying on experts --
6 there was a lot of additional research done as well
7 as part of the GAPMS process. So I wanted to
8 clarify that.

9 BY MS. DEBRIERE:

10 Q. But part of writing the report was consulting
11 with these outside experts; correct?

12 A. Yes.

13 Q. And you don't know who made the decision to
14 consult with those experts; is that right?

15 A. Correct.

16 Q. Whoever made the decision -- we don't know who
17 that is. But whoever made the decision, did they
18 require approval before they could implement that
19 decision?

20 MR. PERKO: Object to form.

21 THE WITNESS: I don't know.

22 BY MS. DEBRIERE:

23 Q. Okay. As the bureau chief who oversees the
24 team who wrote this GAPMS report, did you have an
25 expectation that they would come to you for approval to

1 consult with outside experts that would then be paid?

2 A. Can you repeat that.

3 Q. As the bureau chief, the person who oversees
4 the team that wrote the GAPMS report on treatment for
5 gender dysphoria, did you have an expectation that they
6 first ask you permission before they consulted with
7 outside experts who charged for their services?

8 A. No.

9 Q. Why didn't you have that expectation?

10 A. I can't really answer that, as I was not part
11 of the decision to consult with the experts.

12 Q. Who was part of the decision?

13 A. I don't know.

14 Q. But you know you were not part of it. Okay.

15 At the bottom of the After the Request Form, it
16 states -- for Dr. Van Mol, which is Exhibit 10 -- it
17 states supervisor approval is required. What does that
18 mean?

19 A. In the routing hierarchy for approval.

20 Q. Approval of what?

21 A. For invoices for My Florida Marketplace. I'm
22 the direct supervisor of D.D. Pickle.

23 Q. So your approval is required for D.D. Pickle to
24 pay this bill?

25 A. Yes.

1 Q. Okay. But your approval was not required for
2 D.D. Pickle to incur this bill?

3 MR. PERKO: Object to form.

4 THE WITNESS: I don't remember if there was a
5 formal approval to initiate the services.

6 BY MS. DEBRIERE:

7 Q. Did you have to have approval to authorize this
8 payment to Dr. Van Mol?

9 A. I can't remember. I don't know where this goes
10 next in the routing.

11 Q. Okay. Did you ask permission to approve this
12 from anyone?

13 A. I can't remember a specific conversation. But
14 I knew it was approved by the agency to consult with --
15 to have the consultant services.

16 Q. Okay. Related to that, the last sentence is --
17 how did you know that?

18 A. How did I know what? Can you repeat that.

19 Q. I think you had responded that you knew the
20 agency had approved it. And so my question was: How
21 did you know that?

22 A. I don't remember the specific conversation.
23 But I do know that it was approved by leadership.

24 Q. And how do you know that?

25 A. There must have been a conversation. I just

1 can't remember an exact -- if there was an exact
2 conversation or a document I signed. I can't remember.

3 Q. Okay. Do you remember who you had the
4 conversation with or had the document signed by?

5 A. I don't remember.

6 Q. The last sentence under that first paragraph,
7 it says, "Verification of the availability of funding
8 and approval from executive leadership was obtained
9 prior to any work being conducted for this project."

10 Who was that executive leadership?

11 A. The majority of my discussions were with my
12 direct supervisor. But Tom Wallace ultimately signed
13 the report. And I don't know outside of that who all
14 was involved.

15 Q. Do you need a break?

16 A. Yeah.

17 (Brief recess.)

18 BY MS. DEBRIERE:

19 Q. Who decided the amount in those forms?

20 A. I don't know how the amount was negotiated.

21 Q. Did you follow up on the amount being
22 requested -- ask any questions about it?

23 A. I can't remember if I asked any questions.
24 But, again, as it states on the form -- the availability
25 of funding approval for leadership.

1 Q. So you think whoever that leadership was had
2 approved that amount?

3 A. I don't know how the reimbursement for the
4 services was negotiated.

5 Q. Okay. So you didn't ask any questions about
6 the amount or what it was being used for?

7 MR. PERKO: Object to form.

8 THE WITNESS: I knew what it was being used
9 for. But I can't remember if I asked any questions
10 about the amount.

11 MS. DEBRIERE: Okay.

12 THE WITNESS: I can't recall any.

13 BY MS. DEBRIERE:

14 Q. Are there any subject matter experts for the
15 services listed in that exclusion that are full-time
16 employees with the agency?

17 MR. PERKO: Object to form.

18 THE WITNESS: I don't believe so, since the
19 services outlined in the policy were not clearly
20 outlined in any existing coverage policy that would
21 have had any subject matter expert assigned to the
22 coverage policy.

23 BY MS. DEBRIERE:

24 Q. Do you have a subject matter expert in surgery?

25 A. I don't know if it's one person or more than

1 one. We have an area that's responsible for the
2 coverage policies we talked about earlier that contain
3 coverage for surgical procedures.

4 Q. So you have a subject matter expert for
5 outpatient hospital services?

6 A. Yes.

7 Q. And do you have a subject matter expert for
8 inpatient hospital services?

9 A. I don't know if it's the same person.

10 Q. Okay. But do you have a subject matter expert
11 in inpatient, it just might be the same person?

12 A. There's a team responsible for oversight of
13 those policies, yes.

14 Q. Was that team involved in the development of
15 this GAPMS report?

16 A. Not to my knowledge. But I can't speak to all
17 of the research and activities that were part of the
18 completion of the project.

19 Q. Who is that team -- that team that are the
20 suggest matter experts in inpatient and outpatient
21 hospital services?

22 A. That would be John Matson under Jesse Bottcher
23 who is responsible for primary and preventive surgeries,
24 including dental.

25 Q. Okay. You had mentioned before the break that

1 you had communications about the development of the
2 GAPMS report with legal counsel; is that correct?

3 A. I believe so. I can't remember if it was part
4 of the report or part of the rule. I know for sure with
5 the rulemaking process that legal is involved in that
6 process normally. And they were in this instance as
7 well.

8 Q. Did that legal include outside counsel?

9 A. I don't know. I don't remember meeting with
10 outside counsel.

11 Q. Okay. You don't remember with meeting with
12 Holtzman & Vogel, the law firm?

13 A. No.

14 Q. Did you communicate with any other State
15 agencies like the Florida Department of Health about the
16 GAPMS report?

17 A. I personally did not.

18 Q. Did anybody at the Agency for Health Care
19 Administration?

20 A. I don't know.

21 Q. Did you communicate -- were there any
22 communications between AHCA and the Governor about the
23 development of this report?

24 A. I don't know.

25 Q. Did you personally communicate with the

1 Governor's office about the development of this report?

2 A. No.

3 Q. Did you personally communicate with the
4 Governor's office about the exclusion of treatment for
5 gender dysphoria?

6 A. No.

7 Q. Were there any communications between AHCA and
8 people that provided public comment at the hearing?

9 A. I'm sorry; can you repeat the question.

10 Q. Were there any communications between AHCA --
11 prior to the hearing, were there any communications
12 between AHCA and the people who provided public comment
13 at the hearing?

14 A. I don't know.

15 Q. Did you personally communicate with anyone who
16 provided public content at the hearing prior to the
17 hearing?

18 A. No.

19 Q. Was anyone at AHCA aware that specific people
20 would provide public content at the hearing prior to the
21 hearing?

22 A. I don't know.

23 Q. Were you aware that there were any specific
24 members of the public who would provide public comment
25 at the hearing prior to the hearing?

1 A. No.

2 Q. The person who is identified as authoring the
3 GAPMS report on gender dysphoria is Matt Brackett;
4 correct?

5 A. Yes, he was the primary author.

6 Q. Do you recall a meeting between you, Mr. Weida,
7 and Mr. Bottcher discussing who the author of the report
8 would be?

9 A. I don't remember if Jesse was in any of the
10 conversations.

11 Q. Okay. Did Jesse ever express a concern to you
12 about someone -- anyone on his team drafting the GAPMS
13 report on gender dysphoria treatment?

14 A. Prior to?

15 Q. At any time.

16 A. Can you say that again.

17 Q. Did Mr. Bottcher ever express to you concerns
18 over someone on his team drafting the GAPMS report on
19 the treatment for gender dysphoria?

20 A. Not that I can recall.

21 Q. Was the GAPMS decision tree used before you
22 decided to undertake the GAPMS analysis that is
23 contained in the June 2022 report?

24 A. I don't know.

25 Q. Who would have that information?

1 Did Secretary Marstiller in her letter to Tom
2 Wallace -- did she direct Tom Wallace to undertake the
3 GAPMS process?

4 MR. PERKO: Object to form.

5 THE WITNESS: I can't recall the details of the
6 letter.

7 MS. DEBRIERE: Me neither. Do we have a copy?

8 MS. CHRISS: It's the last page right there.

9 It's Attachment A.

10 MS. DEBRIERE: Oh. It's the very back of
11 Exhibit --

12 MR. PERKO: It's not attached to ours.

13 MS. DEBRIERE: Okay.

14 MS. DUNN: Why don't you pull it off and mark
15 it as a separate exhibit.

16 MS. DEBRIERE: So we'll mark the letter from
17 Simone Marstiller dated April 10th, 2022, as Exhibit
18 11. And that's Attachment A to the June 2022, GAPMS
19 report related to the treatment for gender
20 dysphoria.

21 (Plaintiff's Exhibit No. 11 was marked for
22 identification.)

23 BY MS. DEBRIERE:

24 Q. So in this letter is Secretary Marstiller
25 directing Mr. Wallace to undertake the GAPMS process?

1 MR. PERKO: Object to form.

2 THE WITNESS: Yes.

3 BY MS. DEBRIERE:

4 Q. Do you think that Secretary Marstiller
5 undertook a decision tree prior to writing this letter
6 and sending it to Mr. Wallace?

7 MR. PERKO: Object to form.

8 THE WITNESS: I don't know.

9 BY MS. DEBRIERE:

10 Q. Has the secretary of AHCA ever personally
11 completed a decision tree on the GAPMS process?

12 A. I don't know.

13 Q. Would it be unusual if the secretary of AHCA
14 completed a decision tree on the GAPMS process?

15 A. I don't know.

16 Q. Looking at the GAPMS report itself, does it
17 contain a fiscal analysis?

18 A. I don't know off the top of my head.

19 Q. Yeah. No, take your time.

20 A. No, I do not see a fiscal analysis.

21 Q. Do you see anything related to cost
22 effectiveness?

23 A. No.

24 Q. Do you know why that was not included?

25 A. No.

1 Q. Is budget neutrality in reaching a GAPMS
2 decision important?

3 MR. PERKO: Object to form.

4 THE WITNESS: I don't know. I know that that's
5 something when determining a coverage determination
6 that is taken into consideration. But specific to
7 the GAPMS process, I don't know.

8 BY MS. DEBRIERE:

9 Q. Okay. Who would know that? Would the person
10 responsible for writing GAPMS reports know that?

11 A. Yes. Or Jesse Bottcher or Matt Brackett.

12 Q. Or Jeff English?

13 A. Yes.

14 Q. Who decided which services would be assessed in
15 the GAPMS report?

16 A. I don't know.

17 Q. So typically a request comes in from the public
18 for a specific service. In this instance, the request
19 came from the secretary; correct?

20 A. Yes.

21 Q. So would it have been the secretary who decided
22 which services should be assessed?

23 A. I can't recall how the decision was made. I do
24 know that that was part of conversations we had during
25 this process. But I can't recall exactly how the

1 decision was finalized.

2 Q. Was there ever a discussion about narrowing the
3 types of services to be included?

4 A. I don't recall specifically. I know that the
5 coverage of behavioral health services was something
6 that was always covered. But outside of that
7 specifically, I can't remember.

8 Q. Was there ever any discussion about undertaking
9 the GAPMS process for a set of services simultaneously
10 as opposed to a single service?

11 A. Can you clarify.

12 Q. In the discussions about writing the report or
13 assessing the services, were there ever any concerns
14 raised about undertaking the process for a set of
15 services as opposed to a single one?

16 A. I don't recall specifically.

17 Q. Was there any discussion about EPSDT?

18 A. I can't remember if it was specific to the
19 development of the report or the rulemaking more
20 specifically. But I believe there was.

21 Q. And what was discussed?

22 MR. PERKO: I'm going to object for a second.
23 Did that include counsel? Did those discussions
24 include counsel?

25 THE WITNESS: Yes.

1 MR. PERKO: And who was that?

2 THE WITNESS: I don't remember.

3 MR. PERKO: But it did include counsel?

4 THE WITNESS: I believe it was a discussion on
5 the rulemaking with counsel.

6 MR. PERKO: I'm going to instruct the witness
7 not to answer.

8 BY MS. DEBRIERE:

9 Q. Were all discussions had in front of counsel
10 about EPSDT?

11 A. I don't remember.

12 Q. How about comparability?

13 MR. PERKO: I'll ask you the same thing.

14 THE WITNESS: Can you remind me what you're
15 referencing when you say comparability. I think you
16 mentioned that at the very beginning of the day.

17 MS. DEBRIERE: Comparability is a requirement
18 under the Federal Medicaid Act in the administration
19 of the coverage of the Medicaid services.

20 THE WITNESS: I don't recall.

21 BY MS. DEBRIERE:

22 Q. Were there communications with the Centers for
23 Medicare and Medicaid Services about AHCA's decision to
24 assess whether the services listed in the exclusion were
25 experimental?

1 A. I don't know. I personally did not have any
2 conversations.

3 Q. Who communicates with CMS about those kinds of
4 things?

5 A. Those kinds of things, you mean changes in
6 coverage?

7 Q. Does CMS ever reach out to AHCA about concerns
8 they have about an action that they're taking related to
9 Medicaid coverage?

10 A. Yes.

11 Q. Who would be the point person at AHCA to have
12 those conversations?

13 A. So if an update to a federal authority were
14 needed, that would be either Catherine Mcgrath or
15 myself.

16 Q. Okay. You would not have had -- have you had
17 any conversations with CMS about the GAPMS report
18 related to the treatment of gender dysphoria?

19 A. No.

20 Q. Has Catherine?

21 A. Not to my knowledge.

22 Q. Have you had any conversations with CMS about
23 the exclusion of the treatment for gender dysphoria as
24 contained in Rule 59G-1.050?

25 A. I have not.

1 Q. Has Catherine?

2 A. Not to my knowledge.

3 Q. Has anybody else at AHCA?

4 A. I don't know.

5 Q. Okay. You mentioned a second ago that you
6 weren't sure if you were talking about EPSDTs as it
7 related to the report or the rulemaking. When you make
8 that distinction, are you referring the writing of the
9 report versus the adoption of the rule?

10 A. Yes.

11 Q. Okay. How was it decided that the conclusions
12 from the GAPMS report should be adopted into rule?

13 A. I'm trying to remember the specific
14 conversations. But I do believe those were
15 conversations with counsel as well.

16 Q. Okay. The expedited GAPMS that you were
17 involved in from start to finish, was that decision
18 adopted into rule?

19 A. It was just one other GAPMS. And I don't
20 believe any rule update was needed for that one.

21 Q. Why was a rule update needed for this GAPMS
22 report?

23 MR. PERKO: If that's discussion with counsel,
24 I will instruct you not to answer.

25 THE WITNESS: Because there was not any policy

1 language that clearly explained the coverage, it was
2 determined that developing policy language was the
3 best approach. Anything past that was -- how that
4 process went was conversation with counsel.

5 BY MS. DEBRIERE:

6 Q. How often in your day-to-day in making
7 decisions in your job do you have to consult with legal
8 counsel?

9 A. Often.

10 Q. Okay. So does that mean -- okay. Like, every
11 day?

12 A. I would say the majority of days.

13 Q. Okay.

14 A. And I'll just specify. I have some sort of
15 contact or interaction with legal counsel.

16 Q. On most days?

17 A. Yes. And, again, because the rule promulgation
18 does require review and some other documents we route
19 are managed care contracts also route through legal.
20 Just to give you examples of why it's quite often.

21 Q. They're all contacts with legal counsel about
22 things related to the doing of your job?

23 A. The development of policy and -- yes.

24 Q. Okay. So there was -- you said there was --
25 the reason that it needed to be adopted into rule is

1 because there was no clear coverage policy on the
2 services at issue; is that correct?

3 A. I can't remember all the factors that went into
4 the decision. But I believe that was one of the factors
5 when it was assessed that there was no coverage policy
6 specific to the treatment of gender dysphoria.

7 Q. Were there existing coverage guidelines?

8 A. Not to my knowledge.

9 Q. At the time were you aware of existing pharmacy
10 policies related to the treatment of gender dysphoria?

11 A. At what time? Can you specify.

12 Q. It was 2017/2016.

13 A. I was not with the agency in 2016. So I would
14 not have been part of any development of policy at that
15 time.

16 Q. But when you were deciding whether to adopt
17 this exclusion into the rule, did you do any review of
18 existing coverage guidelines or past coverage decisions?

19 A. I believe we did. But I can't recall the
20 specifics.

21 Q. Did you review past GAPMS reports regarding the
22 treatment of gender dysphoria?

23 A. I believe we did.

24 Q. And why weren't they enough to establish the
25 coverage policy?

1 MR. PERKO: Object to form.

2 THE WITNESS: I don't know.

3 BY MS. DEBRIERE:

4 Q. 59G-1.050, Subpart 7 -- it bans Medicaid
5 coverage for puberty blockers, hormones and surgery if
6 done so to treat gender dysphoria; correct?

7 A. It covers that Medicaid does not cover those
8 services for the treatment of gender dysphoria; correct.

9 Q. Does it distinguish between adults and
10 children?

11 A. No.

12 Q. So the exclusion applies equally to both
13 children and adults; is that correct?

14 A. Yes.

15 Q. Okay. And it excludes Medicaid coverage for
16 puberty blockers and hormones and surgery to treat
17 gender dysphoria, but it does not exclude Medicaid
18 coverage for those services to treat other diagnoses; is
19 that correct?

20 A. Correct.

21 Q. And I just forgot you answer; I apologize.
22 Were you involved in the rule hearing held on July 8th
23 regarding the exclusion set forth in 1.050?

24 A. No.

25 Q. Were you aware that outside legal counsel

1 participated in that hearing?

2 A. I don't know if I was made aware prior to
3 today. I can't remember.

4 Q. At rule hearings you've been in in the past, do
5 the State agencies have a panel of subject matter
6 experts who respond to public comment during the
7 hearing?

8 A. I can't cite the specific language, but it's
9 actually required per Chapter 120 that the agency has
10 subject matter experts who can speak to the contents of
11 whatever is being discussed at a public meeting
12 available.

13 Q. Other than the July 8th hearing, are you aware
14 of any time that any agency has retained outside subject
15 matter experts to participate on that panel?

16 A. I'm not aware of any.

17 Q. To your knowledge is this the only time AHCA
18 has created a slogan to advertise the conclusion in its
19 GAPMS memo?

20 MR. PERKO: Object to form.

21 BY MS. DEBRIERE:

22 Q. Are you aware of the slogan "Let kids be kids"?

23 A. I've seen the website, yes.

24 Q. In your experience has AHCA ever designed a
25 website page for any other rule adoption?

1 A. I can't remember if it was specific to rule
2 adoption. But I can think of a couple of examples where
3 we created web pages for policy updates; for example,
4 for home and community based settings rule that was an
5 administrative rule as well as a federal rule. There's
6 a specific external web page for updates regarding that
7 and information on that rule.

8 When we received the American Rescue Act
9 funding approval, we created a web page with information
10 on that funding and what those funding could be used
11 for. So I feel like it's pretty common for us to update
12 our external website when there's important information
13 to communicate.

14 Q. In those other examples, did AHCA ever develop
15 a slogan to go along with those web pages?

16 A. Not in the examples that I used, I don't think.

17 Q. Did they issue press releases?

18 A. The American Rescue Act funding may have had
19 one. But I can't remember.

20 Q. Okay. Just going back quickly. My co-counsel
21 has pointed out to me that in Chapter 120 it says that
22 at the rule hearing agency staff must be available but
23 not an expert. Do you think maybe you were confusing
24 that requirement that an expert needs to be available
25 under 120?

1 A. I think it says an agency staff with knowledge.

2 Q. Okay. "Ensure that staff are available to
3 explain the agency's proposal and to respond to
4 questions or comments regarding the rule." Is that the
5 provision you were --

6 A. Yes.

7 Q. -- thinking of? Okay.

8 Typically when AHCA decides not to cover a
9 particular service, where is that information included?

10 MR. PERKO: Object to form.

11 THE WITNESS: I think it depends on the policy.
12 Each policy has different exclusions, if there are
13 any, with the service. Or most of the coverage
14 policies include a section specific to exclusions.

15 MS. DEBRIERE: Most of the policies? Is that
16 what you said? I apologize.

17 THE WITNESS: Most of the coverage policies.

18 BY MS. DEBRIERE:

19 Q. Okay. And those coverage policies are service
20 specific policies?

21 A. The examples I was thinking of, yes, were
22 service specific coverage policies and include -- I
23 can't remember exactly what section in the example of
24 where to find that in the coverage policy. But, yes, it
25 would include exclusion specific to the coverage that's

1 being described in the policy.

2 Q. Okay. The exclusion on the treatment of gender
3 dysphoria, is it in a service specific coverage policy?

4 A. No. This is a general Medicaid policy. But it
5 does include coverage information including what Florida
6 Medicaid reimburses for and what it does not.

7 Q. Does it speak to the exclusion of any other
8 services under Florida Medicaid but those services
9 excluded for the treatment of gender dysphoria?

10 A. Yes.

11 Q. Which ones?

12 A. No. 4 is an example. (4)(b), that speaks to
13 that Florida Medicaid does not cover continuous services
14 after the emergency has been alleviated.

15 Q. Is that a specific service? Or is that the
16 length of time for any service?

17 A. I apologize. It's emergency service. It's
18 under the section for emergency Medicaid.

19 Q. But, again, is that speaking to the coverage of
20 any service deemed emergency?

21 A. It's specific to emergency services provided to
22 aliens who meet all Florida Medicaid eligibility
23 requirements except for citizenship.

24 Q. It says an exclusion under Subpart 7 speaks
25 specifically to the exclusion of sex reassignment

1 surgeries; correct?

2 A. Services for the treatment of gender dysphoria.

3 Q. But only three services.

4 A. Four.

5 Q. What are examples of procedures that alter
6 primary or secondary sexual characteristics that are not
7 related to surgery?

8 A. I don't know.

9 Q. Just going back to the surgery, why not include
10 that in service specific policies that discuss surgery?

11 A. Can you repeat the question.

12 Q. Looking at the exclusion of sex reassignment
13 surgeries, why was that not included in the coverage
14 policies related to surgeries that we discussed earlier?

15 A. I don't recall the specific conversation on how
16 it was decided that this was the most appropriate
17 policy. And I do believe that most of that conversation
18 was with counsel.

19 Q. So same question for puberty blockers. Why
20 wouldn't you include that in a pharmacy coverage policy?

21 A. I don't know.

22 Q. And Subpart 7's subject line is "Gender
23 Dysphoria"; correct?

24 A. Yes.

25 Q. And that's a diagnosis?

1 A. I don't know clinically the definition.

2 Q. We've been talking about the treatment of
3 gender dysphoria; right?

4 A. Yes.

5 Q. So in order to exclude treatment of gender
6 dysphoria, it would be the exclusion of a treatment for
7 a diagnosis; correct?

8 A. Yes. But I can't speak to the specifics of the
9 diagnosis or what that means in clinical terms.

10 Q. Okay. For the July 8th hearing, do you know
11 how many public comments were submitted?

12 A. I don't know.

13 Q. Do you know if it was more than 100?

14 MR. PERKO: Asked and answered.

15 THE WITNESS: I know it was a lot.

16 BY MS. DEBRIERE:

17 Q. Okay. And do you know how long it took AHCA to
18 review and consider the comments before adopting the
19 final rule?

20 A. I don't know the length of time. But I know
21 that all the public comments were reviewed.

22 Q. Who reviewed them?

23 A. I know Cole Giering did. I don't know if
24 anybody else -- if anybody else did.

25 Q. Okay. So after the July 8th hearing up until

1 the final adoption of the rule, other than reviewing and
2 considering public comment, what else did AHCA do before
3 adopting the rule?

4 A. Can you repeat the question.

5 Q. So after the July 8th hearing up until the
6 final adoption of the rule, other than reviewing public
7 comment, what other activities did AHCA undertake in
8 deciding to adopt the rule?

9 A. I don't know. I can't remember specific to
10 this rule. But after it's been determined there's no
11 changes needed to the rule, the filing for adoption
12 would be the next step.

13 Q. How do you reach that decision that no changes
14 should be made?

15 MR. PERKO: Object to form.

16 THE WITNESS: There's various factors involved
17 in that decision. And it really depends on the
18 specific circumstances.

19 MS. DEBRIERE: Okay. I don't know what it
20 would be labeled, but do you have an exhibit -- it's
21 an email from Ms. McGriff to Magellan.

22 MS. CHRISS: Yes. The email exchange between
23 Magellan and AHCA.

24 MS. DEBRIERE: Thank you.

25 Court Reporter, just for your reference what we

1 just marked as Exhibit 12 is Bates stamped
2 DEF_00288753 to 000288756.

3 (Plaintiff's Exhibit No. 12 was marked for
4 identification.)

5 BY MS. DEBRIERE:

6 Q. So Magellan is emailing several people at AHCA.
7 And she says, "Attached are the internal criteria not
8 publicly posted."

9 What are the internal criteria?

10 A. I don't know.

11 Q. Does Magellan rely on internal criteria for the
12 coverage of Medicaid services?

13 A. I don't know.

14 Q. What does "CCM" mean? It's right after that
15 sentence. "Attached are the internal criteria 'not
16 publicly posted' CCM."

17 A. I don't know.

18 Q. What does gender code mean?

19 A. I don't know.

20 Q. Do you know hot had significance of "B for
21 both" is?

22 A. I do not.

23 Q. Who is Linda Simone Moore?

24 A. Who?

25 Q. So there's a sender up top here -- I'm sorry.

1 Leslie.

2 A. Moore-Simons.

3 Q. I need reading glasses. Leslie Moore-Simons.
4 That's exactly right.

5 A. I don't know.

6 Q. Okay. Who is Susan Williams?

7 A. She works for Ashley Peterson in the pharmacy
8 unit in the Bureau of Medicaid Policy.

9 Q. Okay. And who is Arlene Elliott? I'll just
10 note the date that Arlene's email was sent was
11 8/21/2017.

12 A. Currently Arlene Elliott is in a different
13 division at the Agency for Health Care Administration.
14 But at this time, she was the AHCA administrator over
15 the pharmacy policy section of the Bureau of Medicaid
16 Policy.

17 Q. And what unit is she in now?

18 A. I don't know. She's no longer in the division
19 of Medicaid.

20 Q. What division is she in?

21 A. I believe it's Health Quality Assurance.

22 Q. Do you know when she left her position in the
23 Bureau of Medicaid Policy?

24 A. I believe it was spring or summer 2021. I'm
25 not sure the exact date.

1 Q. Okay. Earlier in the exchange -- and yet dated
2 later -- is the email dated April 20th, 2022, from Elica
3 King-Wilson at Magellan. And she's included some
4 language which she underlined and bolded. And it says,
5 "All requests require vetting by AHCA before a final
6 determination is made."

7 And it appears this is related to a final
8 determination as to whether -- well, it says -- Leslie
9 noted, "MMA does have an internal gender dysphoria
10 criteria, which is attached."

11 MMA stands for?

12 A. I don't know in what context she's using it.

13 Q. Okay.

14 A. But to me, MMA would normally stand for managed
15 medical assistance.

16 Q. I assume you're confused because this is coming
17 from Magellan which is not a managed medical assistance
18 program; is that right?

19 A. Yes. So I don't know if that's what she's
20 referring to.

21 Q. And it says, "This internal document serves for
22 GnRH analog use to delay puberty in adolescents with
23 gender dysphoria." This document was provided by AHCA
24 due to a fair hearing request received for Lupron for a
25 recipient with this diagnosis" -- meaning gender

1 dysphoria. And it goes on with the underlying language
2 that all of those requests -- coverage of Lupron for
3 gender dysphoria -- need to be vetted by AHCA before a
4 final determination is made.

5 Were you familiar with that process at all?

6 A. No. I don't know what process they were
7 referring to.

8 Q. Would Ashley Peterson know?

9 A. I don't know. But she does work closely with
10 Magellan.

11 Q. Okay. Did AHCA work with managed care plans to
12 implement the exclusion in 1.050?

13 A. They were notified. But the specifics of how
14 that communication happened, I can't recall.

15 MS. DEBRIERE: Okay. Can I have the SMMC
16 Policy Transmittal relating to the Non-Coverage of
17 Gender Dysphoria Treatment.

18 MS. DUNN: Do you want the policy or the
19 emails?

20 MS. DEBRIERE: Could you do both.

21 MS. DUNN: Do you want them together?

22 MS. DEBRIERE: That would be great. But
23 separate exhibits.

24 (Plaintiff's Exhibit No. 13 was marked for
25 identification.)

1 (Plaintiff's Exhibit No. 14 was marked for
2 identification.)

3 BY MS. DEBRIERE:

4 Q. So right now we're looking at an email that's
5 Bates stamped DEF_000258835 to 000258838. It's an email
6 from D.D. Pickle CC-ing you. And it's to Jason Weida.

7 In this -- I'm sorry. Looking specifically at
8 an email dated August 22, 2022, from D.D. to Ashley
9 Peterson and Matt Brackett. It states, "Ashley, Ann
10 wants to include the 60-day language in the alert?"

11 What alert is D.D. Pickle referring to?

12 A. I believe it was the provider alert.

13 Q. And what's a provider alert?

14 A. It's the main way -- one of the main ways we
15 communicate information to our providers and external
16 stakeholders.

17 (Plaintiff's Exhibit No. 15 was marked for
18 identification.)

19 BY MS. DEBRIERE:

20 Q. I'm handing you a document that's marked as
21 Exhibit 15, called Florida Medicaid Health Care Alert
22 Sign-Off Form, starting at Bates stamp DEF_000258839.

23 Is this the provider alert you were referring
24 to?

25 A. Yes. It looks to be a provider alert regarding

1 the coverage of treatment for gender dysphoria.

2 MS. DEBRIERE: Okay. And then what was the
3 transmittal?

4 MS. DUNN: It was 14.

5 BY MS. DEBRIERE:

6 Q. No. 14 -- can you look at that document. And
7 that's Bates stamped DEF_000258833.

8 What is this document?

9 A. It looks to be a draft -- a policy transmittal.

10 Q. And who does that go to?

11 A. This specific one is marked to be sent to the
12 medical assistance and specialty plans.

13 Q. Is that the final that was sent?

14 A. It does not appear so, no.

15 Q. Okay. How do you know that?

16 A. The policy transmittal number is not completed
17 and it's not signed.

18 Q. Okay. Going back to the provider alert, was
19 that the final that was sent?

20 A. I can't tell from this document if this was the
21 final that was sent.

22 Q. Okay. Would you be able to tell from any of
23 the versions whether it was the final?

24 A. Seeing the actual email alert would be how I
25 would make sure. My team actually does not send out the

1 final provider alerts. So that's typically how I would
2 look at the final version.

3 Q. Okay. And the policy transmittals and the
4 provider alerts -- are those available on the agency's
5 website? The finals?

6 A. Yes.

7 Q. Okay. So turning back to that email exchange
8 where D.D. mentions you by name.

9 What is 60-day language?

10 A. I believe she's referring to the continuity of
11 care.

12 Q. What is continuity of care?

13 A. It's a contract requirement for the plans to
14 provide services for a period of time. I don't know if
15 it's specific to when they change plans. I can't recall
16 the exact contract language, but it's a contract
17 provision.

18 Q. And are services previously being covered
19 supposed to be continue being covered for 60 days
20 according to the 60-day language?

21 A. I can't recall the exact parameters of the
22 requirement.

23 Q. Do you recall why --

24 MR. PERKO: Counsel, we're getting on seven
25 hours here.

1 BY MS. DEBRIERE:

2 Q. Do you recall why the 60-day language -- you
3 wanted the 60-day language included in this alert?

4 A. I can't remember the conversation around this.
5 And I can't speak for D.D.

6 Q. Well, D.D. is speaking for you; right?
7 The subject is "GD Policy Transmittal";
8 correct?

9 A. Yes.

10 Q. And what does "GD" stand for?

11 A. Based on the attachments, I would conclude that
12 it is for gender dysphoria.

13 Q. Okay. And this would be discussion had after
14 the rule was adopted excluding coverage of services for
15 the treatment of gender dysphoria; correct?

16 A. Can you repeat that question.

17 Q. The date of this email is after the rule was
18 adopted to exclude coverage of services for treatment of
19 gender dysphoria.

20 A. I believe so.

21 Q. You don't recall why you thought it was
22 important to have the 60-day language included in the
23 alert?

24 A. I don't recall the specifics of the
25 conversation. But I believe it was to ensure if there

1 was any current reimbursement or authorization that
2 would apply.

3 Q. Current authorization of treatment of gender
4 dysphoria?

5 A. Of the services listed in Rule 1.050, No. 7.

6 Q. Did any plans state to AHCA that they would
7 continue coverage of the services excluded in the rule
8 even though that rule had been adopted?

9 A. I don't know.

10 Q. Who would know that?

11 A. I don't know who it would have gone to. If
12 there was a question, the communications typically go
13 through the contract managers.

14 Q. Okay. Do you know if all plans have
15 implemented the exclusion contained in the rule?

16 A. I don't know.

17 Q. Are you familiar with the variance and waiver
18 process under Chapter 120?

19 A. Yes.

20 Q. Okay. What is the purpose of that statute?

21 MR. PERKO: Object to form; calls for a legal
22 conclusion.

23 BY MS. DEBRIERE:

24 Q. What is the purpose of the variance and waiver
25 process?

1 MR. PERKO: Object to form.

2 THE WITNESS: I don't know.

3 MR. PERKO: Counsel, we're getting on seven
4 hours here.

5 MS. DEBRIERE: All right. Let me just consult
6 with my team for just a second.

7 (Brief recess.)

8 MS. DEBRIERE: We'll all set with direct.

9 Thank you for your time, Ms. Dalton.

10 MR. PERKO: I don't have any questions.

11 THE COURT REPORTER: Would you like to read or
12 waive?

13 THE WITNESS: Read.

14 THE COURT REPORTER: Would you like to order at
15 this time?

16 MS. DEBRIERE: Yes.

17 THE COURT REPORTER: Would anybody like to
18 order a copy?

19 MR. PERKO: Yes.

20 (This deposition was concluded at 6:05 p.m.)

21 - - -

22

23

24

25

CERTIFICATE OF OATH

STATE OF FLORIDA:

COUNTY OF LEON:

I, GREG T. SMITH, Notary Public, State of Florida,
do hereby certify that ANN DALTON personally appeared
before me on January 24, 2023 and was duly sworn and
produced her ID badge as identification.

Signed this 30TH day of JANUARY, 2023.

A handwritten signature in black ink that reads "Greg T. Smith". The signature is written in a cursive, slightly stylized font. The "G" is large and loops around the "T". The "S" is also large and loops around the "M".

GREG T. SMITH

Notary Public, State of Florida

My Commission No.: GG933698

Expires: March 21, 2024

CERTIFICATE OF REPORTER

STATE OF FLORIDA:

COUNTY OF LEON:

I, GREG T. SMITH, Notary Public, State of Florida, certify that I was authorized to and did stenographically report the deposition of ANN DALTON; that a review of the transcript was requested; and that the foregoing transcript, pages 6 through 175, is a true and accurate record of my stenographic notes.

I further certify that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 30TH day of JANUARY, 2023.

A handwritten signature in black ink that reads "Greg T." followed by a stylized flourish consisting of a long horizontal line with a small upward curve at the end.

GREG T. SMITH

1 KATHERINE J. DEBRIERE, ESQUIRE
DEBRIERE@FLORIDAHEALTHJUSTICE.ORG

3 January 30, 2023

4 RE: Dekker, August v Marstiller, Simone
1-24-23 Ann Dalton, Job# 5662663

6 The above-referenced transcript is available for
7 review.

8 (The witness/You) should read the testimony to
9 verify its accuracy. If there are any changes,
10 (the witness/you) should note those with the reason
11 on the attached Errata Sheet.

12 (The witness/You) should, please, date and sign the
13 Errata Sheet and email to the deposing attorney as well as
14 to Veritext at Transcripts-fl@veritext.com and copies will
15 be emailed to all ordering parties.

16 It is suggested that the completed errata be returned 30
17 days from receipt of testimony, as considered reasonable
18 under Federal rules*, however, there is no Florida statute
19 to this regard.

20 If the witness fails to do so, the transcript may be used
21 as if signed.

22 Yours,
23 Veritext Legal Solutions

24
25 *Federal Civil Procedure Rule 30(e)/Florida Civil Procedure
Rule 1.310(e).

Dekker, August v Marstiller, Simone
1-24-23 Ann Dalton, Job# 5662663

E R R A T A S H E E T

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PAGE_____ LINE_____ CHANGE_____

REASON_____

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

(WITNESS NAME)

DATE

[& - 30th]

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[3100 - adheres]

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[ahca - approve]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

AUGUST DEKKER, et al.)

Plaintiffs,)

VS.)

) NO. 4:22-CV-00325-RH-MAF

JASON WEIDA, et al.,)

Defendants.)

VIDEOCONFERENCE DEPOSITION OF
G. KEVIN DONOVAN, M.D., M.A.
LOCATED IN SAND SPRINGS, OKLAHOMA
TAKEN ON BEHALF OF THE PLAINTIFFS
ON MARCH 22, 2023

REPORTED BY: JANA C. HAZELBAKER, CSR

A P P E A R A N C E S

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* * * * *

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that the videoconference deposition of G. KEVIN DONOVAN, M.D., M.A., may be taken on behalf of the Plaintiffs, on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma, by Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, pursuant to Notice.

IT IS FURTHER STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that all objections, except as to the form of the question, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

* * * * *

1 G. KEVIN DONOVAN, M.D., M.A.,
2 having been first duly sworn at 9:03 a.m. CST,
3 deposes and says in reply to the questions propounded
4 as follows, to wit:

5 DIRECT EXAMINATION

6 BY MS. DUNN:

7 Q So, good morning, Dr. Donovan. As I
8 mentioned before, my name is Chelsea Dunn. I'm an
9 attorney for the plaintiffs in the lawsuit Dekker,
10 et al. versus Weida. I will be deposing you today.
11 I work for an organization by the name of Southern
12 Legal Counsel.

13 If you don't mind just introducing yourself
14 and stating and spelling your name for the record, I
15 would appreciate it.

16 A Yes. My full name is Gerard Kevin Donovan.
17 G-e-r-a-r-d, K-e-v-i-n, D-o-n-o-v-a-n.

18 Q Thank you, Dr. Donovan. Just as an initial
19 question, have you ever been deposed before?

20 A Yes.

21 Q Okay. I'm going to go over a couple ground
22 rules, just so that we're on the same page for
23 expectations today and that there's no confusion.

24 The court reporter here is writing down
25 everything you say, so if you can respond to my

1 questions using verbal answers, for example, yes or
2 no instead of shaking your head or nodding, that
3 would be a lot -- it's a lot easier for her to
4 transcribe our conversation today.

5 We also -- I think in natural conversation
6 people have a tendency to start answering a question
7 sometimes before it's done, so if you can be careful
8 not to speak over me or to begin answering my
9 question until I finish it, I will try to do the same
10 and not talk over you as well. Is that fair?

11 A Yes, ma'am.

12 Q You're welcome, as we mentioned before, to
13 take a break at any time. Please just answer -- if
14 you'll finish answering the question that's on the
15 table before you request a break, that -- you know,
16 that -- we would ask that you finish answering the
17 question before we take a break.

18 You can also speak to your attorney at any
19 time, but, again, please finish answering my question
20 unless there is an issue of privilege.

21 You can also -- if you, later in the
22 deposition, realize that you gave an answer earlier
23 that wasn't full and complete, you're welcome to
24 supplement your testimony. Or if you realize that
25 you were mistaken, you can also correct your

1 testimony, please just let us know.

2 You can also ask for documents to refresh
3 your memory as to something. So if there's something
4 that would help your memory, please let us know what
5 that is.

6 Have you taken any medications today that
7 would affect your ability to answer my questions
8 truthfully and fully?

9 A No.

10 Q Are you ill or is there anything else going
11 on that would affect your testimony today?

12 A No.

13 Q The oath you've taken that the court
14 reporter provided is the same oath that you would
15 take in a court of law. So do you understand that
16 you are testifying today under penalty of perjury?

17 A Yes.

18 Q And your oath is to answer, not just
19 truthfully, but also the whole truth. So do you
20 understand that you're expected to give full and
21 complete answers today?

22 A Yes.

23 Q Thank you.

24 Before we begin, I just want to talk a
25 little bit about the topic of our deposition today.

1 So this case is about healthcare that is commonly
2 used to treat individuals -- I'm sorry, to treat
3 gender dysphoria for transgender people. We refer to
4 that sometimes as "gender-affirming care." Are you
5 comfortable with my use of that term?

6 A You can use any terminology that you want.

7 Q And if I refer to gender-affirming care, do
8 you understand that that means, for example, medical
9 treatment such as the administration of cross-sex
10 hormones, gender-confirming surgeries, or
11 puberty-blocking medications?

12 A I do.

13 Q Have you been retained as an expert witness
14 by the defense in this case?

15 A Yes.

16 Q And you understand that you -- your report
17 was submitted to the Court by the defendants as
18 expert testimony in order to advance their case
19 against the plaintiffs?

20 A Yes.

21 Q And what expert testimony were you
22 specifically asked to provide in this case?

23 A I was asked to testify as a medical
24 ethicist.

25 Q And what opinions were you asked to

1 provide?

2 A Opinions about the propriety of the
3 gender-affirming care.

4 Q And what are your opinions as to the
5 propriety of gender-affirming care?

6 A I think it's problematic.

7 Q And when you say "problematic," what do you
8 mean?

9 A I mean I think that there are some problems
10 regarding the approach, the diagnosis and treatment
11 approach.

12 Q Can you explain what problems you believe
13 there are with the diagnosis and treatment approach
14 for gender-affirming care?

15 A Well, geez, that's a lot, but then we have
16 hours, don't we?

17 I think that the -- that there are problems
18 in the concept.

19 I think there are problems in the
20 application of that concept to a diagnosis for
21 individuals.

22 And I am aware of problems that have been
23 identified by many others, in terms of the treatments
24 themselves and the justification for them.

25 Q When you say problems identified by

1 "others," who are those others?

2 A Oh, they're in the literature.

3 Q Your opinions are fully set forth in your
4 expert declaration that was signed on February 15th,
5 2023; is that correct?

6 A I believe so.

7 Q So I will pull up that document so that we
8 can both confirm.

9 (Document is displayed).

10 Can you see the document labeled "Expert
11 Declaration of Kevin Donovan, M.D., M.A."?

12 A Yes, I can.

13 Q Is this your expert report?

14 A Looks like it.

15 Q Do you need to review it to be sure?

16 A No, no. Let's just go ahead.

17 Q Okay. I'll just quickly scroll down to
18 where your signature is.

19 Can you confirm that you signed this
20 document?

21 A It looks like it. Thank you.

22 (Whereupon, Exhibit Number 1 was marked for
23 identification purposes and made a part of the
24 record.)

25 Q (By Ms. Dunn) So I would like to ask that

1 this be marked as Plaintiffs' Exhibit 1.

2 Did anyone besides you contribute to
3 writing this report?

4 A No.

5 Q Did anyone besides you edit this report?

6 A I don't recall. I know I submitted it to
7 the defense attorneys and I don't think that they --
8 they may have edited something on it for clarity.
9 I'm not sure.

10 Q And when you say you "submitted it to
11 defense attorneys," who did you submit it to?

12 A Well, I sent it in to -- to Gary Perko or
13 Michael Beato or somebody in that group.

14 (Whereupon, Exhibit Number 2 was marked for
15 identification purposes and made a part of the
16 record.)

17 Q (By Ms. Dunn) I'm going to stop sharing
18 this document and I'm going to show you a document
19 that was provided to us as your bibliography for your
20 report.

21 (Document is displayed).

22 Dr. Donovan, do you recognize this
23 document?

24 A It looks -- I think so, yeah.

25 Q And is this a document that you prepared?

1 A Yes.

2 Q And what -- what is it?

3 A I'm sorry?

4 Q What --

5 A It's a bibliography.

6 Q And it's a bibliography for -- for what?

7 A In reference to my previous paper.

8 Q And so this is a bibliography of the
9 sources you considered and relied upon in the expert
10 declaration that we marked as Plaintiffs' Exhibit 1?

11 A Yes.

12 Q And this is -- I'll -- this exhibit will be
13 marked as Plaintiffs' Exhibit 2.

14 This document was not originally sent along
15 with your report; is that right?

16 A Correct.

17 Q So this was provided upon request by
18 plaintiffs' counsel?

19 A Yes.

20 Q Are these all of the sources you relied
21 upon in preparing the report and expert declaration
22 that was marked as Plaintiffs' Exhibit 1?

23 A That would be difficult to say because so
24 many things I rely on are also part of my own
25 expertise. But in terms of articles, I think that's

1 a reasonable summation.

2 Q Are there any other sources you can
3 identify that you relied upon for your expert
4 declaration that is not listed in this bibliography?

5 A No, not at present.

6 Q When did you first become aware of this
7 case, Dr. Donovan?

8 A Some months ago.

9 Q Can you give us an estimate of perhaps the
10 time of year?

11 A I'm trying to think when I first was
12 contacted. It was -- it was probably -- I'd have to
13 go back and look. It was probably in the fall or
14 something. Or, no, it was probably the end of
15 summer.

16 Q End of summer.

17 And do you recall who contacted you?

18 A I believe I got an email from Gary Perko
19 asking if I would be willing to help them with the
20 case.

21 Q When were you formally engaged as an expert
22 witness in this matter?

23 A If I can -- I think I've got this handy.

24 MR. BEATO: Dr. Donovan, just from your
25 memory.

1 THE WITNESS: Oh. Sometime in the fall.

2 Q (By Ms. Dunn) Have you been contacted by
3 Holtzman Vogel previously to be an expert witness in
4 any other matter?

5 A No.

6 Q You also prepared a report to support the
7 Florida Medicaid rule prohibiting coverage for
8 gender-affirming medical treatments; is that right?

9 A Yes.

10 Q That report was an attachment to a, quote,
11 "generally accepted professional medical standards"
12 report prepared by the agency for healthcare
13 administration?

14 A I believe so.

15 Q All right. So a couple of those terms that
16 I just used are terms where we frequently use
17 abbreviations.

18 So when I refer to GAPMS, G-A-P-M-S, I'm
19 referring to Generally Accepted Professional Medical
20 Standards, which is a -- it's a standard employed by
21 the Agency for Healthcare Administration of Florida.

22 When I refer to AHCA, that's A-H-C-A, and
23 that stands for Agency for Healthcare Administration,
24 and that is the Florida Medicaid agency who is the
25 defendant -- one of the defendants in this case.

1 Do you understand that?

2 A Thank you. Yes.

3 Q And if you -- if you later in the
4 deposition can't recall what those acronyms mean,
5 please feel free to ask for clarification.

6 A It's almost certainly going to be needed.

7 Q Okay. Who contacted you to provide your
8 report in support of the AHCA GAPMS memo?

9 A Someone from -- I believe it was the health
10 department in Florida.

11 Q Do you remember the name of that
12 individual?

13 A No, I'm sorry, I don't.

14 Q I apologize. I have a sinus infection, so
15 I might cough occasionally.

16 Do you recall any -- the names of any other
17 individuals at AHCA that you worked with in providing
18 and submitting the report for the GAPMS memo?

19 A I think there was only, like, one or two
20 names. And, no, I'm sorry, I don't -- I don't have
21 those in my head.

22 Q You don't recall them. Okay.

23 Do you know how the agency got your name in
24 order to contact you about that report?

25 A It must have been suggested to them by

1 someone else, but I'm not sure.

2 Q What did you do to prepare for today's
3 deposition?

4 A I re-read some of the things that I had
5 submitted, as well as some other articles on the
6 topic.

7 Q And when you say you "re-read things you
8 had submitted," which things that you submitted did
9 you re-read?

10 A The two that you've just mentioned.
11 Perhaps I should be -- re-familiarize myself with
12 what I said.

13 Q And so that would include the expert
14 declaration that we marked as Plaintiffs' Exhibit 1?

15 A Yes, ma'am.

16 Q And that also includes the report you
17 submitted to the Agency for Healthcare Administration
18 in support of its GAPMS process?

19 A Yes.

20 Q You said you reviewed some other articles
21 in preparation for today. Which articles were those?

22 A Oh, about perhaps a dozen different
23 articles, including the one I just saw in the British
24 Medical Journal yesterday.

25 Q Can you please clarify what article that

1 was?

2 A Well, fortunately, that one I can tell you
3 because it's still sitting here.

4 It was entitled "BMJ Investigation: Gender
5 Dysphoria in Young People is Rising and so is
6 Professional Disagreement," by Jennifer Block.

7 Q All right. What other articles have you
8 reviewed?

9 A Well, certainly articles that I'd already
10 used to -- to compose my various expert witness and
11 expert opinion papers.

12 Q That --

13 A And other things -- and, quite frankly,
14 other things I just kind of peruse randomly, so I
15 didn't really make notes of which they were. I
16 probably have -- some of them were online and some of
17 them I actually have as printouts from an old file.
18 And I -- I couldn't tell you specifically.

19 I also was sent the -- some of the forms or
20 reports from the attorney's office, and of course I
21 reviewed those as well. But some of those --

22 Q What --

23 A -- were some of the things we've just been
24 talking about.

25 Well, the -- the expert witness

1 declarations from the people on the plaintiffs' side.

2 Q Which expert declarations from the
3 plaintiffs' side did you read?

4 A Karasic and Antonnaria.

5 Q Were there other expert declarations in
6 this case that you reviewed, including any of the
7 defendants' expert declarations?

8 A I'm sorry, there was a third one from the
9 plaintiffs' side, but it seemed to have so little to
10 do with what I had been talking about. I'd have to
11 go back and see who that was by.

12 And I actually didn't have a -- an
13 opportunity, because I got them so late, to look at
14 all the defendants' declarations.

15 Q Did you look at any of the defendants'
16 declarations?

17 A Not in depth, no.

18 Q Did you review even briefly any of the
19 defendants' declarations?

20 A Probably. Probably.

21 Q Do you recall --

22 A But because they were -- yeah, not -- I
23 cannot specifically recall because they just were
24 parallel to what I was focusing on and didn't overlap
25 that much.

1 Q Did you have any meetings with anyone in
2 order to prepare for today's deposition?

3 A We had about a 10- or 15-minute meeting
4 with the defense attorneys.

5 Q Which defense attorney?

6 A I think it was Gary Perko and one other in
7 the room.

8 Q Did you talk or speak with anyone else
9 about your deposition in preparation?

10 A My wife.

11 Q I'm sorry, I was getting some background
12 noise on my laptop I wanted to get rid of.

13 So you earlier mentioned that you had some
14 things right beside you that you had used to prepare
15 for today. What are those things?

16 A Oh, the -- I'm trying to make sure I have
17 the right -- my expert report.

18 The -- the "Ethicist's View of Transgender
19 Treatment for Children" that I had sent in.

20 And, actually, I was just looking at that
21 BMJ article because it had just come out.

22 Q Are those the only three things that you
23 have?

24 A Oh, I mean, no. Look at my study. I've
25 got a lot of things in my files, but not things that

1 I've been looking at this morning.

2 Q So when you say you have things right
3 beside you, it's merely your expert report, your
4 report that you submitted during the GAPMS process,
5 and the article from the British Medical Journal that
6 you referenced?

7 A That's -- yeah, that's a pretty fair
8 summary.

9 Q Is that --

10 A I mean, there are other things I could
11 find, but that's it.

12 Q But when you're -- I'm sorry. I'm speaking
13 about the things that you're referencing that are
14 right beside you that you said you could refer to.

15 Is there anything other than those three
16 documents that I just listed?

17 A Not currently, no, but I -- like I said, if
18 you need me to, I can find things. They're all close
19 by.

20 Q Well, so -- so I think what we're
21 experiencing right now is one of the limitations of a
22 virtual deposition, which it's obviously much more
23 convenient because we're all able to be in our own
24 respective locations.

25 But, generally, if someone were to come to

1 a deposition with paperwork, we would be entitled to
2 see what that paperwork is.

3 And so what I'm trying to understand is
4 what paperwork have you compiled in order to use in
5 this deposition? What is sitting beside you that you
6 intended to reference or that you brought with you
7 or -- or put together for the purposes of this
8 deposition?

9 A Okay. No, I think you've got it then.
10 That was it.

11 Q Okay. Thank you.

12 Have you been deposed -- I'm sorry, you
13 told me you've been deposed before, Dr. Donovan. Can
14 you explain to me the circumstances in which you've
15 been deposed before?

16 A Well, I've been an expert witness for both
17 sides in malpractice trials.

18 Q How many times have you been deposed
19 before?

20 A Maybe as many as half a dozen.

21 Q Is medical malpractice the only subject on
22 which you've been deposed in the past?

23 A There was one trial in which we were
24 discharging a faculty member with cause and so I
25 testified in that as well. "We" being the

1 university.

2 Q But that would be an employment dispute?

3 A Yes, I guess so.

4 Q And which university was that that you were
5 working for?

6 A That was the University of Oklahoma.

7 Q The malpractice cases that you were deposed
8 in, what types of care were at issue in those
9 approximately six cases?

10 A I'm not sure what you mean by "what types
11 of care." Medical care.

12 Q What type of medical treatment was at
13 issue?

14 A Oh, my background is in pediatric
15 gastroenterology, so those were all associated with
16 that type of care.

17 Q Okay. So they were all cases related to
18 pediatric gastroenterology treatments?

19 A Correct.

20 Q And have you testified at trial in any
21 matter?

22 A At one of those, yes.

23 Q Which --

24 A One of those malpractice cases.

25 Q So one of the medical malpractices?

1 A One of the medical malpractice cases went
2 to trial.

3 Q Were there any other cases that you have
4 testified at trial?

5 A Not that I recall.

6 Q Okay. Have you submitted written expert
7 reports in other cases?

8 A I actually don't recall doing that.

9 Q Have you -- is it fair to say that you have
10 never provided an expert report previously about the
11 treatment of gender dysphoria?

12 A Yes, that's fair.

13 Q Is it also fair to say that you've never
14 testified previously about the treatment of gender
15 dysphoria?

16 A That's correct.

17 Q Did you know any of the defendants' other
18 experts prior to this case?

19 A Personally, no.

20 Q Had you ever met any of the defendants'
21 other experts prior to this case?

22 A No.

23 Q Did you know any of the plaintiffs' experts
24 prior to this case?

25 A Not personally. I mean --

1 Q How did you -- did you know them in some
2 other capacity?

3 A I have seen people at meetings.

4 Q Has a court ever disqualified you as an
5 expert witness, to your knowledge?

6 A No.

7 Q Has a court ever limited the scope of your
8 testimony, to your knowledge?

9 A No.

10 Q Have you ever provided testimony in support
11 of the claims of a transgender person?

12 A No.

13 Q All right. I'm going to pull up another
14 document, if it will cooperate.

15 MR. BEATO: Take your time.

16 (Document is displayed).

17 Q (By Ms. Dunn) Do you recognize this
18 document, Dr. Donovan?

19 A Can I see this? Is that the question?

20 Q Do you recognize the document?

21 A Oh, yes.

22 Q And what is this document?

23 A This is my curriculum vitae that was
24 prepared for Georgetown University School of
25 Medicine.

1 Q And this is the curriculum vitae that was
2 provided to us, along with your expert report. Do
3 you recall providing it for that purpose?

4 A Yes.

5 Q Is this document a complete and accurate
6 depiction of your professional experiences, your
7 curriculum vitae?

8 A I believe so.

9 (Whereupon, Exhibit Number 3 was marked for
10 identification purposes and made a part of the
11 record.)

12 Q (By Ms. Dunn) And I would like to mark this
13 as Plaintiffs' Exhibit 3.

14 So I'm going to begin by asking you some
15 questions about your education. So you received your
16 medical education at the University of Oklahoma in
17 the years of 1970 to 1974?

18 A Correct.

19 Q And then you received your -- I'm sorry,
20 you completed a pediatrics residency at the Baylor
21 College of Medicine --

22 A Yes.

23 Q -- in -- 1974 through 1977?

24 A Correct.

25 Q Your fellowship was in pediatric

1 gastroenterology at the University of Oklahoma from
2 1977 to 1979; is that right?

3 A Yes.

4 Q And then you did an additional fellowship
5 at the National Institutes of Health in the neonatal
6 and pediatric medicine branch?

7 A Yes.

8 Q And that was in 1979 through 1980?

9 A Yes.

10 Q And then you additionally got your masters
11 in bioethics at the University of Oklahoma in 1994?

12 A Correct.

13 Q Why did you return to graduate school in
14 order to get your degree in bioethics?

15 A I had been asked to be the chair of the
16 ethics committee at our teaching hospital and I
17 thought that I should develop more expertise. And I
18 had a great interest in the topic.

19 Q And when you say "at the university" or
20 "medical school," are you speaking of the University
21 of Oklahoma?

22 A Well, I was at the University of Oklahoma,
23 but I took a sabbatical and went to study at
24 Georgetown with Edmund Pellegrino at that time.
25 That's when I began the masters and then completed it

1 at the University of Oklahoma.

2 Q But you said you had been asked to chair
3 the ethics committee at -- at where? At which
4 institution?

5 A At one of our teaching hospitals, Saint
6 Francis Hospital.

7 Q Okay. I see a hospital. Okay.
8 Have you received any other medical
9 education besides what we just discussed?

10 A Well, all physicians receive continuing
11 medical education, so quite a bit of that, but I
12 haven't acquired any other degrees.

13 Q All right. And you mentioned the
14 Pellegrino Center for Clinical Bioethics. I'm going
15 to scroll down to your reference to your position
16 there.

17 What is the Pellegrino Center for Clinical
18 Bioethics?

19 A It is probably best characterized as a
20 think tank in bioethics. It provides education,
21 provides for both students and trainees in medicine,
22 as well as for faculty. It provides ethics
23 consultation in the hospital and pursues scholarly
24 activities, including writing papers.

25 Q You were the director of that center from

1 2012 to 2020?

2 A Yes.

3 Q And what is that? What did being director
4 of that center entail for you specifically?

5 A Well, I basically helped with the -- the
6 planning and the activities of the center, as well as
7 the education -- educational activities and the
8 consultation activities in the hospital.

9 Q In this role, did you routinely work in a
10 hospital where you would evaluate patients for
11 medical conditions and refer and prescribe them for
12 treatment?

13 A That isn't a part of bioethics.

14 At the time I was still seeing patients in
15 my medical specialty and so I did consultations there
16 as well. But bioethicists do not directly treat
17 patients. They do respond to consultations from
18 treating physicians, nurses and families to help them
19 sort through ethical issues.

20 Q And as the director of the Pellegrino
21 Center, were you actively consulting on those types
22 of cases?

23 A Yes.

24 Q Did you engage in your clinical practice in
25 pediatric gastroenterology the entire eight years

1 that you were the director of the Pellegrino Center?

2 A No. I stopped around 2018. They were
3 short-handed when I arrived, but they acquired more
4 faculty, and I was fairly busy with my primary job.

5 Q Can you quantify how frequently you would
6 provide ethical consultations as the director of the
7 Pellegrino Center?

8 A We did it in rotation. We had a team that
9 did it. And I think we were getting maybe 150 or
10 more consults annually.

11 Q So the center would receive 150 consults
12 total annually?

13 A Uh-huh. Yes.

14 Q And how many -- it was on a rotation. How
15 many different individuals from the Pellegrino Center
16 were rotating through those consultations?

17 A Approximately, four.

18 Q So would it be fair to say that there were
19 approximately 35 to 40 consultations for each -- each
20 individual?

21 A Approximately. The problem with the math
22 is that we had a couple of people who didn't take
23 consults as frequently because of their other jobs
24 and others who did it more frequently. I was in the
25 "more frequently" category. But, overall, that's

1 close enough.

2 Q The Georgetown University -- I'm sorry, the
3 Pellegrino Center at Georgetown University was
4 established to "fill a unique need for bioethics
5 that's oriented towards clinical medicine and
6 strongly rooted in the Catholic and Jesuit
7 tradition."

8 Is that a fair description of its mission
9 or purpose?

10 A Yes.

11 Q Can you explain what it means to have a
12 program of bioethics that is strongly rooted in the
13 Catholic and Jesuit tradition?

14 A Well, Jesuits have a somewhat unique
15 approach to education, as you're probably aware.
16 They do like to focus on what they call
17 "cura personalis", or care of the whole person.

18 The particular approach that Edmund
19 Pellegrino used in the ethical sphere was called
20 "virtue ethics" as opposed to, say, the more -- other
21 approaches. Some would be casuistry, some would be
22 ideological, and some would be -- well, he was also
23 heavily philosophical, although he, himself, was not
24 a philosopher. Several of our members were and had
25 Ph.Ds in philosophy, as well as other things.

1 Q How does theology interact with ethical
2 challenges that arise in the care of particular
3 patients for ethicists at the Pellegrino Center?

4 A I'm sorry, could you repeat that? You kind
5 of flaked out a little bit.

6 Q Yeah, of course.

7 What role does theology play for the
8 consultants at the Pellegrino Center in assisting
9 with the ethical challenges that arise in the care of
10 patients?

11 A I wouldn't say that it plays a direct role
12 because, you know, it is theological principles just
13 like philosophical principles. And just ethical
14 principles are always there in the background, in
15 terms of how we assess and -- and work through
16 various cases.

17 Q Is Georgetown University Medical Center a
18 Catholic healthcare institution?

19 A Yes.

20 Q I want to share another document.

21 (Document is displayed).

22 Do you recognize this document,
23 Dr. Donovan?

24 A Yes.

25 Q What is this document?

1 A These are the Ethical and Religious
2 Directives for Catholic Healthcare Services, commonly
3 referred to as the "ERDs."

4 (Whereupon, Exhibit Number 4 was marked for
5 identification purposes and made a part of the
6 record.)

7 Q (By Ms. Dunn) ERDs.

8 I'd like to mark this document as
9 Plaintiffs' Exhibit 4.

10 Is Georgetown University Medical Center --
11 I'm sorry. Let me -- I'm going to restart that
12 question.

13 Are ethical consultations and advisements
14 at the Pellegrino Center for clinical bioethics
15 guided by these ethical and religious directives?

16 A Yes, they are.

17 Q And are your views as an ethicist guided by
18 this document?

19 A Yes.

20 Q Did you rely on this document during your
21 active work as an ethical consultant at the
22 Pellegrino Center?

23 A Yes.

24 Q I'm going to turn to Page 9 of the document
25 and zoom in on Directive Number 5.

1 This directive reads: "Catholic Healthcare
2 Services must adopt these directives as policy,
3 require adherence to them within the institution as a
4 condition for medical privileges and employment, and
5 provide appropriate instruction regarding the
6 directives for administration, medical, and nursing
7 staff, and other personnel."

8 Did you follow this directive during your
9 time as the director of the Pellegrino Center?

10 A Yes.

11 Q I'm now turning to Directive Number 9 which
12 states that, "Employees of a Catholic healthcare
13 institution must respect and uphold the religious
14 mission of the institution and adhere to these
15 directives. They should maintain professional
16 standards and promote the institution's commitment to
17 human dignity and the common good."

18 As director of the Pellegrino Center and an
19 employee of G Medical Center, are you bound to uphold
20 the religious mission of the institution?

21 A Yes.

22 Q And as the director of the Pellegrino
23 Center and an employee of the Georgetown University
24 Medical Center, you had to adhere to these directives
25 as well; is that correct?

1 A Yes.

2 Q And you have to adhere to these directives
3 without exception; is that correct?

4 A I don't know what that would mean.

5 Q Well, so it means that a doctor at a
6 Catholic hospital can't provide a patient with
7 medical care that is not aligned with the mission of
8 the institution; is that right?

9 A Yes, I can accept that.

10 Q So you can't even refer a patient for a
11 type of care that is not aligned with these
12 directives?

13 A That would depend on the circumstances of
14 the issue at hand.

15 Q So I'm going to stop sharing this document
16 and open one more.

17 (Document is displayed).

18 Do you recognize this article, Dr. Donovan?
19 I'm happy to scroll through it if that would help.

20 MR. BEATO: Oh, Dr. Donovan, I believe
21 you're muted. Happens to me all the time.

22 THE WITNESS: Yes, I was muted and also not
23 recognizing it, so it's a twofer.

24 Q (By Ms. Dunn) This is an article that was
25 published in 538. I'm going to scroll down to Page 6

1 of this article and I will show you -- here you are
2 quoted in this article.

3 Is that -- is this "Dr. G. Kevin Donovan, a
4 bioethicist at Georgetown University," is that you
5 that this article is referencing?

6 A It should be, yes.

7 Q And so you say here that, "Catholic
8 healthcare institutions need to be careful to ensure
9 that they're not perceived as offering or endorsing a
10 prohibited form of care."

11 Is that -- do you recall making that
12 statement?

13 A I don't recall. I must have been
14 interviewed over the phone, but I would agree with
15 that statement.

16 Q And so would referring a patient for a type
17 of care that is not aligned with a Catholic
18 healthcare institution be consid- -- or be
19 potentially perceived as offering or endorsing a
20 prohibited form of care?

21 A It would be -- depend on why it's not
22 aligned with the -- with the values you're talking
23 about.

24 Q Well, let's give an example. Would this
25 include a referral for contraceptives?

1 A For contraceptives, you really -- well, it
2 also depends on how you're using the term
3 "contraceptive" because, you know, birth control in
4 general is not prohibited, but certain forms are.

5 Q So it would include referring a patient for
6 a prohibited form of contraceptive?

7 A Yes.

8 Q In this article you're referred to as a
9 "Catholic ethicist." Is that something you would
10 label yourself as?

11 A I don't typically, no, although both words
12 are correct.

13 (Whereupon, Exhibit Number 5 was marked for
14 identification purposes and made a part of the
15 record.)

16 Q (By Ms. Dunn) And I don't think I asked
17 yet, but I would like to mark this exhibit as
18 Plaintiffs' Exhibit 5.

19 I'm now going to return to the -- what has
20 been marked as Plaintiffs' Exhibit 4, the Ethical and
21 Religious -- the ERDs, as you refer to them.

22 And we're going to look at Directive
23 Number 3, which is on Page -- and, I'm sorry, I'm
24 going to share my screen in just one moment.

25 (Document is displayed).

1 We're looking at Directive Number 3 which
2 is on Page 9.

3 So this lists certain people whose social
4 condition puts them at the margins of our society and
5 makes them particularly vulnerable to discrimination.

6 Are LGBTQ people included in this list of
7 people whose social conditions make them particularly
8 vulnerable to discrimination?

9 MR. BEATO: Object to form, but,
10 Dr. Donovan, you can answer that question.

11 THE WITNESS: Well, I was -- I was reading
12 the paragraph that she mentioned. And the -- the
13 answer would be they're not specifically listed.
14 They're certainly not eliminated. They would be
15 considered people vulnerable to discrimination.

16 Q (By Ms. Dunn) But they're not listed here
17 in this list of individuals that the Catholic
18 Healthcare Institution should distinguish itself by
19 service to an advocacy for?

20 A I don't see them in that particular
21 listing, no.

22 Q All right. Thank you. So we will move
23 away from this document for now.

24 I want to go back just briefly to a piece
25 of paper I can't find right now. Here we go.

1 (Document is displayed).

2 Are you currently the director of the
3 Pellegrino Center?

4 A No.

5 Q When did you leave?

6 A Just before -- well, during the pandemic.

7 Q Okay. And why did you leave?

8 A Well, because I had been doing it for
9 nearly ten years and had already found someone to
10 turn it over to.

11 Q And so you made the choice to leave that
12 institution?

13 A Yes.

14 Q Do you remain on faculty at the Pellegrino
15 Center?

16 A I am still working part time until the end
17 of this semester.

18 Q And what does that mean, to be working part
19 time?

20 A That means that I participate in
21 educational activities and meetings by Zoom
22 primarily, but also write papers with my colleagues
23 and such.

24 Q How many hours -- are you still currently
25 teaching classes at the Pellegrino Center?

1 A Not this semester.

2 Q How recently were you still teaching
3 classes there?

4 A I had been helping out last semester.

5 Q And did you teach a full course on your own
6 or would your role have been more of a guest
7 lecturer?

8 A More of a guest lecturer.

9 Q When you were the director of the
10 Pellegrino Center, did you teach classes?

11 A Oh, well, we had classes for medical
12 students, classes for residents, and classes in our
13 master's program, so, yes.

14 Q And would you be the professor of an entire
15 course or, again, would it be more of a guest
16 lecturer role?

17 A Both.

18 Q What classes did you primarily teach?

19 A For students, it was really just bioethics,
20 medical ethics. It was an ongoing course for medical
21 students throughout the year.

22 Q So it was just a general bioethics/medical
23 ethics course?

24 A Yes.

25 Q Did you do hospital rounds as a treating

1 doctor at the Georgetown Medical Center?

2 A I did that in pediatric gastroenterology
3 until I stopped, as I mentioned before.

4 Q And are you currently a clinical ethical
5 consultant at the center?

6 A No.

7 Q When did you stop doing ethical
8 consultations?

9 A When I was no longer in the vicinity.

10 Q So when you left in 2020, that would be
11 when your ethical consultation --

12 A Yes.

13 Q You also have listed on your resume -- and
14 I will quickly open it. I'm sorry, "resume." Your
15 CV. I'm using the lawyer term.

16 -- that you are a -- if I can pull it up.
17 Sorry.

18 (Document is displayed).

19 -- "senior clinical scholar at the Kennedy
20 Institute for Ethics."

21 How is that different from being the
22 director of the Pellegrino Center?

23 A The Kennedy Institute of Ethics is a
24 separate think tank at the other end of the campus
25 and they tend to focus more on philosophical issues

1 rather than patient care issues.

2 Q Were the ethics practiced at the Kennedy
3 Institute also aligned with the Catholic and Jesuit
4 tradition of Georgetown University?

5 A For some --

6 Q Were they --

7 A -- but not for all of the faculty, no.

8 Q Okay. Were they impacted at all by the
9 ethical and religious directives issued by the U.S.
10 Conference of Catholic Bishops that we referenced as
11 Plaintiffs' Exhibit 4?

12 A Those only apply to hospital practice.

13 Q All right. And then prior to your work at
14 Georgetown, you were the director of the Oklahoma
15 Bioethics Center?

16 A Yes.

17 Q What did this role entail?

18 A It was a very similar position to the
19 Kennedy Institute.

20 Q It was more philosophical rather than
21 patient care?

22 A No, excuse me, I'm sorry, to the Pellegrino
23 Center. No, it was not philosophical, it was
24 teaching students, it was working in the hospital, it
25 was writing papers.

1 Q So you provided ethical consultants (sic)
2 related to patient care?

3 A Yes, but not as the director of the
4 Bioethics Center. That was a separate issue for the
5 various hospitals in town, each of which had their
6 own --

7 Q Okay.

8 A -- arrangements.

9 Q So your role as the director of the
10 Oklahoma Bioethics Center was mostly teaching and
11 writing?

12 A Yes.

13 Q And any clinical ethical consultations you
14 were doing were in your role at various hospitals?

15 A Correct.

16 Q You're also -- later in your CV -- and
17 let's see how quickly I can get here.

18 (Document is displayed).

19 Here you list that you're part of the
20 "Dean's conference committee on medical ethics."

21 What was that?

22 A Oh, well, the -- the Dean was having us put
23 on little conferences for -- educational conferences
24 on ethics.

25 Q Okay. So that was just in order to plan

1 and arrange for educational conferences on ethics
2 issues?

3 A Right.

4 Q And you have listed your role as chairman.
5 Were you chairman for all 25 of those years?

6 A Yes, I believe I was.

7 Q All right. I'm going to stop sharing
8 temporarily.

9 So I'd like to talk a little bit about your
10 clinical experience as a pediatric
11 gastroenterologist. So we've -- you have said that
12 before your bioethics appointments your practice
13 primarily focused on pediatrics gastroenterology; is
14 that correct?

15 A Correct.

16 Q Can you just give kind of a broad overview
17 of what field of practice that is?

18 A It concerns itself with the digestive
19 disorders in childhood.

20 Q Your last position in pediatric
21 gastroenterology was when you were the chief of the
22 division of pediatric gastroenterology at the
23 University of Oklahoma?

24 A Yes.

25 Q And that ended in 2012?

1 A Yes. That's other than the work I -- I
2 also contributed at Georgetown.

3 Q Okay. So you did do -- I recall now. You
4 said that you did some pediatric gastroenterology
5 work while you were at Georgetown until 2018; is that
6 right?

7 A Yes.

8 Q Are you currently working as a pediatric
9 gastroenterologist?

10 A No.

11 Q Are you currently teaching any pediatric
12 gastroenterology courses?

13 A No.

14 Q Have you ever treated patients experiencing
15 gender dysphoria?

16 A Not to my recollection.

17 Q In your report on Page 3 -- so we'll look
18 back. Your report was marked as Plaintiffs'
19 Exhibit 1. So we'll look back at that document.

20 (Document is displayed).

21 On Page 3 you say that you "have never
22 prescribed medications nor referred for surgery any
23 patients that consider themselves transgender."

24 Is that an accurate statement?

25 A Yes.

1 Q Is that professional decision guided by the
2 ethical and religious directives of the Catholic
3 Healthcare Services?

4 A No.

5 Q You wouldn't -- as a routine matter, you
6 would not have been providing such treatment as a
7 pediatric gastroenterologist; is that right?

8 A That's correct.

9 Q And as a bioethicist, you do not typically
10 do routine evaluations of patients and refer them for
11 treatment; is that correct?

12 A That's correct.

13 Q So in your professional capacity, referring
14 or providing -- I'm sorry, providing gender-affirming
15 care or referring patients for gender-affirming care
16 would not be something you would have had routinely
17 done, even if you hadn't chosen, personally decided
18 not to do it; is that right?

19 A Correct.

20 Q Do you currently have an active license to
21 practice medicine in any state?

22 A In Oklahoma. I've given up the Washington
23 license.

24 Q So you no longer -- your license to
25 practice medicine in Washington has expired?

1 A Yes.

2 Q And when we say "Washington," we're
3 speaking about Washington, D.C., not the state of
4 Washington?

5 A Correct.

6 Q Your Oklahoma medical license, what type of
7 medical license is it?

8 A It's like an emeritus license. I use it
9 for my --

10 Q And what is that?

11 A I use it in my volunteer work here. I'm
12 not practicing as a clinician anymore.

13 Q And what does your volunteer work entail?

14 A I have worked for the Oklahoma emergency
15 response people and for various charities around
16 town.

17 Q And are you providing patient care in those
18 capacities?

19 A No, not directly.

20 Q So under this license, can you actively
21 practice medicine?

22 A No, I no longer am an active clinician.

23 Q Have any -- has any of your previous
24 medical licenses been suspended for any reason?

25 A No.

1 Q Have you ever received any formal
2 discipline by the Board of Medicine of any state or
3 jurisdiction?

4 A No.

5 Q Have you ever been the subject of a medical
6 malpractice lawsuit?

7 A Once.

8 Q Can you describe the circumstances of that
9 lawsuit?

10 A There was a complication in a -- after a
11 procedure, and the family filed suit and the defense
12 prevailed.

13 Q Was that one of the six cases that you
14 referenced being deposed in earlier or --

15 A Yes.

16 Q -- was that separate?

17 Have you ever been the defendant in a
18 lawsuit about discrimination in your medical
19 practice?

20 A No.

21 Q Okay. I would now like to talk a little
22 bit about the awards and professional associations
23 that you list in your curriculum vitae, so I'm going
24 to share my screen again. Let me first get to the
25 right place.

1 (Document is displayed).

2 So here we have -- let's see -- the section
3 of your CV that lists "Honors and Awards." And I'd
4 like to ask about the Knighthood that you have
5 received.

6 You list it as "Knight Grand Cross Vatican,
7 the Equestrian Order of the Holy" -- I'm not going to
8 say this properly, I'm sorry -- Equestrian Order of
9 the Holy -- what's that -- the word that starts with
10 "S"?

11 A Sepulchre.

12 Q -- "Sepulchre of Jerusalem." What is this
13 award -- or "Knighthood," what does that mean?

14 A Well, this was an organization founded by
15 Godfrey of Bouillon during the crusades, and they now
16 provide funds for the care and education of
17 Palestinians in the Holy Land.

18 Q What is the significance of this honor to
19 you specifically?

20 A It's -- yeah, I think it's a good thing to
21 do.

22 Q Why did you receive the honor? What did
23 you do to receive this honor?

24 A They never specifically told me.

25 Q Does it have any significance to your

1 career in medicine?

2 A I would assume it must. I didn't have to
3 slay any dragons.

4 Q I guess I'm wondering, like, why is it
5 important to list on your CV?

6 In what way is it relevant to your
7 professional experience?

8 A Well, it's -- it's an honor, much like the
9 other things that are listed.

10 You know, if I were British and the queen
11 had knighted me, I would probably list that, too, and
12 assume it had to do with something in my career.

13 Q So you assume that you received the
14 Knighthood because of your professional service?

15 A That's a fair guess, but I've never --
16 never been told.

17 Q Okay. Are there any requirements or
18 expectations of you as a result of receiving this
19 Knighthood?

20 A Yes. We are supposed to contribute
21 financially for the welfare of the people living in
22 Palestine and the Holy Land.

23 Q And those financial contributions are the
24 extent of the expectations?

25 A Yes.

1 Q I'm now going to scroll down to what you've
2 listed as "Public Service." So here you list your
3 position as the chairman of the board of directors of
4 Birthright, Incorporated, of Tulsa.

5 What is this organization?

6 A Oh, it's an organization to lend assistance
7 to pregnant women and their babies.

8 Q As chairman of the board of that
9 organization, what do you do?

10 A Well, I don't anymore. This thing needs
11 updating because I -- I stopped when we left the
12 Tulsa area.

13 But, basically, the organization looks for
14 ways to supply things like diapers and formula and
15 medical care, or direct them towards medical care,
16 things like that. And some educational things about
17 parenting.

18 Q When did your service to this organization
19 end?

20 A When I moved to Washington, D.C.

21 Q Okay. So that would have been in 2012?

22 A Correct.

23 Q Birthright, Incorporated, is not any sort
24 of medical association; is that right?

25 A Not -- I wouldn't characterize it as

1 "medical," no.

2 Q The next line you note that you have been
3 the medical ethics consultant to the Catholic Diocese
4 of Tulsa.

5 Is that still an active service that you're
6 providing?

7 A No. The problem -- and I'll explain it
8 now -- is that Georgetown required the CV to be
9 split, for whatever reason, rather than
10 chronological. So those things that were being done
11 while I was at the University of Oklahoma or in Tulsa
12 were separated, which also means that they didn't all
13 get updated.

14 Q So this would have also ended when you
15 moved to Georgetown in 2012?

16 A Yes.

17 Q And that also goes for your role as the
18 director of healthcare issues for the Catholic
19 Diocese?

20 A Everything. Everything that was listed in
21 Tulsa would have stopped when I was no longer in
22 Tulsa.

23 Q Under what circumstances does the Catholic
24 Diocese need advice regarding healthcare issues?

25 A Just from time to time for one issue or

1 another. I might be --

2 Q Can you -- oh, I'm sorry.

3 A -- called or -- pardon?

4 Q Do you recall any specific examples of why
5 you would be called on these issues?

6 A Issues such as -- you know, currently
7 there's a lot of concern about brain death, but
8 before that, things like salpingectomies and such.
9 Just -- no, I -- it's rather random and it didn't
10 come up very often, in terms of the Diocese itself.

11 Q What about your role as a medical ethics
12 consultant. What did that entail?

13 A Oh, well, you mean like for the various
14 hospital systems?

15 Q No, for the Catholic Diocese of Tulsa, this
16 position here.

17 A I assume that that was referring to what
18 we've just been talking about.

19 Q Are these two positions separate?

20 A Honestly, I don't remember the study
21 section for the community organization.

22 This terminology was apparently dictated by
23 Georgetown when my secretary re-did the resume, CV,
24 so I'm not quite sure how she abstracted that out of
25 my previous CV, which is a lot easier to read.

1 Q I see. So to your recollection you served
2 a single role with the Catholic Diocese of Tulsa and
3 not two distinct roles?

4 A Yes.

5 Q And the Catholic Diocese of Tulsa is a
6 religious institution?

7 A Yes.

8 Q Are you familiar with an organization by
9 the name of the Catholic Medical Association?

10 A Yes.

11 Q Are you a member of the Catholic Medical
12 Association?

13 A No.

14 Q Have you ever been a member of the Catholic
15 Medical Association?

16 A I was going to say no, but I think they
17 actually gave me an honorary membership, when I gave
18 them a talk once, for a year. So possibly, yes.

19 Q Do you recall when that was?

20 A I don't know. Ten years ago.

21 Q Give me just one moment of patience.

22 MR. BEATO: No problem. Take your time.

23 Technology is not my friend, I can say on the record,
24 so take your time.

25 THE WITNESS: And doctors are noteworthy

1 for their patience.

2 MR. BEATO: Very true.

3 MS. DUNN: I'm looking for a document.

4 It's not where I expected it to be, but I will be --

5 I will be able to find it quickly.

6 (Document is displayed).

7 Q (By Ms. Dunn) So I'm showing you a press
8 release that was issued by a Catholic Medical
9 Association that we obtained online.

10 Have you ever seen this document before?

11 A I -- no.

12 (Whereupon, Exhibit Number 6 was marked for
13 identification purposes and made a part of the
14 record.)

15 Q (By Ms. Dunn) I've marked this exhibit as
16 Plaintiffs' Exhibit 6, and I'm just going to zoom in
17 briefly.

18 Were you ever appointed to the Human Fetal
19 Tissue Research Advisory Board of the National
20 Institute of Health?

21 A I was.

22 Q Do you know why the Catholic Medical
23 Association would have issued a press release stating
24 that one of their members, you, was appointed to this
25 board?

1 A I don't know. Wishful thinking?

2 Q Are you familiar with the mission of the
3 Catholic Medical Association?

4 A In a general way, I suppose.

5 Q Are you familiar with resolutions that the
6 Catholic Medical Association has endorsed?

7 A I'm sorry, as I said, I'm not a member and
8 I don't keep up with what they're doing.

9 Q Are you familiar with the -- and I hope I'm
10 saying this right -- Lozier Institute?

11 A Yes.

12 Q Are you affiliated with the Lozier
13 Institute?

14 A Yes. They have asked me to speak on
15 various occasions.

16 Q They've listed you on your website as -- on
17 their website as an associate scholar. Is this an
18 accurate description of your affiliation?

19 A I believe so.

20 Q Okay. Is your affiliation with the Lozier
21 Institute active?

22 A I wouldn't say so, no.

23 Q When would you say that it ended?

24 A It was never particularly active. I mean,
25 they did list me as -- on their -- on their list of

1 associate scholars and I did go out and give a talk
2 on research ethics for them in Kansas at one point,
3 but it was never a very active relationship.

4 Q Did you provide them with a biography to
5 list on their website?

6 A I would assume so, yeah.

7 Q Other than the one talk you mentioned, what
8 other -- have you played any other roles with the
9 Lozier Institute?

10 A I believe they were the ones who suggested
11 that I be on the human fetal advisory committee.

12 Q And how did you get appointed to that?
13 Was that a position that you sought?

14 A No.

15 Q So how did the Lozier Institute -- how was
16 the Lozier Institute involved with that appointment?

17 A I think that they made a suggestion. I
18 actually don't know. People approach me at times and
19 say, "Will you serve? Would you be willing to help?"
20 And if I'm interested, I'll say, "Yes."

21 Q And who approached you about that
22 appointment? Was it someone from the Lozier
23 Institute?

24 A I think it was actually from HHS.

25 Q So I guess I'm just curious why you mention

1 that they were involved with that --

2 A Because I --

3 Q -- like, eventual appointment.

4 A I -- I believe they asked if I would be
5 interested if I were approached.

6 Q Okay. And then you were later approached?

7 A To the best of my knowledge.

8 Q Are you familiar with an organization known
9 as the American College of Pediatricians?

10 A Yes.

11 Q Are you a member of the American College of
12 Pediatricians?

13 A No.

14 Q Have you ever been a member of the American
15 College of Pediatricians?

16 A No, I don't believe so.

17 Q Are you at all familiar with the various
18 position statements of the American College of
19 Pediatricians?

20 A No, not really.

21 Q Okay. I'd like to move on to your
22 "Research Publications and Presentations."

23 So, first, with regard to your clinical
24 research, have you ever conducted primary research
25 involving patients?

1 A When you say "primary research," how are
2 you using the term?

3 Q I suppose I'm using it like -- so not like
4 a literature review, but an actual research study
5 that involves human subjects.

6 A Yes.

7 Q Can you describe what those research
8 studies were?

9 A We've been involved in research studies
10 that were multi-institutional on things -- on drugs,
11 and we've been involved in some smaller studies, if I
12 recall, you know, at the local level as well.

13 I'm struggling right now to remember what
14 would be --

15 Q Well, let's start --

16 A All of these were within the realm of
17 pediatric gastroenterology.

18 Q Okay. So, do you recall, were they during
19 your time with the University of Oklahoma?

20 A Yes.

21 Q All of them were during your time at the
22 University of Oklahoma?

23 A In terms of clinical research, yes.

24 Q And they were all related to -- the
25 research studies were all related to pediatric

1 gastroenterology?

2 A Yes, I believe so.

3 Q Have you ever conducted any sort of
4 research -- primary research on gender-affirming
5 medical treatments?

6 A No.

7 Q So you've not conducted primary research
8 on, for example, puberty blockers?

9 A No.

10 Q You haven't conducted primary research on
11 cross-sex hormones?

12 A No.

13 Q And you haven't conducted primary research
14 on gender-affirming surgeries?

15 A That's correct.

16 Q Have you ever been the principal
17 investigator of a publicly-funded research grant?

18 A I'm sorry that I'm blocking -- I'm trying
19 to remember if I was PI or not.

20 Q Well, would it --

21 A Yeah. But I've been involved in research
22 grants, yes.

23 Q So let's say either a co-investigator or a
24 principal investigator, have you --

25 A Yes.

1 Q -- ever been?

2 A Yes.

3 Q Do you recall what that research grant was
4 for?

5 A Not at present. I'm sorry.

6 Q That's okay. Were you ever an investigator
7 for a publicly-funded research grant for the study of
8 gender-affirming medical care?

9 A No.

10 Q And would that -- the research grants that
11 you are -- that you referenced where you may have
12 been an investigator, was that while you were at the
13 University of Oklahoma?

14 A Yes, it would have been. Well, there
15 was -- there were a couple of small grants that we
16 did in bioethics issues at Georgetown, but they
17 weren't clinical investigations.

18 Q Have you ever been an investigator on a
19 privately-funded research grant?

20 A Well, the Scholl Institute gave us some
21 money at Georgetown for the small thing I was talking
22 about. But, once again --

23 Q But it wasn't that one?

24 A -- it wasn't -- it wasn't a clinical thing.
25 We were looking at the -- it's been over ten years

1 ago, but we were -- I could look it up.

2 Q You say, "we," you mean yourself and other
3 individuals at the Pellegrino Center?

4 A Correct.

5 Q And you've never received a
6 privately-funded research grant to study any sort of
7 gender-affirming medical care?

8 A Correct.

9 Q And you've never received any grant that
10 involves the treatment of gender dysphoria?

11 A Correct.

12 Q Have you ever taught a course on gender
13 dysphoria?

14 A No.

15 Q Have you ever addressed gender dysphoria in
16 any of the courses you have taught?

17 A Yes.

18 Q Which -- can you describe in what context?

19 A Well, in the courses that we've had for
20 either medical students or -- actually, for graduate
21 students.

22 Q And can you explain what -- what the
23 curriculum was that addressed gender dysphoria?

24 A It would be a single class on that, not a
25 curriculum.

1 Q But what was being taught? What
2 specifically -- what was the subject that was being
3 discussed?

4 A Well, we'd be talking about basically
5 gender dysphoria and transgender individuals and
6 gender-affirming care.

7 Q And what perspectives were being discussed
8 or shared?

9 A Without recalling specific aspects of it,
10 they would be very compatible with what I've already
11 written in the reports you just referenced.

12 Q It would be consistent with the -- when you
13 say "reports," we're talking about the expert report
14 you submitted in this matter that's Plaintiffs'
15 Exhibit Number 1?

16 A And the -- and the other one, which was --

17 Q The GAPMS memo report?

18 A Yes, ma'am.

19 Q And when were you teaching these courses?

20 A In the past five years.

21 Q While at the Pellegrino Center?

22 A Yes.

23 Q And were these for medical students or
24 graduate students?

25 A To my knowledge, only for graduate

1 students.

2 Q And when you say "graduate students," that
3 would be -- was there a particular graduate school
4 that was receiving the course where this was
5 discussed?

6 A It was at Georgetown.

7 Q But -- I'm sorry, like a specialty. Like a
8 specialty of graduate school or was it a
9 cross-discipline course?

10 A It would have to be a cross-discipline
11 course from the way you describe it, yes.

12 Q I guess I'm just cur- -- you know, how do
13 I -- so, for example, my husband is a professor. He
14 teaches a type of physics. So he teaches primarily
15 students in the department of physics. They're
16 students of the University of Florida, but they're
17 graduate students in the department of physics.

18 So my question is, was there a particular
19 department that the students were graduate students
20 in, or was it -- was it a course that was available
21 to multiple disciplines?

22 A It -- it was a master's program at
23 Georgetown that's all done through their graduate
24 education office, but it would be open to a wide
25 variety of people who are interested.

1 Q Okay. And how many times would you say
2 that this topic was addressed in that course?

3 A In the course? Once.

4 Q So you only -- I'm sorry. How many courses
5 did you teach for that? So it was one day of a
6 course. How many times was that particular topic
7 addressed?

8 A Probably once or twice.

9 Q Okay. And what is the name of the course?

10 A It was -- the problem is I'm -- I'm
11 struggling because I didn't like the name of it, but
12 it was assigned. But it was basically an
13 introductory course in bioethics.

14 Q Okay. Is that the name that we would -- if
15 we were to look in the graduate school catalog, is
16 that the name it would be?

17 A No. I could go find it. They had an
18 abbreviation for it, CACE, but that didn't really
19 give me a good name for the course, either.

20 Q What did "CACE" stand for?

21 A I was afraid you were going to ask that. I
22 actually -- I -- it was, like, Advanced Clinical
23 Ethics or something like that. I don't recall
24 exactly. I'm sorry.

25 Q That's all right. Thank you for searching

1 your memory.

2 A And finding nothing.

3 Q All right. So a large part of your CV
4 includes presentations that you've given. And so in
5 order to make this a little more manageable, I'm
6 going to adhere to the different sections that you
7 have in your CV, which include a division of
8 presentations for -- you know, between those done
9 while you were working at Oklahoma and then those
10 done while you were at Georgetown, which begin later
11 in your CV.

12 Is that a fair way to kind of -- to try to
13 break it down?

14 A Sure.

15 Q So here we start on Page 11. And these are
16 lectures and workshops that you've listed that are
17 national pediatrics.

18 And that goes until this section -- I'm
19 sorry. There's "National Pediatrics" and then
20 "Regional Pediatrics." So these are all "Pediatrics:
21 Lectures and Workshops," and it goes until Page 25 of
22 your CV.

23 Were any of these presentations related to
24 the treatment of gender dysphoria in pediatric
25 patients?

1 A No.

2 Q And these are presentations, so it looks
3 like they may have started in 1982 and they go until
4 2004.

5 So is it fair to say that for that whole
6 period of time you didn't present on the topic of
7 gender-affirming medical care?

8 A That's true.

9 Q And then the next section, which starts on
10 Page 26, is about your bioethics presentations. And
11 this is a similar time period, appears to be from the
12 early 1980s until -- until maybe 2008 or 2009.

13 Were there any bioethics presentations
14 about the treatment of gender dysphoria in either
15 pediatric or adult patients?

16 A No.

17 Q All right. I'm just going to ask. So,
18 obviously, in some cases the title of the
19 presentation and the forum isn't totally clear to us
20 from what's listed, so I just have a couple questions
21 about specifically some of these presentations.

22 So here in 2009 you gave a presentation to
23 the Bioethics Dean's Conference at the Schusterman
24 Learning Center. That was called "The Faith Factor:
25 How does religion or spirituality affect medical

1 care?"

2 What was this presentation about?

3 A Dr. Meixel was talking about some of his
4 patients that -- where either religion or
5 spirituality had made some effect in how they were
6 approached and how we supported them.

7 Q How does religion affect medical care?

8 I guess, what is the takeaway?

9 A Well, it -- there was no single takeaway
10 because, of course, different people have different
11 approaches.

12 If you're a Jehovah's Witness, everybody
13 will know, you know, that you're supposed to be
14 avoiding blood products.

15 You know, if you are Muslim or if you are
16 Jewish, not only are there dietary requirements, but
17 if you're observant there may be some strict
18 requirements in terms of the approach to medicine,
19 brain death, transplantation, issues like that.

20 Q On a couple different pages -- so you list
21 presentations to St. Mary's Church in Tulsa.

22 Was that your church?

23 A Yes.

24 Q And so in -- I guess, in what capacity were
25 you giving presentations at your church?

1 A Because they asked me.

2 Q And were you presenting your views as a
3 doctor or your views as a Catholic in these
4 presentations?

5 A I don't know what presentations we're --

6 Q So here we have --

7 A -- talking about.

8 Q -- on one, "Life and Death Issues: The
9 Catholic Perspective."

10 A Again, I -- actually, that was 1997. I
11 really don't know what was discussed except I assume
12 it had both to do with life and death.

13 Q There's another presentation on the topic
14 "Catholic Morality."

15 Do you recall this presentation?

16 A No. That was 1993. Been a while.

17 Q You presented at Oral Roberts University in
18 1991. I know, obviously, it was quite some time ago,
19 but the title of the presentation was, "Is There a
20 Christian Medical Ethic?"

21 Do you recall what that presentation was?

22 A No, I don't.

23 Q All right. So I'm going to ask about just
24 a couple more presentations and then I think we're
25 due for a short break.

1 So I'm going to move to the presentations
2 that are listed later in your CV. We -- I mean, I
3 believe -- and you can correct me if I'm wrong --
4 that these would have been presentations that you
5 would have given since you went to Georgetown. I
6 think that's what this title indicates; is that
7 correct?

8 A Yes, I believe so. Once again, I'll have
9 to apologize. I didn't prepare this CV myself. This
10 was done by a couple of people trying to fit the
11 Georgetown format, but -- that's the way it looks
12 like it's divided.

13 Q So -- and that's -- you know, I think we
14 got the hang of it, but obviously if there's anything
15 that needs clarification, please let us know.

16 So were any of these presentations that you
17 gave while at Georgetown University specific to the
18 treatment of gender dysphoria?

19 A Not that I recall. It really wasn't
20 something people were requesting at that point.

21 Q You have never given any sort of lecture or
22 presentation on the treatment -- medical treatment of
23 gender dysphoria, aside from that course that we
24 talked about where you would do one session for your
25 students?

1 A I think that's correct.

2 Q And have you ever presented on or lectured
3 on providing informed consent for gender-affirming
4 care?

5 A Providing informed consent, quite a bit.
6 For gender-affirming care, no.

7 MS. DUNN: All right. I think that's all
8 of my questions about presentations, so I -- if we'll
9 just -- I think we'll take maybe a five-minute break.

10 (Recess taken from 10:31 a.m. to 10:37
11 a.m.)

12 Q (By Ms. Dunn) We're going to return to your
13 CV, Dr. Donovan, and I'm going to Page 60, which
14 lists your publications. And this is described as
15 "Original Papers in Refereed Journals."

16 Does the word -- does "refereed" mean the
17 name thing as "peer-reviewed"?

18 A Yes.

19 Q Okay. I will use the term "peer-reviewed"
20 today, but our understanding is those are
21 interchangeable?

22 A Yes.

23 Q So you have 17 papers listed under
24 "Bioethics" as "original papers and refereed
25 journals."

1 Of these 17 papers, which were original
2 articles that you were the primary author that
3 underwent a peer-review process?

4 A These are the papers, I think, before
5 Georgetown then. And if I'm the first author, my
6 name will appear first.

7 Q So on a number of these articles your name
8 doesn't appear at all.

9 A Then I'm the sole author in that case.

10 Q I'm sorry?

11 A Then I would be the sole author.

12 Q Well, so here I'm looking, for example,
13 Number 3, which is from the AAP Committee on
14 Bioethics titled "Professionalism in Pediatrics."

15 There are two other authors and the AAP
16 Committee on Bioethics, but your name is not listed
17 at all. What was your contribution to this article?

18 A Mary Fallat and Glover and I were all on
19 the Committee on Bioethics. And so she was the
20 primary author on this, but we all contributed and
21 discussed it.

22 Q Contribute to the actual text of the
23 article or just to discussions about the article?

24 A Both. Depends on the article, but, yes,
25 usually both.

1 Q For Number 5, again we have an author
2 DS Kiekema and the AAP Committee on Bioethics called
3 "Responding to Parental Refusals of Immunizations of
4 Children."

5 Is this also an article that you were an
6 author on?

7 A Yes, these all were while I was on the
8 Committee on Bioethics at American Academy of
9 Pediatrics.

10 And Doug Diekema, in that case, was the
11 primary author.

12 Q Is it common that someone who contributed
13 to an article isn't listed as an author?

14 A When you look at the paper itself, they
15 list all the members.

16 Q All right. Well, so let's look at one of
17 these then.

18 (Document is displayed).

19 All right. So this is a copy of the
20 article listed -- that we just talked about. I
21 believe it's listed as -- one quick second.

22 This article is listed as Number 3 in the
23 "Bioethics" section of "Original Papers and Refereed
24 Journals," and this is the article called
25 "Professionalism in Pediatrics."

1 And the listed authors are Mary Fallat,
2 Jacqueline Glover, and then it says the "Committee on
3 Bioethics."

4 So are you saying that because the
5 Committee on Bioethics is listed that every member of
6 that Committee on Bioethics is an author of this
7 document?

8 A Yes, we co-author it.

9 Q How many members would -- are on the
10 Committee for Bioethics -- or Committee of Bioethics?

11 A If you scroll down you should be able to
12 get all their names. There are about half a dozen
13 typically. It would sometimes vary.

14 Q So this is what you're referencing?

15 A Yeah.

16 Q Okay.

17 A That's me.

18 Q All right. So other than the publications
19 that were -- that you are a co-author on because you
20 are a member of the Committee on Bioethics, which --
21 let me -- I'm going to pull back up your -- oh,
22 that's the wrong -- I'm sorry. I'm pulling your CV
23 back up.

24 (Document is displayed).

25 Which of these articles -- and just let me

1 know if you need me to scroll further. So other than
2 the publications that were -- that you are a
3 co-author on because of your membership in the
4 Committee on Bioethics of the American Academy of
5 Pediatrics, which articles are peer-reviewed journal
6 articles?

7 A Well, everything listed in this list should
8 be a peer-reviewed journal article.

9 Q So let's start with this first article,
10 bio -- sorry, "The Disabled and Their Lives of
11 Purpose."

12 So this article, do you recognize this?

13 A Uh-huh. Yes.

14 Q And actually I'm just realizing, for the
15 court reporter's benefit, I probably need to note
16 that the exhibit we just looked at, which was the
17 "Professionalism in Pediatrics" article, is going to
18 be marked as Plaintiffs' Exhibit 7.

19 (Whereupon, Exhibit Number 7 was marked for
20 identification purposes and made a part of the
21 record.)

22 Q (By Ms. Dunn) This article -- did you write
23 this article, Dr. Donovan?

24 A Yes.

25 (Whereupon, Exhibit Number 8 was marked for

1 identification purposes and made a part of the
2 record.)

3 Q (By Ms. Dunn) I will mark this article as
4 Exhibit 8.

5 So this article was published in 2007; is
6 that correct?

7 A Yes.

8 Q And it is four pages long?

9 A Approximately.

10 Q Looks like maybe a little over four.

11 Did this article summarize any sort of
12 original research?

13 A It was all original. Typically, the
14 articles in bioethics may be empirical research or
15 they may be learned opinion, if you will, or
16 perspectives.

17 Q So how would you describe this particular
18 article? Was it --

19 A More like the latter.

20 Q The learned opinion?

21 A Uh-huh.

22 Q Okay. And where was this article
23 published?

24 A It says "The Linacre Quarterly."

25 Q Do you know anything about that journal?

1 A Yes. It's the journal published by -- I
2 believe that's CMA.

3 Q So The Linacre Quarterly is the official
4 publication of the Catholic Medical Association?

5 A Yes.

6 Q Do you know if the individuals who serve as
7 peer-reviewers for this journal are required to be
8 members of the Catholic Medical Association?

9 A You're not even supposed to know who the
10 peer-reviewers are in a refereed journal.

11 Q Yeah, I understand the concept of blind
12 review, but do individuals who have -- that's a
13 different question.

14 Do peer-reviewers have to be members of the
15 Catholic Medical Association?

16 A I don't know.

17 Q Now, do you recall what the peer-review
18 process for that article entailed?

19 A I don't remember it being any different
20 than the peer-review process for any other articles.
21 You submit it, they send it out to their
22 peer-reviewers. Peer-reviewers make suggestions
23 or -- or recommend that it be published or not be
24 published.

25 Q All right. So going back to your CV. So

1 this first article there was -- it did appear in a
2 peer-reviewed journal and that journal was the -- is
3 the official journal of the Catholic Medical
4 Association.

5 This article -- Number 2. This article --
6 was this article published in a peer-reviewed
7 journal?

8 A Oh, I had forgotten Mary and I did that.
9 Okay. I believe it was being
10 peer-reviewed, but that publication looks like was in
11 eMedicine and I don't know.

12 Q What is that publication?

13 A That's an online journal.

14 Q So we attempted to find this article using
15 that website and could not.

16 So this says "From WebMD" and we're -- I'm
17 just trying to figure out what that means. Is this a
18 Web -- is this an article that was published on
19 WebMD?

20 A Apparently, yes.

21 Q So -- but WebMD is not a peer-reviewed
22 medical journal.

23 A It shouldn't be, no, so I don't know why
24 that's there, but --

25 Q Okay. So, then, are --

1 A If, unless -- yeah, I don't know. I don't
2 know.

3 Q So is 2 -- we can say that's not an article
4 in a peer-reviewed medical journal?

5 A I would have to try and find it myself.

6 Q Okay.

7 A Once again, these things may have been
8 jumbled a little because they were all redone upon my
9 arrival at Georgetown.

10 Q Sure. Number 3, we already talked about,
11 that is a publication that you were a co-author on as
12 a member of the Committee of Bioethics.

13 A Uh-huh.

14 Q Number 4 is an article that was published
15 in a state medical journal?

16 A Uh-huh.

17 Q Is that -- that was a peer-reviewed medical
18 journal?

19 A I believe it was.

20 Q Do you know that for sure?

21 A I can't recall.

22 Q Number 5, again, it looks like this was --
23 oh, no, I'm sorry, this was also in a state medical
24 journal. Do you know if this was a peer-reviewed
25 medical journal?

1 A It was the same journal and I believe --
2 I'm not sure they're publishing that journal anymore,
3 but I believe they were reviewing it at a peer
4 review. I believe.

5 Q Do you know that for sure?

6 A I couldn't tell you.

7 Q Number 8 was another -- it's a clinical
8 report from the American Academy of Pediatrics.

9 Is that -- was that something that you were
10 a co-author on because of your position on the
11 Committee of Bioethics or was it a different type of
12 publication?

13 A Well, Mary and I were on the committee
14 together. She's a pediatric surgeon. I don't know
15 if that was done separately or through the committee
16 at the time.

17 Q Okay. Number 8 here, we have an article
18 titled "Ethical Issues with Genetic Testing in
19 Pediatrics."

20 This was also one that you are a co-author
21 on as a member of the AAP Committee on Bioethics?

22 A Yeah. It looks like all the rest on that
23 page fit in that same category.

24 Q Okay. So we -- we -- so 8 through -- well,
25 let's go down. Eight through 14, it looks like, were

1 all publications that you were a co-author on as a
2 member of the Committee on Bioethics?

3 A Looks like it.

4 Q And do you know if these -- that type of
5 publication is peer-reviewed?

6 A Well, it's peer-reviewed but not in the
7 usual fashion because it goes through the internal
8 workings of the American Academy of Pediatrics.

9 And I'm not sure the best way -- maybe
10 that's why they listed these as "refereed" rather
11 than "peer-reviewed." Although, I wouldn't have
12 thought there was a difference. But they are
13 reviewed and then sent back or accepted or not
14 accepted. So to that extent there's a similar
15 mechanism.

16 Q When you say "accepted" or "not accepted,"
17 do you mean --

18 A For publication.

19 Q -- accepted by the Academy of -- the
20 American Academy of Pediatrics at large?

21 A Well, no. No. The academy at large
22 doesn't peer-review. I mean, it would be -- or
23 referee. It would be through the mechanisms of the
24 various editorial boards and the hierarchy.

25 Q Okay. And these types of publications, the

1 clinical reports and the policy statements, are
2 these -- do you consider these types of publications
3 reliable?

4 A I'm not sure what you mean by "reliable."

5 Q Are they the type of materials that
6 physicians would routinely rely on in conducting a
7 clinical practice?

8 A Yes.

9 Q All right. The last three articles on this
10 page are Numbered 15 through -- I'm sorry, not on
11 this page, in this section -- are Numbered 15 through
12 17.

13 And so 15 was published in a journal by the
14 name of Christian Bioethics and it was titled
15 "Decisions at the End of Life: Catholic Tradition."

16 Was this a peer-reviewed article?

17 A Yes.

18 Q And are you familiar with the mission
19 statement of the Christian Bioethics Journal?

20 A No.

21 Q Is it -- are you -- are you aware that that
22 journal offers contributions and publications from
23 Christian perspectives?

24 A I would have assumed that by its name, yes.

25 Q 16, the article "Does Shooting Abortionists

1 Reveal a Lack of Faith?"

2 This is also a publication in Linacre
3 Quarterly; is that right?

4 A Yes.

5 Q And that Linacre Quarterly, again, is the
6 journal -- the official journal of the Catholic
7 Medical Association?

8 A I believe so, yes.

9 Q Do you recall if this article would be
10 considered empirical research versus a learned
11 opinion like the article we discussed before?

12 A No, that would be a learned opinion.

13 Q And I should have asked that for 15 as
14 well. Would that article have been empirical
15 research or a learned opinion?

16 A If I recall -- and remember, that was, you
17 know, a long time ago, about -- over 20 years ago,
18 but it would have combined a little bit of both
19 because it would have required some research, but not
20 empirical research. It wasn't -- you can do
21 bioethics articles that actually involve live people
22 sometimes, but this was not in that category.

23 Q Okay. And then 17, again, was published in
24 that state journal we previously discussed?

25 A Yes.

1 Q All right. And then this next section of
2 articles, these are all articles related to your
3 practice as a pediatric gastroenterologist?

4 A Yes.

5 Q All right. I'm going to now skip down to
6 the end of your CV where your publications from your
7 time at Georgetown are listed.

8 So I am flipping to what is Page 78 on your
9 CV. I guess there's no limitation here like in the
10 other section that notes that these are publications
11 in peer-reviewed or a refereed journal.

12 Do you know which of these articles
13 appeared in peer-reviewed or refereed journals?

14 A Well, the journal articles should have been
15 in peer-reviewed or refereed journals, but not
16 everything there is a -- a journal article, as you
17 can see. Some of them were chapters in books.

18 Q And your Number 1 is a chapter in a
19 book; is that right?

20 A Correct, in the geriatrics book.

21 Q Okay. Number 2 and 3 are pieces in the
22 Italian Encyclopedia of Bioethics?

23 A That's right.

24 Q All right. Number 4, is this a
25 peer-reviewed journal article?

1 A Yes, it is.

2 Q You're sure it's a peer-reviewed journal
3 article, not an editorial?

4 A On which one, Number 4?

5 Q Ebola, Epidemics, and --

6 A I think that was -- no, that was in an
7 online journal. I think that was just an article, I
8 believe.

9 Q Are you seeing this new document?

10 A Oh, it says "editorial." Okay. So that
11 must have been an editorial.

12 Q Okay. So this article was an editorial,
13 not a peer-reviewed research article -- or
14 peer-reviewed article?

15 A Correct.

16 Q Okay. The next -- oh, I should go back to
17 your -- let you see, too.

18 (Document is displayed).

19 The next article here, Number 5, also --
20 this is also an editorial by the name of "Doctors,
21 Documentation, and the Professional Obligation: Has
22 everything changed?"

23 A Okay.

24 Q That's an editorial; is that right?

25 A Yeah. That surprised me because they

1 decided to make it an editorial.

2 The next one was just a local publication
3 at Georgetown, though.

4 Q And this is like an online student
5 newspaper; is that right?

6 A Yeah.

7 Q This article here titled "Beneficence in
8 Utero, a Framework for Restricted Prenatal
9 Whole-Genome Sequencing to Respect and Enhance the
10 Well-Being of Children," that was an article in the
11 American Journal of Bioethics?

12 A Yes.

13 Q And this is -- was that article
14 peer-reviewed?

15 A Yes.

16 Q Do you -- are you aware of the difference
17 between an open peer commentary and a peer-reviewed
18 article?

19 A Well, this was AJOB commentary, as I
20 recall, but it's a peer-reviewed journal.

21 Q Well, it's a peer-reviewed journal but was
22 the article itself peer-reviewed?

23 A I don't know how AJOB does it, but seeing
24 as how they accepted the article, I would assume that
25 they had some peer review involved.

1 Q If you'll give me just one second, I'm
2 trying to pull up the article and I'm having trouble.
3 So I'm going to stop sharing and try to figure this
4 out.

5 MR. BEATO: No problem. Take your time.

6 Q (By Ms. Dunn) All right. I apologize. I
7 was having trouble opening the type of file.

8 (Document is displayed).

9 So this is a screenshot from the journal of
10 your publication. And this here -- it lists this
11 article as an open-peer commentary.

12 And so are you familiar with whether or not
13 an open-peer commentary is peer-reviewed?

14 A Well, we were invited to offer a
15 commentary, but I don't know that they're
16 automatically accepted. So the process for accepting
17 or not accepting, I would assume, involves some
18 mechanism of review.

19 (Whereupon, Exhibit Number 9 was marked for
20 identification purposes and made a part of the
21 record.)

22 Q (By Ms. Dunn) So I'm just going to share
23 another document.

24 I'm sorry. So if we could mark that last
25 exhibit, which is the article -- I'm sorry.

1 I realize I didn't mark the "Ebola,
2 Epidemics, and Ethics" article. That should be
3 Article -- or, I'm sorry, Exhibit 9.

4 (Whereupon, Exhibit Number 10 was marked
5 for identification purposes and made a part of the
6 record.)

7 Q (By Ms. Dunn) The "Beneficence in Utero,"
8 open-peer commentary, will be Exhibit 10.

9 (Whereupon, Exhibit Number 11 was marked
10 for identification purposes and made a part of the
11 record.)

12 Q (By Ms. Dunn) And I'm now showing you an
13 email which I'm going to mark as Exhibit 11.

14 So I will represent to you that this is an
15 email that we sent to the editors of the American
16 Journal of Bioethics. We asked them if open-peer
17 commentaries are subject of peer review.

18 And their response was that open-peer
19 commentaries are not peer-reviewed.

20 So can we agree that the open-peer
21 commentary you provided that was marked as Exhibit 10
22 was not a peer-reviewed journal article?

23 A There you go. It says "Reviewed by our
24 editorial team."

25 (Document is displayed).

1 Q All right. This article labeled as
2 Number 8, "Physician Assistant Suicide in the Medical
3 Profession," this was another Georgetown specific
4 publication. It looks like perhaps a blog.

5 A Okay.

6 Q Is that correct?

7 A I assume.

8 Q Do you recall writing this publication?

9 A The publication, I probably did. The
10 listing of these were all done by my secretary just
11 when everything -- anything would be published.

12 Q And then Number 9 --

13 A As I recall, she didn't even list --
14 differentiate on these between peer-reviewed and not
15 peer-reviewed, did she?

16 Q She didn't, so that's why we are asking
17 these questions because we were unable to fully
18 determine.

19 A Oh, okay.

20 Q And so Number 9, again, would be a blog
21 post. That would not be a peer-reviewed article?

22 A I can't actually read that, so --

23 Q I'm sorry. Number 9 says -- is "PAS:
24 Unwise, Uncontrollable, and Unnecessary," and then it
25 lists an HTTP that appears to be a blog.

1 A Okay.

2 Q So that would not be a peer-reviewed
3 article?

4 A I wouldn't think so.

5 Q And then Number 10 here, is this a book?

6 A Chapter.

7 Q A chapter in a book?

8 A Yes.

9 Q Do you recall what the name of the book?

10 Oh, I'm sorry, the book is "Palliative Care
11 in Catholic Healthcare - Two Millennia of Caring for
12 the Whole Person"; is that right?

13 A Right.

14 Q And this publication at Number 11 is
15 "PAS" -- and I'm assuming that PAS -- and you correct
16 me if I'm wrong -- is that the acronym for Physician
17 Assistant Suicide?

18 A Correct.

19 Q Okay. "PAS: How should Catholic
20 healthcare respond?"

21 And that article appeared in the Healthcare
22 Ethics USA?

23 A Correct.

24 Q Are you aware that that Healthcare Ethics
25 USA is a publication of the Catholic Health

1 Association?

2 A Yes.

3 Q And this article -- it's not a medical
4 journal that's subject to peer review; is that right?

5 A It's an ethics journal.

6 Q Is it a peer-reviewed journal?

7 A I don't think it is. I think it's one like
8 the other one, editorial reviewed.

9 Q Okay. Number 12 here, this is a book
10 review you wrote?

11 A Yes.

12 Q And so that would not be a peer-reviewed
13 article?

14 A No.

15 Q And 13, another article in the American
16 Journal of Bioethics titled "How We Should Conceive
17 of Creation: Natural Birth as an Ethical Guidepost
18 for Neonatal Rescue."

19 Do you recall if that article was
20 peer-reviewed?

21 A Well, I think that one was. I think that
22 that was a -- I think Doug McAdams actually wanted to
23 do that himself, but that may have been another one
24 where they were responding to an AJOB article.

25 So the reason I wouldn't know is because I

1 wasn't the primary author on those. So if it was
2 peer-reviewed and the comments from the reviewers
3 come back, they come to the primary author.

4 (Whereupon, Exhibit Number 12 was marked
5 for identification purposes and made a part of the
6 record.)

7 Q (By Ms. Dunn) I understand. So I'll just
8 quickly show you the, I guess post -- I don't know,
9 post -- or the journal page that references this
10 article and we'll mark this as Plaintiffs'
11 Exhibit 12.

12 So this article again is an open-peer
13 commentary.

14 A Okay.

15 Q So we can agree that that is not a
16 peer-reviewed article?

17 A It's been a learning experience for me.
18 Thank you.

19 Q I'm going back to your CV.

20 (Document is displayed).

21 The next article is a publication, it looks
22 like, in the Catholic Health Association.

23 Do you know what this -- whether this is a
24 peer-reviewed journal?

25 A I would expect that's only reviewed by the

1 editors.

2 Q This article -- or this publication,
3 "Reflections by a Christian Scholar," here at Line
4 18 -- or Number 18 is an "In Press Proceeding," but
5 is this a lecture that was presented at a conference?

6 A That was -- it was.

7 Q Okay. And it will be published as such?

8 A Yes.

9 Q 19, there's an article that you co-authored
10 with some other individuals that's called "Affirming
11 Ethical Options for the Terminally Ill."

12 This was published in the Heritage
13 Foundation publication; is that right?

14 A Apparently, right.

15 Q And the Heritage Foundation is not an
16 academic medical journal?

17 A No.

18 Q Okay. Would this be a transcript of a
19 lecture as well?

20 A I believe so.

21 Q Okay. And did you participate in that
22 lecture, or in what capacity were you --

23 A I would have given it.

24 Q Would it have been at a Heritage Foundation
25 event? Is that when that occurred?

1 A Yes.

2 Q Okay. The next article at Line -- at
3 Paragraph 20, "The Deadly Advocacy of Doctor-Assisted
4 Suicide."

5 This is a Washington Times article?

6 A Uh-huh. That looks requested.

7 Q Not a peer- --

8 A Not peer-reviewed.

9 Q Not peer-reviewed.

10 21 is an article you wrote with another
11 individual called "Strangers in a Strange Land: How
12 Our Founding Principles and a Bitter Pill Undo the
13 Assimilation of U.S. Catholics."

14 This article was also in The Linacre
15 Quarterly; is that right?

16 A Yes.

17 Q And as we've said, The Linacre Quarterly is
18 the official publication of the Christian -- I'm
19 sorry, the Catholic Medical Association?

20 A Peer-reviewed.

21 Q And this is peer-reviewed.

22 Do you know that this particular article
23 was peer-reviewed?

24 A Yes.

25 Q So, to your knowledge, a commentary is

1 peer-reviewed?

2 A What are you talking about, Strangers in a
3 Strange Land?

4 Q Yes.

5 A Well, they sent it back and forth to us.
6 Did they look -- I don't know how they decide to list
7 things in their journal, but I know that they
8 required us to go through peer review.

9 Q So I guess I'm wondering, is there -- there
10 is a distinction between "editorial review" and
11 "peer review." Are you certain that this particular
12 publication was peer-reviewed?

13 A Well, when they send it back -- and as I
14 recall they sent it back with suggestions -- so that
15 would have been peer-reviewed.

16 Q So --

17 A If you get messages from peer-reviewers,
18 that means it's peer-reviewed.

19 Q Well, I do think there's a difference. I
20 think the editors of the journal can give you
21 comments and edits, but a peer-review process is
22 different and requires practicing professionals who
23 are your peers to provide comments and, you know,
24 editorial sugg- -- or maybe not even editorial
25 suggestions, but to provide comments.

1 So I do think there is a distinction, as
2 noted in that email from American Journal of
3 Bioethics, between editorial review and peer review.

4 So I'm just trying to determine if you are
5 certain that that article was peer-reviewed or
6 whether it could have just been subject to editorial
7 review.

8 A To the best of my recollection, it was.

9 Q It was. Okay.

10 And would you say that that article, the
11 "Strangers in a Strange Land," would that article be
12 better described as empirical research or a learned
13 opinion?

14 A More in the learned opinion category.
15 (Document is displayed).

16 Q Going back to your CV.

17 At 22 we have a document titled "Ethical
18 Dilemmas in Pediatric Lipidology. Endotext
19 Pediatrics."

20 Do you know if that -- is that a book or do
21 you know what -- where that publication appeared?

22 A No, that -- that is done by the
23 endocrinologist I was doing it with, Don Wilson, so
24 he just told me that that was published.

25 Q Okay. So --

1 A And just for my permission and I said
2 "Sure."

3 Q So is it a chap- -- I'm confused. Is it a
4 chapter in a book or a publication?

5 A I believe it's a publication.

6 Q Okay. Number 23 here, this is another --
7 it's a chapter in, I think, the same book that we saw
8 at the beginning, is that right, "Ethical
9 Decision-Making in the Elderly"?

10 A No, that's the subsequent edition of --

11 Q So it's an update to that first entry on
12 this publication list?

13 A Yeah, but it's already been published, so
14 that hasn't been -- caught up yet. But, yes, that's
15 now published.

16 Q Okay. 24, is this another -- your "CPR,
17 DNR, and the Patient's Good," is this another book
18 that you've contributed to?

19 A Yes.

20 Q And 25 would be similar. This "Ethical
21 Issues in the Provision of Nutrition and Hydration"
22 in Pellegrino's Compendium, that's, similarly, a
23 book?

24 A Yes. They --

25 Q And 26 -- I'm sorry.

1 A They told us it will be published this
2 fall.

3 Q Okay. And then 26, which is "Chapter 101
4 ethics in Prenatal/Neonatal Medicine," identified as
5 the "Handbook in Neonatology," is that another book
6 publication -- a book -- a publication related to a
7 book?

8 A Yes.

9 Q Okay. And I believe that's the end of the
10 publications that we have listed in your CV.

11 So you don't have any articles that you've
12 published that underwent peer review where the topic
13 was gender-affirming medical care; is that right?

14 A Yes. I've said that.

15 Q Okay. Well, I'm not sure we talked about
16 publications. We talked about presentations and
17 teaching, but I just want to confirm that you also
18 haven't authored any publications that underwent
19 peer review that were related to gender-affirming
20 care.

21 A Correct.

22 Q You have been listed as an author on one
23 article related to gender-affirming medical care; is
24 that right?

25 A Yes.

1 Q And what article was that?

2 A That was the Laidlaw article.

3 Q And this article was an open-peer
4 commentary; is that right?

5 A Correct.

6 (Document is displayed).

7 Q And this is the article we're talking
8 about?

9 A Yes.

10 (Whereupon, Exhibit Number 13 was marked for
11 identification purposes and made a part of the
12 record.)

13 Q (By Ms. Dunn) All right. I will mark this
14 as Plaintiffs' Exhibit 13.

15 So this article did not undergo
16 peer review; is that right?

17 A Actually, you were the one who pointed out
18 to me it underwent an editorial review, not a
19 peer review.

20 Q Okay. Because it's in the American Journal
21 of Bioethics and we looked at that email which
22 clarified that?

23 A Right.

24 Q Okay. So this commentary argues that
25 minors alone cannot consent to gender-affirming care

1 medical treatments; is that correct?

2 A Yes, that's correct. That minors should
3 not be permitted to consent without the involvement
4 of their parents to the gender-affirming care.

5 Q And so it's not suggesting that parents and
6 legal guardians cannot provide informed consent?

7 A It was responding to an article that said,
8 in fact, that if they don't perform -- or don't offer
9 informed consent, they should be able to bypass the
10 parent.

11 Q But this article itself isn't suggesting
12 that parents can't provide informed consent for their
13 children?

14 A No.

15 Q The article mentions -- so in the first
16 paragraph the article states -- and I will -- I can
17 highlight with my cursor. Actually, I can't. It
18 won't let me.

19 But right here near where my cursor is, it
20 states that, "Watchful waiting with support for
21 gender-dysphoric children and adolescents up to the
22 age of 16 years is the current standard of care
23 worldwide, not gender-affirmative therapy."

24 What is "watchful waiting"?

25 A Okay. They were using the -- the term as

1 a -- as an approach to supporting children without
2 puberty blockers or hormones.

3 Q And watchful waiting is not a type of care
4 that you provided as a clinician; is that right?

5 A That's right.

6 Q And what evidence is relied on to support
7 the contention that watchful waiting is the current
8 standard of care?

9 A Well, he actually -- Dr. Laidlaw listed
10 the -- the article right there, I believe.

11 Q So that's based on the de Vries and
12 Cohen-Kettenis article published in 2012?

13 A Uh-huh. Yes.

14 Q So if we scroll down to the bibliography,
15 that article is listed here. And I believe -- so
16 it's called the "Clinical Management of Gender
17 Dysphoria in Children and Adolescents. The Dutch
18 Approach."

19 What supports the contention that the Dutch
20 Approach is the worldwide standard of care?

21 A I think that he was talking about in places
22 other than America.

23 Q But in what way does this article establish
24 that the Dutch Approach is a worldwide standard of
25 care?

1 A I think it's difficult to answer -- for
2 anybody to answer what is the worldwide standard.
3 Perhaps the Dutch Approach was certainly one that had
4 been significant in the world and they were kind of
5 leaders in the approach to children with transgender
6 care.

7 Q Are there any sources cited that support
8 what the standard of care in the United States would
9 be?

10 A You mean within this article or elsewhere?

11 Q Within this article.

12 A I would have to go back and re-read it to
13 answer that. I'm sorry.

14 Q And we've established today that your field
15 of specialty is not pediatric endocrinology, correct?

16 A Correct.

17 Q Did you write any of the information in
18 this commentary about puberty-blocking medications?

19 A No. No. My contribution was only on the
20 ethical aspects.

21 Q Okay. So if we move further on in the
22 article, this sentence here which provides opinions
23 about GnRH analogues that suggest or assert that they
24 cause infertility, what evidence was relied on in
25 making this assertion?

1 A Once again, I wasn't writing the
2 innercological (phonetic) parts of this.

3 Q So you're not familiar with any of the
4 evidence that would suggest -- or any evidence that
5 would suggest that GnRH analogues cause infertility?

6 A I have read this, yes.

7 Q Is that -- is it not -- I mean, is that
8 fact, that the impact of GnRH analogues on fertility,
9 is that not relevant to the bioethics opinions
10 presented in this article?

11 A Yes.

12 Q So wouldn't it be important to be familiar
13 with any such evidence?

14 A Yes.

15 Q Okay. So what evidence is being cited to
16 support that contention?

17 A Once again, I'm going to have -- I haven't
18 read this article in some time, so I would have to go
19 back through it to see what evidence it cites.

20 Q There's about two paragraphs there. Would
21 you -- would that help you to review to determine if
22 there is evidence being cited to support that
23 assertion?

24 I can zoom out, I can zoom in, whatever
25 makes it easier.

1 A Which -- I'm sorry, where are we reading
2 right now?

3 Q I believe the relevant text is in the
4 section "Puberty-Blocking Agents and Infertility."

5 A Okay. I'm just reading along with you, I'm
6 sure. "There are no randomized controlled studies
7 for the use of puberty-blocking agents including
8 safety for stopping normal puberty. Endocrine
9 Society has published revised clinical guidelines in
10 2017, including adolescents. The" -- better scroll
11 up. Let's see what else we've got.

12 -- "quality of evidence for PBA is noted to
13 be low. In fact, all the evidence in the guidelines
14 with regard to treating children/adolescents is low
15 to very low because of the absence of proper studies.
16 These same guidelines, however, recommend arresting
17 normal puberty at Tanner Stage II. This is highly
18 significant because it's the pubertal stage occurring
19 before menarche in girls and before spermarche in
20 boys. Continued suppression of pituitary gonadal
21 axis by PBA will maintain a state of immaturity of
22 the male and female gonads. As a result, though the
23 child will likely grow in stature, the gonads and
24 entire pelvic genitalia will remain stunted at
25 Tanner 2. The condition of cross-sex hormones will

1 not change this condition. As a result, the patient
2 will be infertile as an adult. The continued
3 administration of cross-sex hormones may lead to
4 permanent sterilization. Gonadectomy, of course,
5 would also ensure sterility."

6 Is that what you were talking about?

7 Q No. I'm talking -- I'm asking. My
8 question is, there's an assertion made here that as a
9 result the patient will be infertile as an adult.
10 And there's no citation provided.

11 So I'm asking what evidence is being relied
12 on to support that assertion.

13 A Okay. And that's a very reasonable
14 question, but I -- this is not the only place I have
15 read that. It is not referenced in this short
16 commentary.

17 Q So there's no evidence being provided to
18 support the assertion that the administration of GRNH
19 analogues leads to infertility as a result?

20 A The evidence is not, apparently,
21 re-presented in this short commentary. I don't say
22 that there's no evidence. I'm saying that the
23 references don't seem to be listed for all the
24 statements in the commentary.

25 Q But there's no evidence being cited in this

1 article to support that assertion?

2 MR. BEATO: Object to form.

3 Dr. Donovan, you can answer that question.

4 THE WITNESS: I think that you're probably
5 right. Reminding you that absence of evidence is not
6 evidence of absence.

7 Q (By Ms. Dunn) The article also suggests
8 that puberty-blocking agents impair adults' sexual
9 function. And I'll scroll down. There's a section
10 here on this.

11 What evidence is provided in this article
12 to support this assertion?

13 A Once again, I think that you're looking for
14 the type of evidence that can be included in much
15 longer articles. These are space-limited, so both
16 the length of the article and the length of the
17 references is not expansive. That doesn't mean that
18 there haven't been multiple reports of either
19 concerns or actual evidence that these things have
20 occurred, they're just not all listed within this
21 article.

22 Q Can you name a study that would support
23 this assertion?

24 A I am certain that there are studies that
25 have supported that assertion. I can't name you one

1 currently. It would take a little research.

2 Q Can you name any study that would support
3 the assertion that the administration of GRN- -- GnRH
4 analogues causes infertility?

5 A The same answer.

6 Q So your assertion is that providing the
7 citation in the text would make this article too long
8 to include. Is that what you're suggesting?

9 A No. No. It was clearly a matter of choice
10 and it was not chosen to include all the references
11 that could have conceivably been included.

12 Q Is it common in medical publications to
13 make an assertion and not provide the evidence on
14 which the author relies?

15 A It is common not to list every possible
16 reference, of course. It is also common to list
17 references. And some of the time you list
18 references, depending on the type of article you're
19 writing, whether it's an original article or a
20 response article, whether it's an extensive article
21 or a brief summary. So there will be variability.

22 Q Well, but this article, though, is
23 discussing the fact that children should not be able
24 to make decisions around medical transition and it
25 relies specifically on these assertions of the

1 harmful impacts and yet it fails to cite any evidence
2 to support those assertions. Is that not right?

3 MR. BEATO: Object to form.

4 Dr. Donovan, you can answer.

5 THE WITNESS: Yeah, I don't -- no, I don't
6 think that's exactly right. Of course, it cites some
7 evidence and you see that there are references
8 listed, but there aren't references listed for
9 everything.

10 Once again, how long is the article, how
11 many references are listed will depend a lot on what
12 you can put in there, how much that even the editors
13 will allow.

14 Q (By Ms. Dunn) Well, there's ten articles
15 listed, and not a single one assert -- not a single
16 one of these articles supports the contentions about
17 the harmful impacts that the authors are alleging.

18 MR. BEATO: I apologize. Is that a
19 question?

20 Q (By Ms. Dunn) Well, you can strike that.

21 MR. BEATO: Counsel, would you mind if we
22 take a five-minute break, or would you like to
23 continue asking questions?

24 MS. DUNN: Let me just finish asking
25 questions about this article and then I think it

1 would be a good time for a break.

2 MR. BEATO: Of course. Of course.

3 Q (By Ms. Dunn) So I'll move on to the
4 section of the article that's more about an
5 adolescent's ability to consent. I assume that that
6 would be relevant to the bioethics contributions you
7 made to this article?

8 A Yes.

9 Q And so here we -- in this section, the
10 "Co-morbid Psychiatric Condition" section, on what's
11 marked with the Bates number AHCA EXP 002078, it says
12 that there's an "additional issue related to an
13 adolescent's decision to take puberty-blocking agents
14 without any parental involvement."

15 And then it cites to "associated
16 psychological conditions."

17 So is this suggesting that because youth
18 with gender dysphoria may have other psychiatric
19 conditions, that that means that they're not able to
20 assent to this type of treatment?

21 A Well, it certainly would be a reason for
22 concern if someone had autism or schizophrenia or
23 profound depression, all of which have been
24 associated with transgender adolescence, that it
25 might impair their ability to provide fully informed

1 consent.

2 Q Currently there are no -- the standards of
3 care regarding the administration of this type of
4 treatment to minors does require parental
5 consent; isn't that right?

6 A Yes.

7 Q And there are protocols used by clinicians
8 to obtain informed consent for patients who do not
9 have capacity to consent for themselves in other
10 circumstances; isn't that right?

11 A Yes.

12 Q So there are frequently situations where
13 patients may have a psychiatric condition that can
14 impact their ability to provide informed consent and
15 there are protocols to -- that apply to those
16 situations?

17 A But those protocols do not allow for the
18 direct consent of the children. That is parental
19 permission being sought.

20 Q Yeah, but there are situations where adults
21 may not have capacity to consent because of
22 psychiatric conditions and there are protocols in
23 place where physicians are still able to obtain
24 informed consent and provide treatment; isn't that
25 right?

1 A That's a different situation altogether if
2 we're talking about an adult. But you're also
3 talking about an impaired adult who, therefore, their
4 ability to provide an informed consent with full
5 capacity would be questionable.

6 Q But what I'm saying is that there are
7 standards and protocols that clinicians engage in in
8 these types of situations; isn't that right?

9 A That's kind of a general statement that's
10 hard to disagree with. There are situations and
11 approaches to situations.

12 Q You published this article with Michael
13 Laidlaw and Michelle Cretella; is that right?

14 A That's right. Correct.

15 Q Are you aware that Michelle Cretella is the
16 executive director of the American College of
17 Pediatrics?

18 A I have heard that. She was not at the
19 time.

20 MS. DUNN: All right. I think that this is
21 probably a good time for the break that you asked
22 for, Michael.

23 MR. BEATO: Excellent.

24 (Lunch recess taken from 11:35 a.m. to
25 12:10 p.m.)

1 Q (By Ms. Dunn) So I wanted to just follow up
2 on one thing we talked about before the break, and
3 that was -- I asked about the affiliation of your
4 co-author, Michelle Cretella.

5 And you stated that at the time of the
6 article she wasn't affiliated with the American
7 College of Pediatricians; is that right?

8 A No. You said she was executive director,
9 and I think she just did that recently.

10 Q Okay. At the time that you all wrote the
11 article together, was she affiliated with the
12 American College of Pediatrics in any way?

13 A Probably.

14 Q Okay.

15 A But, however, I don't belong to the ACP, so
16 I don't know. I mean, I think she was.

17 Q Do you know anything about that
18 organization?

19 A Very little. I mean, it's pediatricians
20 who didn't agree with the AAP on certain issues.

21 Q Sure. So I just -- I'm going to point you
22 to a couple documents, so I'm going to share my
23 screen.

24 (Document is displayed).

25 This is a document from the American

1 College of Pediatricians entitled "Homosexual
2 Parenting: A Scientific Analysis."

3 Have you ever seen this document?

4 A No.

5 Q Okay. So this document is -- it's a policy
6 statement of the American College of Pediatrics which
7 states that, "There's sound evidence that children
8 exposed to the homosexual lifestyle may be at
9 increased risk for emotional, mental, and even
10 physical harm."

11 You were not aware of the American College
12 of Pediatrics' position on this issue when you --

13 A I've never seen this before, no.

14 Q So you were not aware of this policy
15 position when you made the decision to co-author a
16 publication with Michelle Cretella?

17 A No.

18 (Whereupon, Exhibit Number 14 was marked for
19 identification purposes and made a part of the
20 record.)

21 Q (By Ms. Dunn) And I'm just going to mark
22 that -- that exhibit that we just talked about, the
23 American College of Pediatrics' policy statement on
24 homosexual parenting as Exhibit 14.

25 And then I'm going to show you another

1 policy statement from the American College of
2 Pediatricians.

3 Have you ever seen this policy statement?

4 A No.

5 (Whereupon, Exhibit Number 15 was marked
6 for identification purposes and made a part of the
7 record.)

8 Q (By Ms. Dunn) Okay. So I'm going to mark
9 this as Plaintiffs' Exhibit 15. This is a policy
10 statement from the American College of Pediatrics
11 stating that there's "No evidence that psychotherapy
12 for unwanted homosexual attraction is any more or
13 less harmful than the use of psychotherapy to treat
14 any other unwanted psychological or behavioral
15 adaptation."

16 You are not familiar with this policy
17 statement?

18 A Correct.

19 Q And you were not aware of this policy
20 statement when you made the decision to co-author the
21 publication -- a publication with Michelle Cretella?

22 A First time I've seen it was today.

23 Q Would it have changed -- if you had known
24 about this, would it have changed your decision to be
25 an author on that publication?

1 A It didn't seem like those two really are
2 directly connected to each other.

3 Q So would it have changed your decision to
4 be an author --

5 A No.

6 Q -- on that publication?

7 A I don't know. I haven't read the article,
8 so it's hard to say whether it would change or not
9 change.

10 Q Well, I suppose, knowing that -- I mean,
11 I -- just understanding what I -- what I read from
12 this document, that it's a policy position issued by
13 this organization of which your co-author plays a
14 leadership role, that states that there's "No
15 evidence that psychotherapy for unwanted homosexual
16 attraction is any more or less harmful than the use
17 of psychotherapy in other contexts," would knowing
18 that that was a policy position of the American
19 College of Pediatricians have changed your decision
20 to co-author a publication with Michelle Cretella?

21 A I agreed to co-author based on the topic at
22 hand and not anybody else's CV. So the answer would
23 be I don't see how it would.

24 Q And same for the exhibit that we marked as
25 Exhibit 14, the policy statement on homosexual

1 parenting.

2 If you had been aware of that policy
3 statement, would it have changed your decision to
4 co-author a publication with Michelle Cretella?

5 A Well, once again, it's speculative. I
6 don't know exactly what it says, but I was -- I was
7 part of the -- the effort on the other paper simply
8 on the basis of that paper alone.

9 Q We also talked about a number of your
10 publications appearing in The Linacre Quarterly, and
11 that that is the official journal of the Catholic
12 Medical Association; is that right?

13 A Yes.

14 Q Are you aware of -- actually, I'm just
15 going to open -- one second. So I'm going to show
16 you a document.

17 (Document is displayed).

18 (Whereupon, Exhibit Number 16 was marked for
19 identification purposes and made a part of the
20 record.)

21 Q (By Ms. Dunn) So this is a cover page of
22 Resolutions of the Catholic Medical Association. I
23 will mark this exhibit as Plaintiffs' Exhibit 16.

24 Have you ever seen this -- these -- this is
25 a printoff of a web page. So have you ever seen this

1 web page of the Catholic Medical Association?

2 A I don't think so.

3 Q So the website states that, "The following
4 are resolutions accepted as positions at the Catholic
5 Medical Association."

6 And we're going to jump to the resolutions
7 that are listed in the topic of "Family and Sexual
8 Education." Specifically I'm going to look at
9 Resolution 8-12, which is a resolution on transgender
10 treatments.

11 Resolution 8-12 reads that, "The Catholic
12 Medical Association does not support the use of any
13 hormones, hormone-blocking agents, or surgery in all
14 human persons for the treatment of gender dysphoria."

15 Were you aware of this resolution of the
16 Catholic Medical Association?

17 A No. As I've mentioned, I'm not a member of
18 the Catholic Medical Association.

19 Q And if you --

20 A I wasn't aware of this.

21 Q You weren't aware of this?

22 A No.

23 Q If you had been aware of this, would it
24 have changed your decision to publish in the Catholic
25 Medical Association's official journal?

1 A Well, I -- I imagine that I would probably
2 be pleased if anybody agrees with me.

3 Q So are your beliefs aligned with this
4 resolution?

5 A I don't know because I haven't seen the
6 full text of it. I just see a title there.

7 Q So this is the full text of the resolution.
8 The title is "8-12: Resolution on Transgender
9 Treatments." And then it says "Be it resolved."

10 A Well, then, that does sound reasonable.

11 Q Okay. And then if we move down to
12 Resolution 8-13, which is the "Resolution on Gender
13 Dysphoria," it reads, "Be it resolved that the
14 Catholic Medical Association and its members reject
15 all policies that condition all persons with gender
16 dysphoria to accept as normal a life of chemical and
17 surgical impersonation of the opposite sex. Further,
18 that the use of puberty-blocking hormones and
19 cross-sex hormones and surgical reassignment surgery
20 be rejected."

21 Were you aware of this resolution of the
22 Catholic Medical Association?

23 A No. Like I said, I've never seen this page
24 before and I don't know if any of these were ever
25 adopted.

1 Q These are on the website of the Catholic
2 Medical Association as adopted resolutions.

3 A Okay.

4 Q I'll represent that to you. And so if you
5 had been aware of this resolution, would it have
6 impacted your decision to publish in The Linacre
7 Quarterly, the Catholic Medical Association's
8 official publication?

9 A No.

10 Q And are your beliefs around the treatment
11 of gender dysphoria aligned with this
12 Resolution 8-13?

13 A I would not have used this language, but I
14 don't have severe disagreements with it.

15 Q Okay. At this point we're going to turn
16 back to what has been marked as Plaintiffs'
17 Exhibit 1. And that is your report, which is not on
18 my screen anymore, so I'm going to have to stop that
19 share again.

20 (Document is displayed).

21 This, we already identified, as the expert
22 declaration that was provided, written by you and
23 provided to plaintiffs by the defendants in the
24 lawsuit that brings us here today, Dekker versus
25 Weida.

1 You stated that you yourself drafted this
2 report fully and completely?

3 A Yes.

4 Q And does this report comprise the totality
5 of your opinions around the provision of
6 gender-affirming care medical treatments?

7 A Well, when you say "totality," that would
8 mean like I have no other thoughts or opinions, so
9 that's probably not the best way to characterize it,
10 but it certainly is my opinion.

11 Q Okay. So here you state that you "Have not
12 testified as an expert in the past five years at any
13 court hearing, trial or deposition."

14 So when we talked about the depositions
15 that you participated in earlier in our conversation
16 today, those all predated the last five years?

17 A That's right.

18 Q So you -- and we've talked a little bit
19 about your position as the founding director of the
20 Oklahoma Bioethics Center, which you reference here.

21 Does that organization still currently
22 exist?

23 A I am not quite sure of its status. I think
24 someone took it over from me and someone else took it
25 over from him, and I don't know what involvement

1 she's having currently.

2 I know that there is still some bioethics
3 education going on through the university, but I
4 don't know if it's under the umbrella of the
5 Bioethics Center or not.

6 Q In Paragraph 8 you mentioned that you "Have
7 chaired the IRB, the Institutional Ethics Research
8 Board, for 17 years at SFH."

9 What is "SFH"?

10 A That was one of the teaching hospitals.
11 Saint Francis Hospital.

12 Q So "SFH" stands for Saint Francis Hospital?

13 A Correct.

14 Q And are you currently the chair of IRB and
15 Saint Francis Hospital in Tulsa, Oklahoma?

16 A No.

17 Q So the way this is phrased it always seems
18 present tense. When did you stop being the chair of
19 the Institutional Research Ethics Board at SFH?

20 A Oh, when I left Tulsa.

21 Q And when was that?

22 A Or Georgetown.

23 Q So in 2012?

24 A Right.

25 Q Okay.

1 A So it was in the -- 17 years before that
2 or -- yeah.

3 Q So scrolling down to Paragraph 10, you
4 state that you "Have studied and consulted on issues
5 surrounding transgender patients, both minors and
6 adults, locally and nationally."

7 We just -- we discussed your background and
8 your CV extensively and you weren't able to identify
9 presentations, and other than one article,
10 publications surrounding issues on transgender
11 patients; isn't that right?

12 A No, I've not been writing about it but I've
13 discussed it with people locally and nationally.

14 Q And in what context have you discussed it
15 with people?

16 A Well, I'm not quite sure -- what context?

17 Q Well, in what -- who were you discussing
18 these issues with?

19 A Oh, various colleagues.

20 Q Can you name those --

21 A Other bioethicists.

22 Q So let's start with nationally. Who
23 nationally were you speaking about on issues
24 surrounding transgender patients?

25 A I would be speaking to bioethicists, you

1 know, informally, not -- not for meetings or
2 publication.

3 Q Can you name any of the bioethicists that
4 you had these conversations with?

5 A I'm sure I can. I'm not sure if they want
6 to be involved or not, so I'd want to clear it with
7 them first.

8 Q Were these informal conversations that were
9 occurring at meetings of some sort?

10 A Oh, boy, there hasn't been a meeting in,
11 like, three years where people had the opportunity
12 for informal conversation. So, no, these would be
13 either locally or over the phone or Zoom or
14 something.

15 Q So how many Zoom conversations would you
16 say you've had with other national bioethicists on
17 transgender issues in patients?

18 A I mean, the purpose of the -- well, no,
19 that's not true. I was going to say the purpose
20 wasn't specifically to talk about transgender issues,
21 but you'd be talking about bioethical issues in
22 general. But, no, we've had a couple conversations,
23 either by phone or Zoom, maybe half a dozen times
24 where the primary topic probably was transgender
25 issues.

1 Q Now, you say "half a dozen." That means
2 six -- like around six?

3 A Around that, yeah.

4 Q And --

5 A I mean, I don't keep track of them, so I'm
6 just guessing at this point.

7 Q What time period were these conversations
8 occurring?

9 A These would have been in the recent past
10 because not many, many people were having these
11 discussions over ten years ago.

12 Q So in the last ten years you would say
13 you've had approximately six conversations by Zoom or
14 by phone with other bioethicists around --

15 A Well, no. I mean, that's -- that's --
16 that's a little narrow. I know I've had a lot more
17 conversations than that. You know, you asked me
18 about by Zoom, so that would probably be no more than
19 half a dozen, I suspect. By phone, more than that
20 certainly, and even in person. So, I'm sorry, I
21 didn't keep a tally. People call me, ask me my
22 opinion, or if we're in a discussion and they ask me
23 what do I think about such and such, then I'll tell
24 them.

25 Q What you're referencing is kind of informal

1 consultations of your opinion on these things?

2 A Absolutely.

3 Q So I think I'll just say, going back to the
4 ground rules we started with, I may be -- and this
5 may be partially my fault -- occasionally maybe
6 asking you a question too quickly and cutting you
7 off. And so I just want to remind both of us to try
8 not to interrupt each other and -- you know, if you
9 try not to interrupt me with my question, I'll try
10 not to interrupt your answer. I'll pause before I
11 jump in with my -- with additional questions.

12 So this sentence says, "I've studied or
13 been consulted on." So it seems like what we were
14 just talking about was "been consulted on."

15 So what instances -- I guess, can you
16 provide some context for this statement that you
17 "have studied issues surrounding transgender patients
18 locally and nationally"?

19 A Oh, yes. Yes, I've been reading up on the
20 available literature and journals and other places,
21 even in the popular press and in blogs and such.

22 Q So when you say "studied," you just mean
23 reading up on the medical literature?

24 A Reading up on medical literature is
25 studying, you betcha.

1 Q Sure. And I guess I'm wondering, like, how
2 are you -- so in what way are you identifying the
3 sources that you're studying?

4 A How do I --

5 Q How are they coming to your attention?

6 A Oh, well, through -- they're published
7 journals, both online and paper.

8 Q Can you name any studies that have had
9 significance with regard to your position -- or, I'm
10 sorry, let me strike that and start again.

11 Can you name any specific studies that have
12 been meaningful in your position on issues
13 surrounding transgender patients?

14 A Not so easily that there would be any study
15 or a couple of studies that would be meaningful. I
16 take little bits from everything I read and form my
17 own opinions.

18 Q What specific issues have you studied
19 surrounding transgender adult patients?

20 A Okay. I'm having a little trouble --

21 Q Hearing me?

22 A No, I heard you, I just didn't understand
23 you completely I'm afraid. What do you mean, "what
24 issues"?

25 Q Well, you -- I'm just asking what you mean

1 by your terminology. So you say that you "have
2 studied issues surrounding transgender patients."
3 Specifically, what issues related to transgender
4 patients have you studied?

5 A Well, I think that the things that I have
6 read about and been concerned about exactly parallel
7 those that you see in the younger patients, as well,
8 in terms of the concept, the diagnosis and the
9 treatment and the results.

10 Q So can you estimate how many times you've
11 been consulted on issues specific to transgender
12 patients?

13 A No. I mean, these are not formal
14 consultations, these are discussions.

15 Q I'm sorry. So going back to your role
16 providing ethical consultations, either -- I guess at
17 Georgetown would have been primarily the period of
18 time we're talking about. Can you estimate how many
19 of those ethical consults would have related to
20 transgender patients?

21 A None of the hospital consults related to
22 transgender patients as transgender patients.

23 Q So you've not given an ethical consult with
24 regard to patient care for a patient that was
25 transgender?

1 A Not for an individual patient, no.

2 Q And that extends to both children and
3 adults?

4 A Correct.

5 Q Moving on to Paragraph 11 where you say,
6 "For ethical as well as medical reasons, I have never
7 prescribed medications nor referred for surgery any
8 patients that consider themselves transgender."

9 These medical reasons you reference --
10 going back to your specialty, you're a pediatric
11 gastroenterologist. We've established that. That's
12 right, right? Is that right?

13 A Yes.

14 Q Did any of your pediatric gastroenterology
15 patients identify as transgender, to your knowledge?

16 A No --

17 Q To your knowledge --

18 A -- not to my knowledge.

19 Q Oh, I'm sorry, I cut you off again. I
20 apologize.

21 What were you saying?

22 A I just said "not to my knowledge."

23 Q To your knowledge, have any of your
24 pediatric gastroenterology patients been diagnosed
25 with gender dysphoria?

1 A Not to my knowledge.

2 Q Have you ever prescribed a medication to a
3 patient in your role as a bioethicist?

4 A That's not the role of a bioethicist.

5 Q Okay. I just wanted to confirm that.
6 Do bioethicists treat medical conditions
7 with surgical referrals?

8 A That's not the role of the bioethicist.

9 Q Okay. When you -- so turning back to
10 Paragraph 11, when you refer to ethical reasons that
11 you don't prescribe medications, is that because your
12 activities as a bioethicist are informed by your
13 Catholic faith?

14 A No, it's because I think that it's
15 unethical.

16 Q Do you think that it's unethical because
17 it's not consistent with the ERDs that we talked
18 about as Plaintiffs' Exhibit 4?

19 A No, I think it's unethical on the face of
20 it. I don't think you have to be Catholic, Muslim,
21 Jewish, or none of the above to come to the same
22 conclusions.

23 Q In Paragraph 12 you say that, "None of your
24 opinions are biased by professional income."

25 The entirety of your career in medicine

1 didn't involve patients who present to you for a
2 gender dysphoria diagnosis; is that right?

3 A That's correct.

4 Q And none of your writings, presentations,
5 or positions dealt with issues affecting trans
6 people; is that right?

7 A Not entirely right, but mostly right.

8 Q And when you say "not entirely," are you
9 referencing the one article we looked at before?

10 A No, I'm saying I'm very careful about
11 absolutes.

12 Q Understood.

13 In Paragraph 14 you reference your review
14 of the literature. Have you reviewed all of the
15 literature pertaining to gender dysphoria?

16 A No one has reviewed all the literature
17 pertaining to practically anything, including gender
18 dysphoria.

19 Q Is the literature you've reviewed limited
20 to -- or, I suppose, is the bibliography you provided
21 a fair representation of the literature you've
22 reviewed in preparing this expert report?

23 A It would have to be a representation, sure.
24 Provided, it's -- I consider it fair, but it's not,
25 you know, complete. There are many things that I

1 would look at that I didn't consider important enough
2 to include in the bibliography, including the things
3 that I look at and think, "Well, that's wrong, but
4 it's good to know that that's how they feel."

5 Q So are there other sources that you
6 considered in preparing this expert report?

7 A Sure. Many.

8 Q And are you able to list those sources?

9 A No.

10 Q And why not?

11 A Too many. There's just too many. And some
12 of them I read in their entirety, and some of them I
13 didn't, and some of them are just off of things like
14 the CDC site, a WPATH site, and some of them aren't.
15 It's just -- it's a whole gemish. Anybody who just
16 reads an article and considers themselves an expert
17 isn't working hard enough.

18 Q So when you prepare an expert report for
19 submission in a case like this, we are entitled to
20 know what your sources for your expert opinion are.

21 So, you know, I -- I -- I think we either
22 need to understand that that bibliography is the list
23 of sources you relied on exhaustive, or we're
24 entitled to know what additional sources you
25 considered and relied upon in writing this report.

1 Are you able to provide that list?

2 A I could probably -- no, I couldn't, really.
3 I -- there's just -- there's too many things that I
4 look at and read on a relatively frequent, if not
5 constant, basis. And some of them I thought were
6 pertinent and some of them not so pertinent. I
7 thought the pertinent ones would be in the
8 bibliography.

9 But I would be hesitant, like you saw when
10 we were looking at other articles, to say that you
11 have an exhaustive bibliography for any article.
12 There's always more that could be added, but there
13 are some practical limitations.

14 Q If a source is not listed in your
15 bibliography, would that mean that you did not
16 consider it pertinent to your report?

17 A No, I didn't say it wouldn't be pertinent
18 but it may not be something I felt needed to be
19 included.

20 As a for instance, all the regulations that
21 govern human -- research with human subjects. Well,
22 there's huge tomes that include all that. I don't
23 think that that necessarily needs to be included in
24 the brief bibliography that I submitted. You know,
25 all the various statements from medical associations

1 about this one way or the other may have been things
2 that I have read, but I don't see that they added
3 much to my bibliography so I didn't include them.

4 I see something several times a week on
5 this subject and I look at it and I read it and I see
6 if it adds any new information or, you know, can
7 alter my -- my perspective or sometimes reinforce my
8 opinion, but that doesn't necessarily mean that it
9 belongs in the bibliography.

10 Q To be clear, for your work as an expert you
11 wrote a report, which is being submitted to a court
12 of law.

13 Do you understand that?

14 A Yes.

15 Q This report is comprised of your opinions
16 that are being presented to a judge as evidence in a
17 court case.

18 Do you understand that?

19 A Yes.

20 Q Okay. And when we ask for the sources upon
21 which you relied, we are provided with a bibliography
22 that has been marked as Plaintiffs' Exhibit 2, which
23 I will pull up, and I believe has approximately seven
24 sources on it.

25 (Document is displayed).

1 So this was the bibliography we were
2 provided. You've already confirmed that; is that
3 correct?

4 A Yes.

5 Q In submitting that report, we -- so the
6 Federal Rules of Civil Procedure require that an
7 expert who provides a written report must disclose
8 the facts or data that are considered by the witness
9 in forming their opinions.

10 So we are entitled to know all facts and
11 data that you relied upon in forming your opinions.
12 And when we asked for that information, we were given
13 this bibliography.

14 Are there additional sources that needed to
15 be added to this bibliography that are facts or data
16 that were considered by you in forming your opinions?

17 A I didn't feel that I needed to add anything
18 else to the bibliography.

19 Q So this bibliography --

20 MR. BEATO: Chelsea -- I apologize. You
21 can continue, Chelsea.

22 Q (By Ms. Dunn) So this bibliography is a
23 complete document of the facts and data considered by
24 you in forming your opinions in your expert
25 report; is that correct?

1 A Well, I -- those are articles considered by
2 me in forming my report.

3 Those are not the only things that I
4 thought about, nor the only things that I read, nor
5 the only things that have influenced me over the last
6 decade, or over the last year, or over the last few
7 months. You know, there's a lot of things that I
8 have read. I thought these were pertinent to the
9 report.

10 Q Dr. Donovan, I appreciate that these are
11 the most pertinent, but you are required under the
12 Federal Rules of Civil Procedure to provide a report
13 that contains the facts and data that you considered
14 in forming your opinions.

15 A These are facts and data that I considered
16 in forming my opinion. It is not --

17 Q But is it a complete document of those
18 facts and opinions?

19 A Of course not. It can't be because there's
20 no way that I can tell you everything that has
21 affected my thinking.

22 MR. BEATO: So, Dr. Donovan, let me -- let
23 me step in.

24 For the studies that you reference in your
25 bibliography, those are a sufficient and accurate

1 representation of the studies that you relied on when
2 issuing your expert report; is that correct?

3 THE WITNESS: Yes, I believe so.

4 MR. BEATO: And if there are additional
5 studies that you think of that could've -- well,
6 strike that.

7 Okay. So you think it's a sufficient and
8 accurate representation of the studies that you
9 relied on for your expert report, correct?

10 THE WITNESS: I -- yes, with the provisos
11 that I've already said. There are other things that
12 I would consider important, but -- once again, all
13 the CDC documents or -- now, those -- I didn't
14 include those. Did I rely on them? Have they guided
15 my understanding of, for instance, the requirements
16 of appropriate human research? Well, sure.

17 Q (By Ms. Dunn) So setting aside various
18 sources of background knowledge that you brought to
19 this report, when you were writing this report, are
20 these the specific sources you were referencing in
21 writing your report?

22 A I don't know how to answer that any better
23 than I have.

24 MR. BEATO: Then the answer would be "yes."

25 Q (By Ms. Dunn) Are these the only specific

1 sources you referenced in writing your report?

2 A Of course not.

3 MS. DUNN: I'm sorry, we need a short
4 break, please.

5 MR. BEATO: Okay.

6 (Recess taken from 12:44 p.m. to 1:19 p.m.)

7 Q (By Ms. Dunn) So, Dr. Donovan, when we were
8 talking before about the obligations that are
9 associated with submitting an expert report to a
10 federal court, I was referencing a rule which is the
11 Federal Rule of Civil Procedure 26(a) -- I'm going to
12 make sure I get this right -- (a)2(b). And this
13 governs when someone who's been retained as an expert
14 provides a written report to the Court. I'm going to
15 read from that rule.

16 So that rule says: "Unless otherwise
17 stipulated or ordered by the Court, this disclosure
18 must be accompanied by a written report prepared and
19 signed by the witness. If the witness is one
20 retained or specially employed to provide expert
21 testimony in the case or one whose duties as the
22 party's employee regularly involve giving expert
23 testimony.

24 "The report must contain, 1: A complete
25 statement of all opinions the witness will express

1 and the basis and reasons for them.

2 "2: The facts or data considered by the
3 witness informing them.

4 "3: Any exhibits that will be used to
5 summarize or support them.

6 "4: The witness's qualification.

7 "5: A list of all other cases which the
8 witness testified as an expert at trial or by
9 deposition.

10 And, "6: A statement of the compensation
11 to be paid for the study and testimony in this case."

12 Were you instructed that your report was
13 required to contain all of the opinions that you
14 intend to offer in this case?

15 A Yes, I believe I was, but I think perhaps,
16 you know, when we're talking about the opinions that
17 I intend to offer, I don't think that was the
18 conversation you and I were having previously.

19 Q Well, I'm sorry, I'm just starting with the
20 first subsection.

21 A Oh, okay.

22 Q So were you instructed that the report has
23 to contain all of the opinions you intend to offer in
24 this case?

25 A Yes.

1 Q And does your expert report that we've been
2 referencing as Exhibit 1 contain all of the expert
3 opinions you intend to offer in this case?

4 A Yes, I believe so.

5 Q Okay. Were you instructed that your expert
6 report must contain the facts or data considered by
7 you, the witness, in forming those opinions?

8 A Yes.

9 Q Okay. And did you provide all of the facts
10 or data that you considered in forming your opinions,
11 either in the report or in the bibliography that
12 accompanies it?

13 A I would say, yes, in the report or the
14 bibliography.

15 Q Okay. So turning back to your report.
16 Give me a second.

17 MR. BEATO: No problem. No problem
18 whatsoever.

19 Q (By Ms. Dunn) Okay. So back to your
20 declaration. So here you say that you relied on your
21 "years of experience as a physician and medical
22 ethicist and your review of the literature as
23 documented in your report."

24 So we should be able -- your report will
25 demonstrate any literature that you relied upon in

1 forming your opinions; is that correct?

2 MR. BEATO: Dr. Donovan, you're muted.

3 THE WITNESS: It's hard to answer that way.
4 Sorry.

5 Yes, I believe so.

6 Q (By Ms. Dunn) In Paragraph 15 you refer to
7 yourself as an "unbiased observer." And you make
8 comparisons to the fact that it's preferable to have
9 unbiased observers make opinions on the diagnosis of
10 brain death. But those unbiased observers still have
11 to have qualifications in order to render opinions on
12 these issues; is that correct?

13 A Yes.

14 Q And what are your qualifications to render
15 opinions on the provision of gender-affirming care?

16 A Well, they would be, I think, analogous to
17 rendering opinions on the diagnosis of brain death.

18 My perspective is that of an ethicist. I'm
19 not a neurologist or a neurosurgeon or a transplant
20 surgeon, but when you are talking about --
21 particularly in today's topic, you know, whether or
22 not what we are doing constitutes appropriate
23 informed consent and whether or not it is -- or
24 should be considered research versus standard of
25 care, yeah, I've had years of experience in

1 discussing these topics and -- and completely ready
2 and able to render an opinion on it.

3 Q But you've never -- you haven't had any
4 specialized -- well, you haven't been a --
5 participated in presentations or publications around
6 the provision of gender-affirming care specifically?

7 A You mean, if I don't have a large public
8 record on it? It certainly doesn't mean that you
9 haven't been reading up on it, done some research and
10 formed an opinion.

11 Q But you do have a large body of
12 publications and presentations on issues such as
13 physician assisted suicide or brain death; isn't that
14 correct?

15 A Relatively large. Yeah, I've got those
16 things. Those have been issues for many years now.
17 This case, for instance, is certainly less
18 than a year old.

19 Q You reference, in Paragraph 17, a
20 "diagnosis of transgenderism."

21 What is a diagnosis of transgenderism?

22 A Diagnosis of someone who is being
23 transgender or that they believe that they are
24 transgender.

25 Q Where does that diagnosis exist?

1 A Where does the diagnosis what? I'm sorry.

2 Q Exist. Where's that diagnosis provided
3 for? Is that a medical diagnosis?

4 A You mean, who provides the diagnosis? Is
5 that what you're asking me?

6 Q Well, no. Is that a medical diagnosis?

7 A Well, it certainly is supposed to be, yes.

8 Q Where is the criteria for that -- or
9 where's the diagnostic criteria for transgenderism?

10 A Well, the diagnostic criteria for
11 transgender patients is found in both DSM and WPATH.

12 Q And the what?

13 A W-P-A-T-H criteria.

14 Q But that diagnosis is gender dysphoria, not
15 transgenderism; isn't that correct?

16 A Yes. But gender dysphoria only occurs in
17 those who have identified as transgender.

18 Q But transgenderism is not a diagnosis
19 that's reflected in the DSM-5 or in the WPATH
20 standards of care, correct?

21 A Okay.

22 Q Is that correct?

23 A Yes, I believe so.

24 Q You refer here to a person presenting
25 themselves as a -- or a person having a gender

1 identity that's different from the sex assignment at
2 birth as an aberration. Is that fair to say?

3 A I think that's quite fair to say. You
4 know, if you talk about the norm being what is
5 predominant, then that would have to be statistically
6 described as abnorm.

7 Q What is your basis for asserting that a
8 person asserting their gender identity is akin to
9 asserting a delusion that they are a chicken?

10 A Well, I think that if someone came in with
11 something that seemed to define -- defy both the
12 visual evidence and common sense, that you would not
13 necessarily take that at face value.

14 Q Are you a licensed psychiatrist?

15 A No, I'm not a licensed psychiatrist, but I
16 do know the difference between a person and a
17 chicken.

18 Q Have you ever diagnosed any sort of mental
19 health condition?

20 A I'm sure I have because I've had patients
21 who had to be referred.

22 Q You've -- you have been the one to provide
23 the diagnosis of a mental health condition?

24 A Well, when you suspect it, you refer it to
25 someone to care for them, sure.

1 Q But is that providing a diagnosis for the
2 patient or is that referring someone for a diagnosis?

3 A It's a presumptive diagnosis.

4 Q You then state that, "This is the approach
5 now being taken by many psychiatrists and surgeons
6 and endorsed by medical society."

7 Is the approach you're referring to in this
8 sentence the approach of someone saying that they are
9 a woman and someone else immediately clothing them in
10 a dress?

11 A No. I'm saying that the -- the problem is
12 that we are accepting the mis-diagnosis. Or not even
13 a mis-diagnosis, but the mistreatment rather.

14 Q And what is the mistreatment you're
15 referring to here?

16 A In terms of patients with gender dysphoria,
17 I think it's not conceptually sound to say that you
18 are a man or a person in a man's body but you think
19 you're supposed to be in someone else's body or some
20 other body or yourself or alter that body in order to
21 look like that. Those are approaches that just don't
22 really seem to fit with a common sense approach.

23 If we had a patient with anorexia nervosa
24 and she had a dysmorphia and she said, "I am too
25 fat," the last thing that I would recommend we do is

1 to help her body conform to her self-image.

2 Q So you're comparing gender dysphoria to
3 anorexia nervosa?

4 A Well, they're both distortions of bodily
5 image, yes.

6 Q But affirming a patient with anorexia
7 desire to limit their calorie intake could lead to
8 dehydration; is that correct?

9 A And worse.

10 Q And it could lead to starvation or even
11 death?

12 A Yes.

13 Q Yes. And so your position is that it is
14 mistreatment to affirm someone's gender identity if
15 it's not aligned with their sex assigned at birth?

16 A I am saying that we don't have enough
17 information to be certain of the correct approach
18 and, therefore, to embark upon that approach without
19 seeking that information is wrong.

20 Q And what particular types of medical
21 treatment are you referencing?

22 Are you speaking of the administration of
23 cross-sex hormones?

24 A Yes.

25 Q Are you speaking of gender-affirming

1 surgeries?

2 A Yes.

3 Q And are you speaking of the administration
4 of puberty-blocking medications?

5 A Yes.

6 Q And so it is your opinion that affirming
7 someone's gender identity, if it is not aligned with
8 their sex assigned at birth, is mis- -- is medical
9 mistreatment?

10 A I think it is fraught with problems because
11 I think that it is probably applying a treatment that
12 does not match the needs of the patient.

13 Q Earlier you said that you have given
14 presumptive diagnoses for mental health conditions.

15 When you're licensed as a medical doctor --
16 or I guess you're a pediatric endo- -- I'm sorry.

17 Does your license allow you to diagnose
18 mental health conditions?

19 A My license? Yes.

20 Q Okay. So you say that -- so going back to
21 this approach. When you say "this is the approach,"
22 I just want to make sure that we're both talking
23 about the same -- you know, what you are referring to
24 as "this approach."

25 And you're talking about the approach of

1 providing medical care that affirms someone's gender
2 identity when it doesn't match their sex assigned at
3 birth. Is that accurate?

4 A Yes.

5 Q Okay. And you say that "many psychiatrists
6 are taking this approach."

7 What is the basis to say that?

8 A Well, I -- I don't think that that's in
9 contention that many psychiatrists are providing or
10 endorsing gender-affirming care. I didn't
11 specifically give you data on that, but I think that
12 that's pretty widely known.

13 Q You then go on to say that, "Perhaps, as a
14 result the number of individuals who identify as
15 transgender has exploded over the past decade"; is
16 that correct?

17 A It has certainly increased, it has.

18 Q And you said a number of 20 to -- to a
19 factor of 20 to 40; is that right?

20 A That's right, that's what I've read.

21 Q Where did you get that information?

22 A Actually, the CDC had that information in
23 their database.

24 Q So you didn't -- you cited to -- in your
25 bibliography, which I'll quickly turn to -- I stopped

1 sharing. I could have just stayed where I was.

2 (Document is displayed).

3 So you cite to -- here on this first line
4 there's a "CDC Youth Risk Behavior Survey" and then
5 there's a link to the Williams Institute.

6 Is this the data you're using to make that
7 20- to 40-factor assertion?

8 A I believe that's where it came from.

9 Q And so the Williams report that's linked
10 here -- I'll just quickly pull up that source, just
11 so we can look at it together.

12 (Document is displayed).

13 So this is the Williams Institute report
14 that is found at the end of that link.

15 Do you recognize this report?

16 A Not in that form, but I'm sure that must be
17 it.

18 (Whereupon, Exhibit Number 17 was marked for
19 identification purposes and made a part of the
20 record.)

21 Q (By Ms. Dunn) Okay. I'm going to mark this
22 as Exhibit 17.

23 So this study -- I'll zoom in a little
24 bit -- or this report cites to data from the CDC, a
25 couple of different surveys, it looks like, the

1 Behavior Risk Factor Surveillance System, the Youth
2 Risk Behavior Survey, and then some other survey
3 data.

4 Is this the document where you got -- when
5 you reference the CDC, is this the document where you
6 got that information?

7 A I believe so, or links from it.

8 Q Okay. And do you know where in this report
9 it cites a 20- to 40-factor increase?

10 A I'm sorry, I'd have to read the whole thing
11 again to find that.

12 Q So here on this first -- on this first page
13 it says, "Youth ages 13 to 17 comprise a larger share
14 of the transgender-identified population than were
15 previously estimated, currently comprising about
16 18 percent of the transgender-identified population
17 in the U.S. up from 10 percent previously."

18 Is that relevant to how you determined
19 there was a 20- to 40-factor increase?

20 A No, the 20 to 40 is actually what I read in
21 the CDC survey, but I don't see it -- as a matter of
22 fact, I can hardly see what you've got there at all,
23 but that's okay.

24 Q Oh, I'm sorry.

25 A Small print.

1 Q I'm happy to share your screen.

2 So I'll just -- I guess what I'll represent
3 to you is that we could not -- looking at your
4 bibliography, we could not find the 2017 data that
5 you were citing to. So are you saying that you
6 received that information -- that information came
7 directly from the CDC and not from this report?

8 This report is what was linked and we
9 thought that that indicated that that's where it came
10 from.

11 A Well, I -- I believe that that information
12 may be there.

13 That's the executive summary, isn't it?
14 Not the entire report?

15 Q Correct.

16 A Yeah.

17 Q All right. I will stop sharing this
18 document and go back to your bibliography.

19 (Document is displayed).

20 So going back to your report, in
21 Paragraph 19 you state that, "80 percent of young
22 males who present early" -- and I assume that you
23 mean by this present with a gender identity that's
24 different than their sex assigned at birth. Is that
25 what you're referencing?

1 A Yes.

2 Q Okay. So young males presenting early,
3 that "80 percent of those young males would
4 historically revert in their self-perception by the
5 time they had completed puberty."

6 Where did -- what is your evidence of that
7 statement?

8 A Oh, that -- that's been widely published
9 and repeatedly published.

10 Q Can you name the study that that
11 information comes from?

12 A I'm sure I could. It's more than one
13 source, but, yeah.

14 Q Can you name those studies?

15 A Not right now, no.

16 Q Why didn't you cite to this -- the studies
17 that you relied upon in formulating that assertion in
18 this report?

19 A Once again, I had relied upon a large
20 number of things. Not everything that was listed in
21 the bibliography, as I mentioned before.

22 Q But you are aware that it was your
23 obligation to provide the data and resources you
24 relied upon in forming your opinions when you
25 submitted this report?

1 A Well, I understood that I would present my
2 opinion and/or the data in the bibliography. And my
3 opinion has been formed by a much broader reading
4 sources than -- than are involved even in this case.
5 So --

6 Q I understand --

7 A -- my opinion, you know, was not strictly
8 just a matter of -- of opinion on the -- on this
9 particular case. And, in fact, you know, I have read
10 these and somewhere have articles that do demonstrate
11 that. So I thought that that was important.

12 I hadn't really seen anybody contesting
13 that as a fact. Sometimes what people are doing is
14 showing that it may be transition for females, but
15 that -- that is a fact that had been clearly
16 established in the past and I didn't think that that
17 would be very controversial.

18 Q This fact was of significance to your
19 opinion; is that right?

20 I mean, you cited it in your report so it
21 has had some significance to your opinion.

22 A Okay.

23 Q Is that right?

24 A Yeah.

25 Q And you are under an obligation to provide

1 the data and evidence that you are relying upon to
2 come to your opinions. We've discussed that already.

3 Do you understand that?

4 A I -- yes, we've discussed that.

5 Q And you haven't -- you are unable right now
6 to provide the source of evidence on which you relied
7 in making this statement.

8 A Well, you did say that you wouldn't accept
9 anything more at this point. I could, if you want,
10 go back through my files and find that.

11 Q You -- well, so perhaps I should ask it
12 this way. You did not disclose the data or evidence
13 you were relying upon in making this assertion when
14 you submitted your report?

15 MR. BEATO: Counsel, I think we can agree
16 that for this proposition there's not a citation to
17 it and it's not involved in the bibliography. I
18 think we've established that.

19 MS. DUNN: Well, I think the witness needs
20 to say that, though, if you don't mind, Michael.

21 Q (By Ms. Dunn) So you did not disclose the
22 data or evidence you relied upon in making this
23 particular assertion when you submitted your
24 report; is that correct?

25 A I did not. I did not list things in the

1 bibliography that supported every statement that I
2 made.

3 Q Okay. You also say that, "We are now
4 seeing a much larger number of females."

5 What is your source for this assertion?

6 A No one denies that. That data is available
7 as well. And I believe you'll find it in the
8 bibliography. I could go through the articles and
9 bring that out for you, but, you know, I'd have to
10 open up the articles and find them.

11 Q So if we turn to your bibliography, can you
12 tell me in looking at it which of these articles
13 would support that assertion?

14 A Not at this time.

15 Q And you did not specifically provide a
16 citation for that source of -- I'm sorry, for the
17 evidence or data upon which you make this assertion
18 in your report?

19 A I didn't footnote the report itself.

20 Q You then say that, "The two leading
21 explanations for this unexplained phenomenon are
22 greater social acceptance or social contagion."

23 What sources do you rely upon in making
24 that assertion?

25 A Actually, this was suggestions that have

1 been made that I do have listed in there.

2 But I'm -- like I said, the way I write, I
3 read and then I write. But I wasn't asked to
4 footnote these so I didn't. I could find them in
5 the -- in the articles that you have, I'm sure, but
6 it's going to take me some time to pull those out
7 again.

8 Q So these are -- could be described as
9 perhaps hypotheses? Is that what you're suggesting?

10 A Yes. Explanations could be hypotheses.

11 Q But as the literature stands, there's no
12 scientific evidence that links social contagion as a
13 cause of gender dysphoria?

14 A There has been, as you know, a description
15 by Littman and all about the -- about gender
16 dysphoria in young females being almost like a social
17 contagion. And she had documented that. I didn't
18 list that one in there, it's just -- I thought that
19 was a worthwhile and interesting observation.

20 But, once again, it's an unexplained
21 phenomenon with potential explanations. It's not
22 data.

23 Q So just to be clear, are we referencing the
24 Littman report that -- you did list this in your
25 bibliography. Is that what you're referencing right

1 now, the rapid --

2 A Yes.

3 Q -- onset gender dysphoria?

4 A Yes.

5 Q And are you aware that there was a
6 correction issued with regard to this article?

7 A I'm aware that she got a lot of flack about
8 that in a subsequent article as well, yeah. It's --
9 it was not embraced by the community.

10 Q And so you're aware that there was a
11 correction issued by the publication that featured
12 her article?

13 A I had heard about that.

14 Q Have you read it?

15 A Nope.

16 (Document is displayed).

17 Q So what I'm showing you on the screen is
18 the correction to the Littman article that you listed
19 in your bibliography.

20 You have not seen this document before?

21 A I don't recall seeing this.

22 Q You said you don't recall seeing it?

23 A Nope.

24 (Whereupon, Exhibit Number 18 was marked for
25 identification purposes and made a part of the

1 record.)

2 Q (By Ms. Dunn) And we will mark this as
3 Plaintiffs' Exhibit 18.

4 And if you'll look at -- so here it says,
5 "Emphasis that this is a study of parental
6 observations which serves to develop hypotheses."

7 So this specifically says that,
8 "Rapid-onset gender dysphoria is not a formal mental
9 health diagnosis at this time. The report did not
10 collect data from adolescents and young adults or
11 clinicians and, therefore, does not validate the
12 phenomenon."

13 Are you aware that this correction was
14 issued with regard to this hypothesis?

15 A Well, this doesn't actually correct
16 anything that I had just said, though, that you were
17 reading to me because, in fact, I wasn't making a --
18 an argument so much about rapid-onset gender
19 dysphoria, but also pointing out that we are seeing
20 more females currently than in the past when male
21 predominance was the usual or the norm.

22 And then I pointed out that there may be
23 some potential explanations for that. That's all I
24 did.

25 And this still says it's a "study of

1 parental observations and serve to develop
2 hypotheses."

3 Q So this article --

4 A (Inaudible) hypotheses.

5 Q You would agree this article is
6 hypothesis-generating rather than hypothesis testing
7 or validating?

8 A That's all I was using it for.

9 Q Okay. Turning back to your report.
10 (Document is displayed).

11 You say that -- in Paragraph 20 you say
12 that, "There's no biochemical, hormonal,
13 radiological, or genetic basis for confirming a
14 diagnosis of gender dysphoria"; is that correct?

15 A That's correct.

16 Q What is your evidence to make this
17 assertion?

18 A Because there is no evidence. There is --
19 there is no biochemical, hormonal, radiological, or
20 genetic. Nobody has held out that there is. I
21 didn't really think that needed further explication.
22 None of the people treating it say that they have a
23 hormonal or a biochemical or a radiological or a
24 genetic basis that they can point to.

25 Q So you're not aware of any studies that

1 demonstrate that genes or hormones might influence
2 gender identity?

3 A I didn't say that. "Might"? Might is a
4 different thing from diagnosing.

5 (Whereupon, Exhibit Number 19 was marked for
6 identification purposes and made a part of the
7 record.)

8 Q (By Ms. Dunn) So I'm going to share an
9 article titled "Neurobiology of Gender Identity and
10 Sexual Orientation." This was published in the
11 Journal of Neuroendocrinology in 2018.

12 We'll mark this as Plaintiffs' Exhibit 19.

13 Are you familiar with this study,
14 Dr. Donovan?

15 A I am aware of it. I haven't read this
16 article.

17 Q And so you were not aware that this
18 article, on Page 4, states that, quote, "Several
19 extensive reviews by Dick Swaab and coworkers
20 elaborate the current evidence for an array of
21 prenatal factors that influence gender identity,
22 including genes and hormones."

23 A "And evidence of a genetic contribution to
24 transsexuality is very limited." Yeah. I mean,
25 this -- this basically is not diagnostic.

1 Q So my question is whether you were aware of
2 this study when you made your assertion in your
3 report.

4 A This study has nothing to do with what I
5 said. It confirms what I said in that there is no
6 genetic basis that allows us to diagnose it.

7 Are you saying that this is a genetic basis
8 for the diagnosis of gender dysphoria?

9 Q I'm saying that there is evidence in the
10 literature -- that this article notes that there is
11 evidence in the literature that there are prenatal
12 factors that could influence gender identity,
13 including genes and hormones.

14 A There is -- there are suggestions. None of
15 these are proven in humans. These are all hypotheses
16 that I think are worth noting, but none of these are
17 used to diagnose a child or an adult with gender
18 dysphoria or as transgender.

19 Q But my point is that you had not read this
20 study when you made your assertion in your report
21 because you -- you told me when I opened this study
22 that you had not read it; is that correct?

23 MR. BEATO: Object to form.

24 Dr. Donovan, you can answer the question.

25 THE WITNESS: I was aware of the study. I

1 had not read it. I didn't think it was particularly
2 worth a great deal of time when they were unable to
3 use their findings to form a diagnosis on individual
4 patients, which was really what I was pointing to.

5 Q (By Ms. Dunn) Give me just one quick
6 second. Not a break.

7 So, I guess, going back to the report --
8 and I'll just close this other exhibit to hopefully
9 get there.

10 (Document is displayed).

11 When you say -- or when you take issue with
12 the fact that self-report -- that there's no way to
13 confirm a diagnosis other than self-report, are you
14 suggesting that medical conditions that rely on
15 self-support -- I'm sorry, that rely on self-report
16 of symptoms are invalid? I mean, there are other
17 conditions that rely on self-report.

18 A No, I didn't say that. And the term I
19 used, by the way, was self-perception rather than
20 just self-report --

21 Q And what's --

22 A -- because symptoms can be reported.

23 No, I said "self-perception." And all I
24 would say with that is if that's all we have to go
25 on, we should proceed cautiously.

1 Q Is there a difference between
2 self-perception and self-report?

3 A Well, first you have to perceive in order
4 to report.

5 Q You wouldn't agree that just because a
6 diagnosis is based on self-report that it should go
7 untreated?

8 A I'm sorry, please restate that so I'm
9 clear.

10 Q So the mere fact that a diagnosis is based
11 on self-report doesn't mean that the condition should
12 go untreated?

13 A No, it shouldn't go untreated if there is a
14 condition that a patient is reporting. It should be
15 confirmed and the treatment should be conformed
16 appropriately.

17 Q And that sort of confirmation is done by a
18 clinician, according to diagnostic criteria; is that
19 right?

20 A To the extent that you say it, yes.

21 Q So even in the case of patients with gender
22 dysphoria, a clinician is confirming that diagnosis.

23 A Insofar as it can be confirmed, yes.

24 Q But you're not suggesting that there must
25 be a biochemical, hormonal, radiological, or genetic

1 test to confirm every diagnosis?

2 A I don't think there's anyone who is trying
3 to make that diagnosis who would not welcome some
4 sort of confirmatory evidence. And that's what I'm
5 saying. And we don't have that.

6 Q In Paragraph 22 you talk about a "treatment
7 approach that is to provide puberty blockers for
8 young prepubertal patients followed by cross-sex
9 hormones followed by various levels of surgical
10 reconstruction."

11 Are you aware that puberty blockers block
12 puberty?

13 A Well, of course.

14 Q So in what context would a puberty blocker
15 be given to a patient who is prepubertal?

16 A You can only block puberty if it hasn't
17 occurred. So puberty blockers are for those who have
18 not gone through puberty completely. They're not
19 given after Tanner Stage 2.

20 Q But a patient receiving puberty blockers
21 would be at Tanner Stage 2, so they would be
22 beginning to move through the process of going
23 through puberty?

24 A That's what they're supposed to block with
25 those medications.

1 Q And just to confirm this, your clinical
2 practice was not in endocrinology; is that correct?

3 A I was a pediatrician. All my patients were
4 supposed to go through puberty eventually.

5 Q Understood. But your clinical practice was
6 not in endocrinology --

7 A No.

8 Q -- is that correct?

9 A No.

10 Q And what evidence do you have to support
11 your contention that any youth who receives puberty
12 blockers goes on to cross-sex hormones?

13 A It's by far the norm.

14 Q What evidence do you have to support that
15 assertion?

16 A It has been reported repeatedly, including
17 by the people who are using the puberty blockers and
18 cross-sex hormones. It's not in contention.

19 Q But what evidence are you relying on to
20 make this statement?

21 A It's -- that's the multiplicity of sources.

22 Q Is there one source in your bibliography
23 that you can point us to?

24 A I'm sure I can find that as well, yes.

25 Q If I were to show you your bibliography

1 right now --

2 A If I were to read the articles again. I
3 don't even highlight them, typically, but I could
4 find it for you.

5 Q But if I were to show you your bibliography
6 today, you would not be able to identify to me which
7 source contains the support for this assertion?

8 A I suspect it's in more than one.

9 Q But if I provided you with your
10 bibliography today, you would not be able to point me
11 to the -- any one of the specific sources that
12 contain the information to support this assertion?

13 A Given enough time, I would.

14 MR. BEATO: Object to the form.

15 You can repeat that, Dr. Donovan.

16 THE WITNESS: Say what?

17 MR. BEATO: Could you repeat your answer?

18 I made an objection, but could you repeat your
19 answer?

20 THE WITNESS: I don't even remember the
21 last answer. I'm sorry.

22 Q (By Ms. Dunn) Can you point me to which of
23 these sources you rely on in making this assertion?

24 A I'm sure I could, given enough time.

25 Q Can you do it right now?

1 A Nope.

2 Q And then what evidence do you have to
3 support the contention that any person who receives
4 hormones goes on to have a surgery of some sort?

5 A I didn't say that.

6 Q Well, you summarized the treatment approach
7 as being -- as moving from one of these types of
8 treatment to the next.

9 A That's true.

10 Q And do you have any evidence to support the
11 contention that a person who receives hormones then
12 goes on to surgery?

13 A That is the sequence. That's not
14 contentious. That's what WPATH -- I didn't say
15 everyone did, I just said that's the sequence.

16 Q So you say that treatment -- here you say,
17 "Treatment is determined by the patient."

18 What does that mean?

19 A I mean you can't have surgery unless the
20 patient wills it.

21 Q But you also can't have surgery unless a
22 clinician supports it; isn't that correct?

23 A Well, that's true, but that really isn't in
24 contention here.

25 Q Well, this is -- you've framed in your

1 report that this is self-determined. And I -- I just
2 want to be clear, you're not -- your opinion, you're
3 not stating that this is something that happens
4 without clinician approval, correct?

5 A I didn't say it would happen without
6 clinician approval. Patients should not
7 self-castrate.

8 Q In Paragraph 23 you say that, "The studies
9 that support this approach have come under increased
10 scrutiny, with international scientific and clinical
11 bodies expressing concerns about the safety,
12 efficacy, and scientific basis for the current
13 interventions."

14 What international scientific bodies are
15 you referring to?

16 A Those in Finland, Sweden, England,
17 Australia, and New Zealand.

18 Q And what sources are you relying on in
19 making that statement?

20 A Well, the -- and these are published
21 sources as well.

22 Q Are they in your bibliography?

23 A They are in a bibliography. I think that
24 they're in the one that we have for this as well.

25 Q I'm sorry, I don't understand that.

1 Are they in the bibliography that was
2 provided with your expert report -- or after your
3 expert report?

4 A Yes. Certainly the Abbruzzese one mentions
5 that. I'm trying to think which others may have done
6 that.

7 The Levine report may have, as well, and I
8 think I could find it in the Clayton report, too, but
9 I'd have to look.

10 Q Do you have any sources directly from these
11 international scientific bodies, or you're relying on
12 these -- these articles that you've referenced in
13 your bibliography?

14 A No, they've published them.

15 Q I'm sorry, who's published them?

16 A No, no, the various medical associations in
17 those countries have published their concerns. This
18 isn't just from the articles itself.

19 Q And did you rely on those sources when you
20 made this statement in your report?

21 A I also read those, yes.

22 Q And did you cite them in your bibliography
23 to your report?

24 A Once again, I didn't cite everything that I
25 read.

1 Q So you said that you think that this was
2 mentioned in the Abbruzzese article?

3 A I believe it was, yes.

4 Q So I'm just -- I'm going to pull up this
5 article for you -- for us. And this is the
6 Abbruzzese article that's listed in your
7 bibliography. Abbruzzese, Levine and Mason are the
8 authors?

9 A Yes.

10 (Document is displayed).

11 Q I can -- is this --

12 A Oh, no, this isn't the one. They had -- it
13 was an evaluation of the original Dutch studies
14 involved, so it wouldn't be in there.

15 Q So this is the Abbruzzese article that is
16 cited in your bibliography, so when you reference
17 "Abbruzzese" in identifying a source where you would
18 have received this information about the
19 international bodies, you're not speaking of this
20 article called "The Myth of Reliable Research in
21 Pediatric Gender Medicine"?

22 A That's correct.

23 Q You're thinking of an article that's not
24 listed in your bibliography?

25 A I can't say that.

1 (Whereupon, Exhibit Number 20 was marked for
2 identification purposes and made a part of the
3 record.)

4 Q (By Ms. Dunn) Well, there's no other
5 Abbruzzese article -- sorry.

6 Before I move on to there, I'd like to mark
7 this as Plaintiffs' Exhibit 20.

8 So going back to your bibliography, there's
9 no other Abbruzzese article that's listed here.

10 A Then we must assume that it was not the
11 Abbruzzese article.

12 Q Okay. So you can't identify which of the
13 source -- you said it might be in either the Levine
14 or Clayton articles?

15 A I --

16 MR. BEATO: Object to form.

17 Dr. Donovan, you can answer that.

18 THE WITNESS: I believe so. Once again,
19 this was not a controversial statement, so I didn't
20 make a point of highlighting the reference for it.

21 Q (By Ms. Dunn) So did you just -- you
22 decided not to reference anything that you found to
23 be non-controversial?

24 A I didn't say that.

25 Q Just going back to the Abbruzzese study

1 that you did cite, in what way did you rely on this
2 study in your report, do you recall? Or this -- I'm
3 sorry, this article.

4 A Well, they were critiquing the original
5 Dutch studies that talked about the diagnosis and --
6 and, therefore, the treatment protocols for gender
7 dysphoria, only it wasn't called "gender dysphoria"
8 at the time. It was also called the "gender-identity
9 disorder," I think, at that time.

10 And it turns out the literature itself was
11 so poorly done that it shouldn't have served for
12 the -- for the development of the widespread
13 treatment protocol for this condition.

14 Q Are you aware that one of the authors of
15 this article is affiliated with the Society for
16 Evidence-Based Gender Medicine?

17 A Well, it says that there.

18 Q Yeah. Are you familiar with the Society
19 for Evidence-Based Gender Medicine?

20 A Not particularly, no. I've heard of it.

21 Q What do you know about it?

22 A That they have real problems with -- with
23 the diagnosis and treatment of gender identity
24 disorder.

25 Q Are you a member?

1 A No.

2 Q Have you done any work for Society for
3 Evidence-Based Gender Medicine?

4 A No.

5 Q Do you know how they're funded?

6 A No.

7 Q In Paragraph 23 -- I'm sorry, I'll re-share
8 your report so that we can be specific.

9 (Document is displayed).

10 In Paragraph 23 you say that, "Three
11 European countries have begun to form more
12 conservative and cautious treatment guidelines."

13 What countries are these?

14 A Well, Great Britain, you know, the
15 Tavistock Clinic was closed and they re-did their
16 approach.

17 And Finland has said that they are
18 concerned about their own approach.

19 And so is Sweden.

20 I believe France has already done that, as
21 well, too, but I haven't read up on that.

22 Q Did any of these countries ban this sort of
23 medical treatment?

24 A To my knowledge, nobody has yet banned that
25 approach.

1 Q And when you say that they --

2 A But have they expressed concerns? Yes.

3 And re-evaluated, yes.

4 Q What evidence do you have that these
5 countries have formed more conservative and cautious
6 treatment guidelines?

7 A Well, the Brits themselves said that
8 they -- they closed Tavistock in order to actually
9 slow down their enthusiasm for gender affirmation and
10 to spread it around to other clinics and hospitals in
11 Great Britain who would take a more cautious
12 approach.

13 Q What is your source for that?

14 A There's a report in the British literature.

15 Q Is that report cited in your bibliography?

16 A It's not.

17 Q And in England, the care is still being
18 provided, just by local clinics instead of
19 centralized clinic; is that right?

20 A Yes, that's my understanding.

21 Q In Paragraph 24 you assert that, "Initial
22 psychological evaluations of the patient have often
23 become minimal or almost non-existent."

24 What is your evidence for this assertion?

25 A The next line does point out what has been

1 reported. I thought that was also in the
2 bibliography.

3 Planned Parenthood clinics have been
4 reported by those going to them that they will give a
5 prescription after a single visit, sometimes within
6 the same day.

7 Q You're saying that that comes from patient
8 reports?

9 A Uh-huh.

10 Q So the only source that we are given
11 related to Planned Parenthoods from your -- I'm
12 sorry, when we were provided with your sources, was a
13 printoff of the Planned Parenthood of Texas.

14 Is that what you're referencing?

15 A I'm sorry, I'm not sure what you're
16 referring to.

17 Q Okay. I'll pull it up.

18 (Document is displayed).

19 So this was provided to us when we asked
20 for sources upon which you relied. And this was
21 actually provided in response to your GAPMS report.

22 But is this what you were referencing when
23 you say that hormones are provided after a single
24 visit?

25 A Actually, scroll down. I think that may be

1 one of the places where they -- yeah. Well, I guess,
2 "If you are eligible, Planned Parenthood staff may be
3 able to start hormone therapy as early as the first
4 visit."

5 Yeah, I'd say that was it.

6 Q Yeah, is this the only --

7 A At least one of them.

8 Q Is this the only evidence that you have of
9 that?

10 A No.

11 Q What other evidence do you have of that
12 assertion?

13 A There have been patients who have also
14 described this, and that's been published in the lay
15 literature.

16 Q And what literature is that published in?

17 A Online. I'd have to find it.

18 Q These aren't --

19 A But the fact that Planned Parenthood -- the
20 fact that Planned Parenthood also says the same thing
21 made me think that it was probably accurate.

22 Q Are these your patients that we're talking
23 about?

24 A Of course not.

25 Q They're just anecdotes or reports that --

1 A Patients that have gone to Planned
2 Parenthood and received hormonal treatment on the
3 first day.

4 Q And these are things that you've read
5 online?

6 A Yep.

7 Q Have you confirmed this information in any
8 way?

9 A I think Planned Parenthood just confirmed
10 it right in front of us.

11 Q Well, this actually says, "If you are
12 eligible, Planned Parenthood may be able to start
13 hormone therapy as early as the first visit."

14 Do you know what it means to be eligible?

15 A The patient said that they went in and said
16 that they wanted it and they got it. That sounds
17 like they were eligible.

18 Q But does it say that there are no
19 psychological exams being provided? This report does
20 not say that, correct?

21 A It would be difficult to follow the
22 guidelines in a single day, seeing as how it's
23 supposed to be over a prolonged period of time to
24 confirm the diagnosis.

25 Q But you have not confirmed that Planned

1 Parenthood is doing -- the patient may have gotten a
2 psychological exam elsewhere and then gone to Planned
3 Parenthood.

4 How -- have you confirmed that that's not
5 what's happening?

6 MR. BEATO: Object to form.

7 Dr. Donovan, you can answer.

8 THE WITNESS: You mean, have I visited the
9 Planned Parenthood office and asked to see the
10 psychological report that didn't exist? No.

11 Q (By Ms. Dunn) And so you're basing this
12 assertion on reports that you've seen online and this
13 statement from this website?

14 A And there are other reports for other
15 locations. It's not just Planned Parenthood who have
16 done this. But, yes, I think if a patient goes to
17 Planned Parenthood, says they didn't bring a
18 psychological report, that they were given their
19 hormones on the first day. One of them said over the
20 phone even. That seems like it's plausible. And
21 nobody has come out to deny it.

22 Q But you haven't confirmed that this is
23 actually the way the care is being provided?

24 A What sort of confirmation are you looking
25 for?

1 Q Well, I guess I'm looking for evidence
2 that's something more than just ambiguous printout of
3 a website and, you know --

4 A And a patient statement?

5 Q -- things you've read online.

6 A I'm sorry. And the patient's statement
7 doesn't count?

8 Q Well, unless you can point -- I think it --
9 without you identifying where online you've seen
10 them, I think it's hard to assign credibility to that
11 sort of statement.

12 And you're not able to identify to us where
13 you read these patient reports?

14 MR. BEATO: Object to form.

15 Dr. Donovan, you can answer the question.

16 THE WITNESS: They could be found.

17 Q (By Ms. Dunn) Did you identify where you
18 read these patient reports in your expert report?

19 A No.

20 Q And did you disclose that in your
21 bibliography?

22 A Actually, I think that was touched on by
23 one or two papers in the bibliography, as well. But,
24 once again, you know, it wasn't the --

25 Q Can you tell us --

1 A -- sole topic of the paper, so I'd have to
2 go through each one.

3 Q Can you identify right now to me which of
4 these articles support that statement that there
5 aren't psychological examinations being provided of
6 patients with gender dysphoria?

7 A Not today.

8 Q Are you aware to do so would be
9 inconsistent with the standard of care prescribed by
10 WPATH?

11 A Absolutely.

12 Q You agree that that would be inconsistent
13 with the standard of care?

14 A Yes.

15 Q And you agree that that would be
16 inconsistent with the standard of care required by
17 the Endocrine Society clinical guidelines?

18 A Yes.

19 Q Do you know of any instances of this
20 happening in the state of Florida?

21 A No.

22 Q Do you know of any instances where someone
23 was prescribed any sort of gender-affirming medical
24 treatment without a psychological evaluation and that
25 was covered by the Florida Agency for Medicaid?

1 A I don't know who's prescribing these in
2 Florida.

3 Q But you're not aware of any instances where
4 someone received a gender-affirming medical treatment
5 without a psychological evaluation and that care was
6 covered by Florida's Medicaid program?

7 A No.

8 MR. BEATO: Counsel, I think we've been
9 going for about an hour. Would you mind if we take a
10 break?

11 MS. DUNN: Absolutely. Let's take a break.

12 (Recess taken from 2:19 pm. to 2:27 p.m.)

13 (Whereupon, Exhibit Number 21 was marked
14 for identification purposes and made a part of the
15 record.)

16 Q (By Ms. Dunn) So before the break we were
17 looking at a PDF of a website of the Texas Planned
18 Parenthood. I did not mark that as an exhibit and so
19 I'd like to have that marked as Plaintiffs'
20 Exhibit 21.

21 All right. So we'll go back to your
22 report, Dr. Donovan. And in Paragraph 25, you
23 reference that, quote, "With further study it has
24 come to light that complications such as arrested
25 maturation, physiological changes, fertility

1 challenges, hematological changes, and osteoporosis
2 can all result from treatment with puberty blockers
3 and may be irreversible."

4 You don't cite any evidence to support this
5 statement in your report, correct?

6 A Within the report or in the bibliography
7 are we saying now?

8 Q Well, so first of all there's no citation
9 here to support this statement; is that correct?

10 A No, I -- like I said, I didn't use
11 footnotes on this.

12 Q And which of the sources in your
13 bibliography provide the evidence to support that
14 assertion?

15 A I think you'll find it in the Levine and I
16 think probably in Robbins as well. Probably in
17 Clayton as well, too, because she was talking about
18 the dangers.

19 Q I'm going to pull up the Clayton article
20 that you reference.

21 A Okay.

22 (Document is displayed).

23 Q Do you recognize this document?

24 A Looks like -- yes.

25 Q And this is the Clayton article that's

1 included in your bibliography?

2 A Yes, looks like it.

3 (Whereupon, Exhibit Number 22 was marked for
4 identification purposes and made a part of the
5 record.)

6 Q (By Ms. Dunn) I'd like to mark this as
7 Plaintiffs' Exhibit 22.

8 This article is a letter to the editor; is
9 that correct?

10 A This looks like, yeah, the one -- the story
11 about Rose. I don't know that they talked as much
12 about the -- in this particular one about the adverse
13 effects. I'd have to look on the next page.

14 (Document is displayed).

15 Okay. It's really hard for me to read this
16 because the print is so small.

17 Oh, that's bigger. That's good. Thanks.

18 Okay. This, I think, concentrates more on
19 the surgical problems than the hormonal problems. Is
20 that right? Slide slowly.

21 Yeah, I think this is one on the -- bring
22 it up a little bit more, if you would, Ms. Dunn.

23 Q Up this way?

24 A The other way, I think. Yeah.

25 Oh, I guess she did talk about hormonal

1 treatments there, but that wasn't really as pointed.

2 Let's go down to the next page. I think
3 that this one was really better for the -- go ahead
4 down.

5 Further down. Thanks.

6 Can you scroll down a little bit? I'm
7 having trouble.

8 Well, she does mention irreversible and
9 long-term adverse effects with the treatments on
10 fertility and sexual function and bone, brain,
11 cardiovascular functioning.

12 So, yeah, she -- this wasn't the highlight
13 of it but she certainly does go into it as well.

14 Q Just to be clear, though she may reference
15 those things, this is a letter to the editor,
16 correct?

17 A Yes.

18 Q And letters to the editor are not
19 peer-reviewed?

20 A No.

21 Q And Ms. Clayton is actually, it appears, a
22 student at the University of Melbourne when she wrote
23 this?

24 A If you say so.

25 Q Well, her email address indicates that

1 she's a student. Do you know otherwise?

2 A No.

3 Q And she --

4 A (Inaudible).

5 Q I'm sorry?

6 A No. I see that now.

7 Q And she is a -- at the School of Historical
8 and Philosophical Studies at the University of
9 Melbourne; is that right?

10 A That's what it says there.

11 Q She's not a medical doctor?

12 A No.

13 Q You also referenced the Robbins article
14 that you cite in your bibliography.

15 A Yeah. Let's look there. I thought that
16 was pretty good, too.

17 Q Is that -- can you read that or should I
18 zoom in more. I'm trying to -- oh, wait, I haven't
19 shared my screen. I apologize.

20 (Document is displayed).

21 Can you read this or should I zoom in more?
22 I'm trying to balance getting --

23 A That's okay. I can see some of that.

24 Q Is this the Robbins article that you were
25 referencing in your bibliography?

1 A I believe so. Looks like it, yes. July
2 '19, yes. Okay.

3 (Whereupon, Exhibit Number 23 was marked for
4 identification purposes and made a part of the
5 record.)

6 Q (By Ms. Dunn) I'd like to mark this as
7 Plaintiffs' Exhibit 23.

8 This is not an article in a peer review
9 research publication, correct?

10 A Neither was the Planned Parenthood thing.
11 I mean, no, I'm just looking for reports. Right.
12 Go ahead.

13 Q So you said that this supported your
14 contention of the harmful effects of puberty blockers
15 that you cite in your report; is that correct?

16 A I'm sorry. Say that again.

17 Q When I asked -- and I'll go back to your
18 report. When I asked what supported your assertion
19 that complications can result from puberty blockers,
20 you said that you believed the Robbins article may
21 provide that information; is that right?

22 A I said that or the Levine. Like I said,
23 I'd have to look, so --

24 Q But I just want to clarify --

25 A -- I'm going to look with you.

1 Q I'm sorry?

2 A Yeah. Yeah. I said I'm perfectly willing
3 to look through these with you.

4 Q Sure. But my question is, this is not an
5 article in a peer-reviewed journal?

6 MR. BEATO: Object to form.

7 Dr. Donovan, you can answer.

8 THE WITNESS: I don't know that this is
9 peer-reviewed.

10 Q (By Ms. Dunn) If we go back to your
11 bibliography, it looks like this is published on a
12 website called thepublicdiscourse.com.

13 A I doubt that's peer-reviewed, then.

14 Q And, in fact, it appears -- and correct me
15 if I'm wrong, but it appears that this article merely
16 summarizes another article; is that correct?

17 A It refers to the Levine article a lot,
18 yeah.

19 Q Okay.

20 A This was not so much to establish the side
21 effects, which had already been reported, but
22 actually to talk about what I thought was interesting
23 which was why informed consent then was difficult,
24 given what we know and mostly what we don't know.

25 Q So, I'm sorry, I don't believe I'd asked a

1 question, so if you can just limit yourself to
2 responding to the questions I ask, I would appreciate
3 it.

4 A I thought I was responding, why we were
5 using something -- why we were using this article.

6 Q That's not what I -- I just asked whether
7 that article was summarizing another article.

8 A Okay.

9 Q So, then, you also stated that it's
10 possible that you were relying on the Levine article,
11 which you cited in your bibliography. And I will
12 pull that up.

13 (Document is displayed).

14 Is this the article you were referencing?

15 A Uh-huh.

16 Q Or you referenced.

17 A Yes.

18 (Whereupon, Exhibit Number 24 was marked for
19 identification purposes and made a part of the
20 record.)

21 Q (By Ms. Dunn) And I'll ask that this be
22 marked as Plaintiffs' Exhibit 24.

23 So do you know where in this article that
24 the complications associated with puberty blockers
25 are discussed?

1 A Let's scroll through it.

2 Q Please tell me if I'm going too fast.

3 A We may have to go back, but keep going.

4 Let's go down further, more so toward
5 the -- keep going.

6 Keep going. Let's go down to see if we
7 can't find a section on the harms as well.

8 Keep going.

9 Q Should I keep going or --

10 A Sure. Sure. Whoa, slow down.

11 Go back a little. Thank you.

12 Okay. Let's go down a little further.

13 Okay. Now, you do see -- I'm sorry, I assumed you
14 saw some of those. No, that was --

15 Q I'm sorry?

16 A Nevermind. It's hard to do it this way.

17 Just keep scrolling down, let's see if we
18 get to the prepubertal part again because he's kind
19 of switching back and forth.

20 Oh, those are the social risks for children
21 being considered for puberty block A, not the
22 physiological risks.

23 I think we've passed it, but keep going
24 down, why don't you.

25 Scroll it. Keep going.

1 No, keep going because you're on the
2 social.

3 No, you're still in the social area. Keep
4 going. I think it's probably above us.

5 Okay. Keep going.

6 Keep going down.

7 Keep going down, please.

8 Oh, go up. Way up where we were talking
9 about the --

10 Q Is this --

11 A Let's go above the --

12 Q -- what you're referencing?

13 A Huh?

14 Q Is this what you're referencing or --

15 A Possibly. Let me -- I think that there was
16 even more than that, so I think he covered it.

17 Okay. Sorry. Let's go back down. Too
18 quick. Too quick. I can't read that fast.

19 Q Sorry, did you not want me to go the whole
20 way down?

21 A Well, no, I wanted to see -- I think it --

22 Okay. Scroll up a little bit.

23 Scroll up a little bit.

24 And up a little bit.

25 Up a little bit.

1 Okay. Up a little bit.

2 Okay. Go on.

3 And I think this is a really good article,
4 but I think it is also focusing more on the informed
5 consent thing than the -- than the puberty-blocking
6 hormone issues.

7 Q So you're not able to identify a place in
8 this article that --

9 A Let's go up a little bit more. Sorry.
10 Let's go --

11 Okay. Not seeing it there.

12 Q Okay. So you're not able to identify where
13 in this article is any evidence to support the
14 assertions you made about complications associated
15 with puberty blockers?

16 A Not in this article.

17 Q Okay. And we looked at the other two
18 articles that you said from your bibliography might
19 contain that information and you weren't able to
20 identify where in those articles?

21 A That's two.

22 Q I'm going to go back to your report.

23 (Document is displayed).

24 So in addition to listing these
25 complications, you say that they may be irreversible.

1 Do you -- can you cite to any evidence for
2 that assertion?

3 A It's a maybe. The problem, of course, is
4 that what we need is evidence-based answers with
5 this. And it's not just that, you know, we're citing
6 the wrong articles today, but for many of these the
7 evidence is pretty thin or non-existent at this
8 point.

9 Q But I'm just asking whether you have
10 evidence cited to support your assertion that these
11 complications may be irreversible?

12 A They may be.

13 Q But you have not provided any --

14 A That doesn't make them --

15 Q I'm sorry. My question is whether you have
16 provided any citation in your report that supports
17 the assertion that these complications may be
18 irreversible?

19 A No, not on this bibliography.

20 Q Okay. So no citations in the report and no
21 sources you can point to on the bibliography; is that
22 correct?

23 A The citations -- none of the citations were
24 in the report. That's (inaudible) footnotes.

25 Q So then in Paragraph 26 you say, "In any

1 medical condition where the cause is unknown, the
2 treatment's uncertain, and the adverse effects of
3 intervention are not fully elucidated, a proposed
4 course of therapy would have to be seen as
5 experimental."

6 So you say "cause unknown."

7 Do causes of medical conditions have to be
8 known in order to treat them?

9 A That's not what it says, but it's certainly
10 helpful. If you know what the cause is, then your
11 treatments can be modeled to the cause more
12 certainly.

13 Q Sure. But does every medical condition
14 have to have an identified cause in order to be
15 treated?

16 A Nope. Advantageous but not necessary.

17 Q Aren't there many medical diagnoses for
18 which a cause is unknown but there is a clearly
19 established treatment protocol?

20 A Yes. I think those are preferable.

21 Q But there are medical diagnoses for which a
22 cause is unknown but there is still a clearly
23 established treatment protocol?

24 A And I said that that would be preferable,
25 yes.

1 Q What does it mean that treatments are
2 uncertain?

3 A It means that we don't really have a good
4 idea of whether or not these are the proper
5 treatments or the proper diagnosis with a proper
6 risk-to-benefit ratio and good outcomes over the
7 long term.

8 Q Is that a scientific phrase that you're
9 using?

10 A Which one?

11 Q That treatment's uncertain.

12 A It's not unscientific.

13 Q You say that, "As a result of this, that
14 the cause is unknown, the treatments are uncertain,
15 and the adverse effects are not fully elucidated,
16 that the treatment must be seen as experimental."

17 Is your definition of whether treatment is
18 experimental guided by the same standards that
19 Florida's Agency for Healthcare Administration uses
20 to determine if a treatment is experimental?

21 A I would imagine they are very close.

22 Q Did you consider evidence-based clinical
23 practice guidelines in determining -- or in coming to
24 your opinion that a treatment is experimental?

25 A If clinical practice guidelines are truly

1 evidence based, then they should be considered. I
2 don't think we have those.

3 Q Do you consider -- do you know what
4 standards the Agency for Healthcare Administration is
5 required by regulation to use in determining that a
6 type of treatment is experimental?

7 A I don't know their regulations.

8 Q So your opinion that this treatment is
9 experimental does not reflect --

10 A Is my --

11 Q So your opinion that it's experimental, it
12 doesn't reflect the agency's standards?

13 A They were asking my opinion, so I gave them
14 my opinion.

15 Q But not based on their standards, based on
16 your own standards?

17 A Yes.

18 Q But you don't offer an opinion about
19 whether gender-affirming medical care is consistent
20 with the standards AHCA uses to determine that
21 treatment is experimental?

22 A Well, I would see their standards and be
23 able to answer that more accurately. I would
24 strongly assume that they use the same sort of care
25 and precision in deciding these things.

1 Q But in formulating the opinions that are
2 contained in this report, you did not -- you had not
3 referenced the standards used by AHCA to determine
4 whether medical care is experimental?

5 A I was using more generalized standards.
6 Widely accepted.

7 Q Does your opinion that the treatments
8 for -- of gender -- I'm sorry -- gender-affirming
9 medical treatments are experimental apply to all
10 medical treatments for gender dysphoria?

11 A Could you rephrase that?

12 Q Yes. So just more clear -- a point --
13 like -- excuse me -- to provide more clarification.

14 This paragraph follows some discussion of
15 puberty blockers.

16 Is your opinion regarding a, quote,
17 "proposed course of therapy as experimental"
18 referencing specifically puberty blockers or is it
19 referencing the other sorts of gender-affirming care
20 we have been discussing today?

21 A I think it should apply to the entire
22 sequence of interventions that we've been discussing.

23 Q So including -- so puberty blockers,
24 cross-sex hormones, and gender-affirming surgeries?

25 A Correct.

1 Q Your report doesn't list any complications
2 attendant to cross-sex hormones; is that right?

3 A It doesn't list them. There were other
4 people actually, as I understood it, listing all the
5 things that you've been asking about, including that.
6 I didn't feel it was necessary to -- to reiterate all
7 that, seeing how what we were really talking about
8 was the ethical implications of informed consent and
9 the --

10 Q Well --

11 A -- and the standards for research versus
12 clinical care.

13 Q So today we're just talking about your
14 report. And so my question is just whether you
15 listed any complications attendant to cross -- the
16 administration of cross-sex hormones.

17 And you did not -- your report does not
18 list such complications; is that right?

19 A That's correct, I believe.

20 Q You also don't offer an opinion about
21 complications related to gender-confirming
22 surgeries; is that correct?

23 A About their complications, I didn't get
24 into that. That's not to say there aren't
25 complications, I just didn't feel the need to iterate

1 them.

2 Q Your report doesn't list those
3 complications?

4 A No need.

5 Q But it does say that those treatments are
6 experimental; is that right?

7 A Yes.

8 Q And you're aware that these types of
9 treatment have all been provided in the clinical
10 context for years and even decades. Are you aware of
11 that?

12 A Of course.

13 Q So gender-confirming surgeries were first
14 performed in the 1930s; is that right?

15 A The first one I knew about was Christine
16 Jorgensen in Sweden.

17 Q Which was in the 1930s; is that correct?

18 A No. I think she was more in the '50s or
19 '60s.

20 Q Cross-sex hormones became available in the
21 1930s as well; isn't that right?

22 A Well, no. The hormones have been
23 available, but -- for this use? Is that what you're
24 talking about?

25 Q Yeah. I'm sorry. Cross-sex hormones were

1 first used for this type of treatment in the 1930s?

2 A These things have been used for a long
3 time. Only recently have they become popular and
4 widely applied.

5 Q Do you think the use of puberty-delaying
6 medications to treat gender dysphoria in adolescents
7 was first referenced in medical literature around 25
8 years ago? Isn't that right?

9 A Sounds right.

10 Q In the next paragraph, Paragraph 27, you're
11 responding to Dr. Karasic's report and you suggest
12 that, "Healthcare providers treating patients for
13 gender dysphoria should include protocols for
14 de-transitioning."

15 Do you have any evidence to support the
16 contention that that is not happening?

17 A I didn't say it wasn't happening. He was
18 concerned about his patient's -- or some patient's
19 de-transitioning.

20 And I said, in that case, you know,
21 protocols to manage that are appropriate.

22 Q But he was referencing the fact that
23 patients were being forced to de-transition by the
24 fact that their medical care would no longer be
25 covered by Florida's Medicaid system, correct?

1 A And I -- I'm assuming that he himself was
2 assuming that's their only source for the ongoing
3 treatment, which I wouldn't know, but he did say
4 that.

5 Q Well, Medicaid is health insurance coverage
6 for individuals who cannot afford to pay for their
7 own healthcare, is it not?

8 A That's true.

9 Q So it's safe to assume that many
10 individuals who have lost coverage for this type of
11 care are unable to access it elsewhere, correct?

12 A There's a fair presumption.

13 Q You reference a, quote, "idea" of a quote,
14 "conveyor belt of treatment."

15 Do you know of any Medicaid patients in
16 Florida that were on a conveyor belt of treatment who
17 were unable to stop receiving gender-affirming
18 treatment if they wanted?

19 A I don't think Dr. Karasic or myself were
20 referring to any individual patients, so, no.

21 Q But you would agree that having to stop
22 receiving gender-affirming medical treatment because
23 you can't afford the treatment is different than
24 voluntarily deciding to stop the treatments, right?

25 A Different in what way?

1 Q Well, it's different for a patient to no
2 longer be able to afford a treatment versus choosing
3 to stop a treatment; is that correct?

4 A Well, there would be differences, but the
5 differences might be financial. The differences
6 probably wouldn't be the effect on the withdrawal
7 from the medications. I think those would probably
8 be about the same.

9 So would there be some differences?
10 Probably.

11 Would there be similarities? Undoubtedly.

12 Q No, I'm sorry, I'm not referencing the
13 impacts of discontinuing that treatment, I'm saying
14 that as a factual matter, it is different for someone
15 to no longer be able to afford a type of medical care
16 than that they choose to stop that medical care.
17 Those are the two different circumstances that should
18 not be treated identically.

19 A Well, those would be the financial impacts
20 that I think you were referring to.

21 Q So when we were talking about the conveyor
22 belt of treatment, I just want to confirm because I
23 think your answer was a little bit ambiguous.

24 You do not know of any patients in Florida
25 who have not been able to stop receiving

1 gender-affirming treatment if they so chose?

2 A My exchange with Dr. Karasic was not about
3 any specific Florida patients, that's correct.

4 Q You're not aware of that actually
5 happening?

6 A No.

7 Q You say that, "To begin treatment of such
8 patients without knowing how to successfully
9 discontinue such treatment, and to not warn patients
10 of this issue in advance, again reflects unfavorably
11 on the issue of informed consent for the treatment of
12 patients identifying as transgender."

13 What basis do you have to believe that
14 patients and clinicians don't know how to continue --
15 discontinue that treatment?

16 A Dr. Karasic was talking about those who
17 would suddenly have to de-transition.

18 I was talking about the need to be able to
19 plan for that.

20 Q But are you --

21 A If you don't plan for that, then what I was
22 saying about it being a medical failure on the
23 practitioner's part would come into play.

24 It is not just a loss of funding, which I'm
25 sure has occurred in other circumstances for

1 patients, but other circumstances as well that might
2 cause them to be forced into de-transition or a
3 decision about that.

4 Q But do you have any knowledge or evidence
5 upon which to suggest that clinicians and patients
6 aren't able to thoughtfully discontinue that
7 treatment?

8 A I'm advocating that they thoughtfully
9 discontinue the treatment.

10 Q And I'm saying, do you have any evidence to
11 believe that's not happening?

12 A I was responding to Dr. Karasic's concern.
13 I wasn't concerned that that wasn't going to happen.

14 Q In your conclusion on Paragraph 28 -- I'm
15 sorry, Paragraph 29 of your conclusion, you compare
16 gender-affirming care to a lobotomy.

17 Are you aware that nearly all lobotomies
18 were performed without informed consent from patients
19 and guardians?

20 MR. BEATO: Object to form.

21 Dr. Donovan, you can answer.

22 THE WITNESS: I wouldn't know how to know
23 that all lobotomies were performed without informed
24 consent. I believe that, in fact, the single case
25 that I did cite was with informed consent.

1 Q (By Ms. Dunn) You cited a case?

2 A Yes, President Kennedy's sister.

3 Q Were you aware that lobotomy was not
4 supported by major medical associations?

5 A Yeah. It was considered innovative surgery
6 at the time for psychiatric problems. It didn't last
7 long enough to seek widespread support from medical
8 association.

9 Q So you cited a single case with regard to
10 the informed consent. Do you have evidence to
11 demonstrate whether or not the care was being
12 provided without informed consent in any other case?

13 A No, no. You're the one who was asking
14 about informed consent for these. I was just
15 pointing out that they did exist and they were a
16 mistake.

17 Q Of course, but you have likened it to
18 gender-affirming care, so I'm just trying to
19 determine whether these -- to your knowledge, these
20 procedures were being done without informed consent.

21 A You are correct that they could not be done
22 with informed consent, seeing as how people had no
23 clear idea of what the long-term consequences would
24 be but proceeded anyway.

25 And to that extent it's very similar to

1 what we're seeing with the treatment for gender
2 dysphoria currently.

3 Q Well, but lobotomies were also not
4 supported by major medical associations at the time.

5 A I don't think the issue in the lobotomy was
6 whether or not there was a major medical association
7 that supported it or not, I think it was actually the
8 procedure itself, and the consequences known or
9 unknown, and the ability to give informed consent for
10 that procedure. That's where you actually find the
11 strongest parallels.

12 Q So just to be clear, the case that you've
13 cited, the sister of President John F. Kennedy, she
14 did not consent to that treatment; is that correct?

15 A I --

16 Q She did not provide informed consent for
17 that treatment?

18 A I don't know.

19 Q When you cited it as --

20 A I don't see how she could.

21 Q -- a case where --

22 A I don't see how she could.

23 Q Okay. But in gender-affirming care
24 situations, there are protocols for informed consent?

25 A A protocol for informed consent is not the

1 same as obtaining informed consent. Only if it's
2 followed, and it has to be followed by providing all
3 the elements of informed consent.

4 Those elements include the capacity to
5 understand what's going on; the absence of coercion
6 in the decision-making process, either positive or
7 negative; the comprehension so that you can
8 understand all the risks, benefits and alternatives
9 that are presented to you.

10 But when those things are not even
11 available, then the possibility of informed consent
12 is reduced or absent.

13 Q What evidence do you have that that isn't
14 happening, that that information is not being
15 provided in this context?

16 A Because the information is not available,
17 according to even the people who are providing it.

18 For instance, Robert Garofalo, who is the
19 chief of adolescent medicine at Lurie Children's
20 Hospital in Chicago, told a podcast interviewer last
21 year that the evidence base remained a challenge.
22 It's a discipline where the evidence base is now
23 being assembled and it's truly lagging behind
24 clinical practice. He said it's -- he thinks it's
25 being done safely.

1 But now I think we're really beginning to
2 do the type of research where we're looking at short,
3 medium, and long-term outcomes of the care that we
4 are providing in a way that I think hopefully will be
5 reassuring to institutions and families and patients,
6 or will also shed a light on the things that we could
7 be doing better.

8 Q Did you cite that podcast in your report?

9 A No, I'm just telling you.

10 Q Did you rely on --

11 A In response to your question. You said,
12 you know, why would I think that.

13 Q Well, saying that there's room for there to
14 be more research and to improve the evidence base for
15 the treatments is different from saying that people
16 are not being fully informed of the risk of which we
17 are aware.

18 MR. BEATO: Object to form.

19 Dr. Donovan, you can answer.

20 THE WITNESS: We first have to be aware of
21 the risks and the benefits. Neither of those are
22 clearly elucidated in the present day.

23 Q (By Ms. Dunn) Well, these treatments have
24 been provided for decades at this point, and so
25 there's some --

1 A Provision --

2 Q -- information --

3 A I'm sorry.

4 Q There is information about the risks. And
5 the standards of care and clinical guidelines that
6 are applicable to this care require that that
7 information be disclosed to the patients and their --
8 and in the case of minors, to the patients and their
9 guardians; isn't that correct?

10 A No, not entirely.

11 Should they be required? Yes.

12 Is it? But the problem is, of course, even
13 when things are done for decades, if they are not
14 well documented, done in an orderly fashion where the
15 risk, benefits, alternatives, and outcomes can be
16 clearly delineated, then, in fact, you can't give
17 informed consent because you don't have the
18 information to give.

19 Q What evidence do you have to suggest that
20 the informed consent process that's being engaged in
21 is not sufficient?

22 A The fact that they can't tell what's going
23 to happen to children and adolescents and young
24 adults ten years from now or 15 years from now or 20
25 years from now because the data is so sloppy the

1 information isn't there.

2 Q What evidence do you have to support that
3 statement?

4 A There is evidence to support that
5 statement. There is evidence from many sources.

6 Q What evidence -- can you please cite to the
7 evidence that you rely upon in making that statement?

8 A I -- I can, but, you know, I -- I turned in
9 a lot of different reports with citations and giving
10 you that answer right today will be difficult, but
11 certainly not impossible if you're willing to receive
12 it.

13 Q Well, I'm asking if you, right now, can
14 cite to me the data and information upon which you
15 are presenting this opinion?

16 MR. BEATO: Object to form. I also think
17 that Dr. Donovan's answers speak for themselves.

18 But, Dr. Donovan, if you want to provide
19 another answer --

20 THE WITNESS: I don't have any other
21 answer. I think I've answered it.

22 Q (By Ms. Dunn) Okay. I think at this point
23 I will stop sharing your expert declaration and we
24 will move on to look at the report you provided in
25 support of Florida's GAPMS process. So let me just

1 pull that up.

2 (Document is displayed).

3 Do you recognize this document,
4 Dr. Donovan?

5 A Yes.

6 Q And what is it?

7 A The title reads: "Florida's Medicaid
8 Project: Treatment for Transgender Children Medical
9 Experimentation Without Informed Consent: An
10 Ethicist's View of Transgender Treatment for
11 Children."

12 Q And this is the report you provided to the
13 Agency of Healthcare Administration in Florida in the
14 course of their process to determine whether or not
15 gender-affirming care was experimental?

16 A Yes.

17 (Whereupon, Exhibit Number 25 was marked for
18 identification purposes and made a part of the
19 record.)

20 Q (By Ms. Dunn) And I'm going to mark this as
21 Plaintiffs' Exhibit 25.

22 How did you become involved in preparing
23 this report?

24 A I was contacted and asked if I would be
25 willing to help.

1 Q And do you recall the names of any of the
2 individuals who you spoke with from the agency in
3 your work with them?

4 A I'm sorry, I don't.

5 Q Did anyone assist you in preparing this
6 report?

7 A No.

8 Q Did you draft the report solely on your
9 own?

10 A Yes.

11 Q Did you consult with anyone in preparing
12 the report?

13 A No, not really.

14 Q Did you consult with anyone not at the
15 agency, any other bioethicist or any other medical
16 professionals?

17 A No.

18 Q Okay. So going into the substance of the
19 report itself. I'm on Page 1 of the report, which is
20 also, in this version of the document, marked as
21 Appendix 237. Just give me one quick second.

22 In the second paragraph here, the second
23 sentence says that, "Currently less than half of
24 state Medicaid programs provide gender-affirming
25 care."

1 Do you see that reference?

2 A Yes.

3 Q And that cites to a Williams Institute
4 report from 2019?

5 A Yes.

6 Q When you say "less than half provide," are
7 you referring just to those states that have
8 affirmatively included coverage for gender-affirming
9 care?

10 A I'm not quite sure what the question means.

11 Q So when you say that "less than half of
12 states cover," does that mean that less than half the
13 states have policies that exclusively provide for
14 coverage?

15 A All that I know is what I read, that less
16 than half the state Medicaid programs provide
17 gender-affirming care.

18 Q So I'm going to pull up the Williams report
19 that you've referenced.

20 Do you recognize this report? Is this what
21 you were relying on? I can scroll down to the
22 executive summary if it helps.

23 Is this the report that you relied on?

24 A It's not on the screen.

25 Q Oh, I'm sorry. Thank you. This is me

1 getting a little tired.

2 (Document is displayed).

3 Is this the Williams report that you
4 referenced?

5 A I don't know. It doesn't look like the way
6 I saw it, but it probably is. Sure.

7 (Whereupon, Exhibit Number 26 was marked for
8 identification purposes and made a part of the
9 record.)

10 Q (By Ms. Dunn) I'll mark this as Plaintiffs'
11 Exhibit 26.

12 So this report actually splits the states
13 into three different categories.

14 One is those states that have affirmative
15 coverage for gender-affirming care. And in that
16 category are 18 states and D.C.

17 Then after listing all those states, it
18 notes that 20 states have no express statute or
19 policy addressing coverage. And so in these states
20 coverage for gender-affirming medical treatments may
21 be covered, but there's not an affirmative coverage
22 policy.

23 And then the last category is the 12 states
24 that have express bans on coverage.

25 Is this the information that you reviewed

1 in making the statement in your report that "less
2 than half the states cover gender-affirming care"?

3 A Yes.

4 Q And would you agree that even fewer than
5 half the states, so closer to 25 percent of states,
6 only 12 states explicitly exclude gender-affirming
7 care. Is that accurate?

8 A That's what it says, 12 have expressed
9 bans, 18 have expressed coverage.

10 Q And the other 20 states may cover
11 gender-affirming care; is that correct?

12 A It's -- the law is silent, it says, so --

13 Q But you don't have any information that one
14 of those states do or do not cover gender-affirming
15 medical treatments?

16 A I'm sorry, you faded out there. Try again.

17 Q I'm sorry. You don't have any information
18 as to whether or not those 20 states in fact do cover
19 gender-affirming medical treatment?

20 A It just says that they -- okay. They're
21 silent. I will remain silent myself.

22 Q I'm just saying you don't have any
23 information to confirm that they do not cover it?

24 A Okay. Nothing --

25 Q It's possible that they do.

1 A Nothing beyond the report itself.

2 Q You reference the Belmont report providing
3 ethical requirements for medical research and
4 informed consent; is that correct?

5 A Correct.

6 MR. BEATO: Chelsea, the GAPMS report is
7 not on the screen.

8 MS. DUNN: Yeah. Thank you. I'll pull it
9 up.

10 (Document is displayed).

11 Q (By Ms. Dunn) So now we're on Page 2 of
12 your report, which is labeled as Appendix 238. And
13 here you reference the Belmont report regarding
14 informed consent for research; is that right?

15 A Yes.

16 Q The Belmont report governs biomedical and
17 behavioral research involving human subjects; is that
18 right?

19 A Yes.

20 Q Those guidelines apply to research being
21 done when human beings are the subjects of that
22 research; is that correct?

23 A Yes.

24 Q The Belmont report does not apply in
25 providing clinical care in clinical settings; is that

1 right?

2 A Well, the way you state it, you have to
3 understand that, first off, the Belmont report was an
4 expert opinion. It was not a law or a regulation
5 itself. It did talk about clinical research. So it
6 will involve human beings in clinical setting.

7 Q Sure. But providing gender-affirming
8 medical treatment in the clinical setting is
9 different than biomedical and behavioral research
10 involving human subjects, right?

11 A I am sad to report that, yes, that's true.

12 Q So these ethical principles don't apply to
13 the type of clinical care that the plaintiffs in this
14 case were receiving?

15 A Absolutely wrong.

16 Q Well, I mean, are you offering an opinion
17 about the clinical care that our plaintiffs have
18 received?

19 A No. You just said that the principles as
20 enumerated in the Belmont report don't apply to
21 clinical care. But, of course, they do. They talk
22 about, you know, the principles of autonomy,
23 beneficence, justice, non-maleficence, and fully
24 informed consent, and all of those apply to clinical
25 care whenever it should be delivered.

1 Q Your opinion, your report, states that,
2 "There are deficiencies in each of these categories
3 in the current approach to treating minors with
4 gender dysphoria."

5 How do you know that?

6 A I think it's kind of spelled out in the
7 report itself.

8 Q Well, what is your evidence, though, for
9 saying that there are deficiencies in the clinical
10 care that's being provided?

11 A By the nature of the care and the inability
12 to give informed consent because of the things that
13 are not known, that are not included in an adequate
14 evidence base.

15 Q Aren't there always unknown risks to
16 medical treatments?

17 A Yes, but we should minimize those to the
18 extent possible. That's the point of doing research
19 on innovative therapies in order to get
20 evidence-based data.

21 Q But the way that you're framing it, someone
22 could never provide informed consent because a doctor
23 could never explain every single possible unknown
24 risk.

25 MR. BEATO: Object to form.

1 Dr. Donovan, you can answer.

2 THE WITNESS: Actually, now you're
3 sounding -- no offense -- a little like a lawyer
4 because, in fact, that's often what is brought up.
5 Of course, physicians can't tell you every unknown
6 risk. How can anyone tell you what's unknown?

7 What they can do is strive mightily to
8 determine what the risks, outcomes, and benefits are
9 through carefully constructed trials that are then
10 widely reported through the -- to the world so that
11 they can then be applied.

12 MR. BEATO: Here's a question, Counsel.
13 Would you mind if we take a five-minute break or do
14 you have related questions that you would like to ask
15 Mr. Donovan?

16 MS. DUNN: No. I was about to pull up the
17 Belmont report, so we can take a break now. It's a
18 fine time.

19 (Recess taken from 3:21 p.m. to 3:26 p.m.)

20 Q (By Ms. Dunn) So, Dr. Donovan, before we
21 broke we were talking about informed consent. Is it
22 your position that nobody can ever provide informed
23 consent to gender-affirming care?

24 A Well, I told you before I'm not fond of
25 absolutes, but I think that there are deficiencies in

1 the body of knowledge about what is termed
2 "gender-affirming care" that prevent fully informed
3 consent from being available.

4 Q Which suggests that there's no way that
5 gender-affirming care can be provided with fully
6 informed consent. Is that your opinion?

7 A I will accept your suggestion.

8 Q Well, I guess, are there circumstances --
9 any circumstances where a patient can provide fully
10 informed consent to gender-affirming care?

11 A I think that's what we answered the first
12 time. I think that we have some serious knowledge
13 gaps. We have embarked on a program of what's termed
14 "gender-affirming care" for a diagnosis of gender
15 identity disorder, now gender dysphoria, that
16 actually started without us knowing all the risks,
17 benefits, alternatives, and long-term outcomes. And
18 I don't think we've made great progress in that
19 regard, even though it's been going on, as you
20 pointed out, for years.

21 Q But the end result of that is that because
22 of these unknowns that you cite, you don't believe
23 that any -- that a patient can provide fully informed
24 consent to any of the gender-affirming medical
25 treatments we're discussing today?

1 A Informed consent can't be obtained without
2 information. That's the informed part. And I think
3 we have an information gap.

4 Q So it's your opinion that a patient can't
5 provide fully informed consent to any of the
6 gender-affirming medical treatments we've been
7 discussing today?

8 MR. BEATO: Object to form.

9 But, Dr. Donovan, you can answer that.

10 THE WITNESS: You're saying to any of them,
11 and they can certainly, you know, consent to certain
12 aspects of them because certain aspects they'll be
13 able to say, you know, "If I do a mastectomy, what
14 are the risks, benefits, alternatives?"

15 How that relates to, you know, gender
16 dysphoria is still problematic, but the surgery
17 itself, it's been done a lot.

18 Q (By Ms. Dunn) Well, so --

19 A In other circumstances, I mean.

20 Q I guess, if a patient can provide informed
21 consent, what is -- I'm -- are you saying the patient
22 can provide informed consent about these treatments
23 or that they cannot?

24 A Well, you were the one who said that --
25 kind of made it an absolute, they couldn't do it to

1 any aspect of them.

2 And I was pointing out that there are
3 aspects of them in which they can be informed.

4 If I were to offer -- if I were a surgeon
5 and offered a patient a mastectomy, I could tell them
6 the risks, benefits, the alternatives to a mastectomy
7 and the expected outcomes. But I couldn't tell them
8 how that would affect their diagnosis of gender
9 dysphoria with certainty.

10 Q So you're saying the treatments themselves
11 might be able to have gender-affirming care, but the
12 treatments for the purposes of the treatment of
13 gender dysphoria cannot be made with fully informed
14 consent?

15 A Yeah, that one was a little jumbled. Can
16 you try again --

17 Q Right.

18 A -- please?

19 Q So you're saying that the procedures
20 themselves may be -- people may be able to provide
21 fully informed consent to the procedures themselves,
22 but they can't provide fully informed consent to the
23 use of those procedures to treat gender dysphoria?

24 A That would be partially true. And that's
25 going to be more true for, for instance, surgical

1 procedures which have been done and would be done
2 again in very much the same mode.

3 You know, using puberty-blocking agents or
4 cross-sex hormones for these indications would be
5 much more difficult, even though we know how those --
6 how those apply in other diagnoses and other
7 indications. So there you have a problem.

8 Q I'm just going to go back to your report.
9 (Document is displayed).

10 You make a reference in the third paragraph
11 that, "The rules for their involvement" -- which is
12 referencing the involvement of children in research
13 studies -- or vulnerable subjects in research
14 studies, are set out in the, quote, "Code of Federal
15 Regulations 46 CFR 401 through 409."

16 So when we looked up this reference we
17 found a section of the U.S. Code that appears to be
18 on shipping.

19 A No, I don't think that was mistyped. I can
20 go right behind me and find that. I mean, the CFR
21 has the rules about informed consent in children on
22 the shelf behind me. I'm pretty sure those are the
23 right numbers. 46: 401-409.

24 Do you want me to go look?

25 Q Well, no, I'll pull up --

1 MR. BEATO: Dr. Donovan, it's --

2 Q (By Ms. Dunn) I'm going to pull it up in
3 one moment.

4 (Document is displayed).

5 So if you see here in the Code of Federal
6 Regulations, we have Title 46, Part 401 to 40 -- here
7 it's just 404, but it appears to be about shipping
8 regulations. I can zoom in, I think.

9 A No, no, no, no, no. You're not in the
10 ICH Guidelines.

11 Q What's different about the citation?

12 A Well, it's the Code of Federal Regulations
13 and ICH Guidelines, Title 21, Good Clinical Practice.

14 Q Title 21?

15 A Uh-huh.

16 Q Okay. So you listed Title 46.

17 A No, no. The -- I think it was Part 46,
18 wasn't it? Yeah, Part 46, "The Protection of Human
19 Subjects."

20 Q Well --

21 A Under Title 45, Part 46.

22 Q I'm sorry, I'm a little confused. So if we
23 could just take it -- so you've listed --

24 A IR -- this is fairly standard and widely
25 available. These are the IRB Clinical Investigator

1 Reference Guides put out by -- you know, by the --
2 well, the NIH and the ICH Guidelines by the FDA
3 because this is FDA regulated.

4 And you're looking for IRB Clinical
5 Investigator Reference Guide, which should be under,
6 I guess, Title 45. Part 46 is "Protection of Human
7 Subjects."

8 Q All right. So maybe this is a citation
9 discrepancy. I'm not sure. What I'm trying to just
10 identify is how we would identi- -- how we would find
11 what you're citing to.

12 So 46 CFR, in legal citation, means
13 Title 46 of the Code of Federal Regulations.

14 What title of the Code of Federal
15 Regulations are you intending to reference?

16 A It's Title 45, Part 46.

17 Q Okay. And is it Sections 401 through 409?
18 Is that correct?

19 A Let me double check and make sure. Yep.

20 Q Okay. Thank you for that clarification.

21 A Sure.

22 Q All right. I'm scrolling down in your
23 report to Page 3, which is marked as Appendix 239.

24 And here we talk about -- you talk about
25 the various interventions, which I'm assuming you use

1 that word to reference the medical treatments or
2 procedures we've been talking about today.

3 And so first you reference "surgeries."
4 You say that, "The semantic shift from sex change
5 operations to gender-affirming surgeries is
6 important."

7 What do you mean by this?

8 A I'm looking for the context.

9 Q The first paragraph under "Surgery," the
10 very last sentence.

11 A Oh, okay. I'm sorry, what's the question
12 there?

13 Q What do you mean when you say "the
14 semantics shift is important"?

15 A It's basically what I was trying to point
16 out with the rest of the paper, that, you know, we --
17 we have switched from calling -- from differentiating
18 gender from sex, to begin with, and then we've
19 started calling it affirming surgery. We don't call
20 it just a mastectomy or a penectomy anymore.

21 So, you know, when you say that I am going
22 to do an affirming surgery for you, that's a very
23 positive connotation when a patient first hears it as
24 well.

25 If you said I'm going to do a mastectomy or

1 penectomy, I think that that probably wouldn't sound
2 as appealing.

3 Q Do you have reason to believe that
4 clinicians are not using the name for the procedure
5 with their patients?

6 A I didn't say that. I just said that they
7 are referring to it now as a "gender-affirming
8 surgery," as you know.

9 Q Well, gender-affirming surgery is the
10 category, but I'm just -- do you have any evidence to
11 believe that the term -- the word penectomy or
12 mastectomy is not being used in individual
13 consultations when someone is seeking that type of
14 surgery?

15 A I have good evidence that they're using
16 gender-affirming surgeries, but I think that that's
17 really kind of the point I was trying to make.

18 Q What evidence are you citing?

19 A Well, they are using "gender-affirming
20 surgery." You used "gender-affirming surgeries." We
21 all hear that.

22 Q Well, we use -- of course we use that term
23 to describe multiple surgeries that are for the
24 purposes of treating gender dysphoria.

25 What I'm asking is whether you have any

1 evidence to support the notion that a clinician isn't
2 using the actual name of the procedure with the
3 patient, i.e., a penectomy or a mastectomy.

4 A No.

5 Q Okay. The shift in terminology -- the goal
6 of that shift in terminology was for there to be less
7 stigma associated with the condition.

8 Is that problematic?

9 A Well, what we have done, then, is to take a
10 gender identity disorder and say that that is no
11 longer a disorder. It's only a disorder if you're
12 unhappy with it.

13 The fact that you are a physical male who
14 believes he is or should be a female is normal or
15 should be treated as normal, according to the shift
16 in the terminology and the shift in the approach. I
17 think a lot of people are having some difficulty with
18 that shift.

19 Q What do you mean "a lot of people are
20 having difficulty with that shift"?

21 A I think that people are finding it
22 difficult to just believe the concept, that this man
23 is actually a female gender or this woman is actually
24 a male gender. I think that part of the evidence for
25 that, because you like evidence, is that we're

1 involved in a lawsuit over that right now.

2 Q But who are the people that are having
3 trouble with that change in semantics or that shift?

4 A Well, I think it's a wide number of people,
5 if you just look at things that are being discussed,
6 but I'm sure the people you're suing would fall in
7 that category as well.

8 Q Do you think this shift is problematic for
9 the individuals experiencing gender dysphoria?

10 A I do.

11 Q Why?

12 A Because I think that -- I think that we are
13 taking a psychological problem and applying a
14 medical/surgical solution to it, which doesn't
15 probably -- no, forget "probably" -- doesn't really
16 directly address the underlying problem.

17 Q What is the underlying problem?

18 A I think the underlying problem is that we
19 have men who assert that they are in a -- that they
20 are females in a male body and the reverse.

21 Q Do you have any evidence to cite to to
22 support the assertion that the medical treatments
23 we're discussing today are not effective in
24 addressing the diagnosis?

25 A I don't think we have evidence one way or

1 the other, but I think that the -- it is highly
2 unlikely if, in fact, the basic underlying problem is
3 psychiatric or psychological.

4 Q But are you -- do you have any evidence to
5 cite, with regard to your assertion that surgeries
6 and medical treatments are not effective in treating
7 the condition of gender dysphoria?

8 A Well, I really think that's what we've been
9 discussing all day is the absence of this evidence,
10 that it is effective.

11 Q But you have not provided any citation to
12 support the fact that it is not effective.

13 A Nor have I seen sufficient proof that it
14 is. So I think that, in this case, when you don't
15 have evidence that what you're doing is good, it's
16 difficult to have evidence that what you're doing is
17 not good because we don't have the long-term outcomes
18 being clearly delineated.

19 I mean, we -- you've pointed out that we've
20 been doing this for over a decade on a larger scale,
21 but for a couple of decades and more on a smaller
22 scale and yet we really don't have -- I can't tell
23 you the number of people who have claimed benefit
24 after 20 years or what that's done to their suicide
25 rate. We do know that in adults the suicide rate has

1 gone up, not down after ten years. But these are
2 important questions that need to be answered and we
3 really should be answering those.

4 Q So my question is not -- my question was
5 specific to whether or not you have provided evidence
6 or citation in your report to support the contention
7 that gender-affirming medical treatments are not
8 effective to treat gender dysphoria.

9 A And my response --

10 Q Have you cited an evidence or citation?

11 I mean, just look at your report,
12 Dr. Donovan. I'm just asking, is there a citation or
13 evidence to support that contention?

14 A And what I'm trying to explain is that in
15 the absence of evidence, you know, that isn't
16 evidence of absence.

17 What we're dealing with right now is an
18 entire situation that is evidence-deficient.

19 Q But I'm not asking about the situation.
20 I'm asking a yes or no question as to whether or not
21 there is a citation or evidence -- a source of
22 evidence cited in your report.

23 MR. BEATO: Object to the form.

24 THE WITNESS: And I not only answered that,
25 but I also gave you a reason why there is no answer

1 for that.

2 Q (By Ms. Dunn) I don't believe I've heard --
3 it's a yes or no question and I don't believe I've
4 heard a yes or a no.

5 MR. BEATO: Object to form.

6 Dr. Donovan, you can answer.

7 THE WITNESS: There is no sufficient
8 evidence as to the outcomes.

9 Q (By Ms. Dunn) So is that a no, that you
10 have not provided a citation to a source of evidence
11 to support the contention that gender-affirming
12 surgeries and medical treatments are not effective to
13 treat gender dysphoria?

14 MR. BEATO: Counsel, I think the report
15 speaks for itself and I think Dr. Donovan's answer
16 speaks for itself.

17 MS. DUNN: Michael, if you have an
18 objection, you're welcome to state it, but I'm asking
19 a yes or no question and I'm not being given a yes or
20 no answer.

21 THE WITNESS: You're not being given a yes
22 or no answer by me because a yes or no answer would
23 be inappropriate. I could give you a yes or no
24 answer, but it would not actually help clarify the
25 truth, it would obfuscate it.

1 Q (By Ms. Dunn) I'm merely asking whether you
2 provided a source of evidence to support your
3 contention that gender-affirming medical treatments
4 are not effective to treat gender dysphoria.

5 If you -- that is a yes or no question.

6 A It is a yes or no question, but a yes or no
7 answer is inappropriate when there is no such
8 evidence. It's like asking for evidence of aliens.

9 You know, have I proven that there is no
10 evidence? Proving the negative is much harder than
11 affirming the positive, as you know.

12 Q But I haven't asked you to prove, I've
13 merely asked if you cited evidence in your report.

14 MR. BEATO: Object to form.

15 THE WITNESS: Evidence to do what?

16 Q (By Ms. Dunn) To support the contention
17 that gender-affirming medical treatments are not
18 effective to treat gender dysphoria.

19 A And how is "support" and "prove" different
20 because I'm confused now.

21 Q A supporting citation just demonstrates
22 that you relied on some sort of evidence. And I'm
23 merely asking if you have cited any such evidence in
24 your report.

25 A There is no such evidence to cite.

1 Q And, similarly, you haven't cited any such
2 evidence in your bibliography?

3 A And there is no such evidence to prove that
4 it is effective long term.

5 Q Back to your report. I just want to make
6 sure I'm in the right place.

7 So you state that, "The lack of sexual
8 maturity in younger patients, especially previously
9 delayed by puberty-blocking agents, makes the sparse
10 tissue more difficult to work with and outcomes less
11 favorable with problems such as wound rupture are
12 more likely."

13 What is your evidence to support this
14 assertion?

15 A This is information that I have received
16 from surgeons. This is not personal experience.

17 Q How did you receive this evidence from
18 surgeons?

19 A This was in reading their reports.

20 Q And are those reports cited here?

21 A No.

22 Q Are they cited in your bibliography?

23 A Everything that's cited here is cited
24 within the body of the thing. This doesn't have a
25 separate bibliography, to my recollection. No, it

1 doesn't.

2 Q Okay. I'm sorry, but it wouldn't be a
3 source that would be cited in the bibliography you
4 provided with your expert report?

5 A This was stated by surgeons who do this
6 surgery, so I don't think it's controversial enough
7 to need a separate citation.

8 Q Well, this is evidence that you're relying
9 on. I'm just asking if you have cited a source for
10 that evidence.

11 A And, no, I didn't, because I didn't think
12 this was anything controversial, seeing as how the
13 surgeons themselves have mentioned this.

14 Q You then say that, "These are challenges
15 that are not routinely described to minors at the
16 beginning of their treatment progression."

17 What is your evidence to support that
18 contention?

19 A Simply because it -- I don't think it's
20 even widely known by people.

21 Q Do you have a source of evidence that you
22 can cite to for that assertion?

23 A Are we talking about the same assertion or
24 something --

25 Q No, the assertion that these challenges are

1 not routinely described. I'm just asking how --

2 A I certainly haven't been able to find them
3 as part of the routine description anywhere in
4 surgery for adolescents, but if I'm wrong, I'd be
5 happy to be corrected.

6 Q Other than this one -- this issue
7 identified with individuals who begin their treatment
8 with puberty blockers, you don't describe any other
9 ethical issues or complications related to
10 gender-affirming surgeries in this part of the
11 report; is that right?

12 A Everything I described is -- is there.

13 Q What do you mean by that?

14 A Well, what did you mean by that? This
15 is --

16 Q Well, I'm asking if there are other ethical
17 issues that you've identified with gender-affirming
18 surgeries.

19 A I think the fact that they're being done is
20 the ethical issue, actually. We're talking in this
21 report on -- not on adults, but on children.

22 Q So now we'll move on to this section that's
23 called "Hormonal Treatment." It's on the same page,
24 Page 3 of your report marked as Appendix 239.

25 Here you again cite to "80 percent of

1 minors who identify as transgender will reverse this
2 identity by the time they reach their mid 20s."

3 Do you cite any evidence in this report to
4 support this assertion?

5 A Actually, I think we found that in the
6 other reference, but I don't have a specific citation
7 on that paragraph, no.

8 Q Are you saying that this source was
9 included in your bibliography?

10 A Yeah. I thought we found that 80 percent
11 when we were looking through there.

12 Q To my recollection, you were not able to
13 identify that source from your bibliography.

14 A Okay.

15 Q Is that inconsistent with your
16 recollection?

17 A It's been a long day, Counselor. I'm not
18 sure.

19 Q But there's no citation here to support
20 that assertion?

21 A That's right.

22 Q You say that, "Sex hormones have an
23 important and lasting effect on brain development and
24 adolescent psychology."

25 That's right here right before the end of

1 this paragraph.

2 There's no citation or source of evidence
3 for this assertion in your report; is that correct?

4 A That's correct, I don't have citations for
5 every statement.

6 Q Do you know of any studies that show the
7 administration of cross-sex hormones to be harmful to
8 brain development?

9 A What I said was they have an important and
10 lasting effect. And I think that, yes, those studies
11 do exist.

12 I think that most people recognize that if
13 they have ever been an adolescent, or had one in the
14 family, it's -- didn't seem like it was that
15 controversial a concept to require a separate
16 citation. But, yes, there is evidence for that,
17 you're right.

18 Q There's evidence for what?

19 A For the fact that there are important
20 effects and lasting effects on brain development and
21 adolescent psychology.

22 Q But you did not cite any research or
23 studies to support this assertion?

24 MR. BEATO: Object to form.

25 Dr. Donovan, you can answer.

1 THE WITNESS: What you see is what you get.
2 Everything that I cited is right there. And if it's
3 not there, then it wasn't cited in this paper.

4 Q (By Ms. Dunn) And in your report you don't
5 describe other ethical issues related to the
6 administration of cross-sex hormones?

7 A I didn't cite any. That doesn't mean there
8 aren't any.

9 Q Specific to this report, there are no other
10 ethical issues related to the administration of
11 cross-sex hormones addressed.

12 A Okay. Not specifically.

13 Q And I'm just -- I see you flipping through
14 papers. Are you just looking at the same report that
15 I have on the screen?

16 A Yes, it's easier to read.

17 Q That's absolutely fine, I just wanted to
18 confirm that's what you're looking at.

19 And if you're looking at a different
20 section than me at some point, if you're referencing
21 it, if you'll just please direct me to that section.

22 A Sure.

23 Q So the next section addresses "Puberty
24 Blockers." You state that, "Children and parents are
25 only told that this is a benign intervention whose

1 effects are easily reversible and that potential
2 effect on the development of bone density may be
3 mentioned."

4 What evidence do you have that this is the
5 exhaustive information provided to children and their
6 parents?

7 A Actually the people who provide them have
8 written this in their own papers. It is not cited --

9 Q Well, who --

10 A It is not cited there, but those people who
11 have written papers about transitioning have
12 frequently said on their websites, you know, what I'm
13 saying there.

14 Q Can you direct us to those sources?

15 A It can be done.

16 Q Can you do that right now today?

17 A No.

18 Q You go on to discuss a case of a child in
19 Sweden. Where did you get this information?

20 A I'm trying to read where you are.

21 Q I'm sorry, it's just the next sentence, I
22 think.

23 A Oh. I'm sorry, that was reported. I
24 didn't cite the -- the location of the report, but it
25 was reported publicly in the literature.

1 Q There's no cite, though, in your report?

2 A Once again, Counselor, if you don't see it
3 right there, you're right, it's not a specific
4 citation.

5 Q You go on to note that, "Sweden changed its
6 guidelines for gender-affirming care to reflect that
7 GnRH analogues should only be used in exceptional
8 cases."

9 Do you know what the criteria in those
10 Swedish guidelines is?

11 A No.

12 Q So I'm going to pull up the Swedish
13 Guidelines for the Treatment of Gender Dysphoria.

14 (Document is displayed).

15 Do you recognize -- have you ever seen this
16 document, Dr. Donovan?

17 A Is that the one from February of last year?

18 Q Let's see if there's a date on it. I don't
19 see a date on it.

20 Do you recognize the document itself,
21 though?

22 A No, I don't. I said I hadn't seen that.
23 And maybe this preexisted the changes, do you think?

24 Q Let's just -- if you want to take a -- oh,
25 I'm sorry. Here if you look at this paragraph this

1 references "2022," so this must be a recent document.

2 A Okay. Let me read then.

3 Q Sure.

4 A "A systemic review published in 2022 by the
5 Swedish Agency for Health Technology Assessment and
6 Assessment of Social Services shows the state of
7 knowledge largely remains unchanged compared to 2015.
8 High quality trials such as RCTs are still lacking."

9 Q I'm sorry, I don't need you to read --

10 A "The evidence on treatment" --

11 Q Sir?

12 A -- "efficacy and safety is still" --

13 Q Dr. Donovan?

14 A I think what I'm looking for is in here.

15 Q Okay.

16 A -- "is still insufficient and
17 inconclusive."

18 Q Yeah, I'm not asking you to read from the
19 document. I'm sorry. I was just asking -- I wasn't
20 able to confirm a date, but I think based on this
21 sentence we can both agree that it was published
22 sometime after -- sometime in 2022 or 2023.

23 A Okay.

24 Q So do you know the criteria that's used to
25 determine if a case is so-called "exceptional" for

1 the purposes of the provision of GnRH analogues?

2 Are you familiar with the criteria?

3 A Well, it's saying here, to minimize the
4 risk it should offer more closely to those used in
5 the Dutch protocol.

6 Q And so that requires "early onset of gender
7 incongruence, persistence of gender incongruence
8 until puberty, and a marked psychological strain in
9 response to pubertal development is among the
10 recommended criteria."

11 Is that accurate?

12 A That's what that says, yes.

13 Q Is this significantly different than, for
14 example, the Endocrine Society guidelines?

15 A I will defer to your knowledge.

16 Q So you are not -- you are not aware whether
17 the new Swedish guidelines are significantly
18 different from the clinical guidelines for endocrine
19 treatment that are used here in the U.S.?

20 A I haven't even had a chance to read this in
21 its entirety, so I can't answer that. I'm sorry.

22 Q Well, but -- so I guess the reason I'm
23 asking is just because you reference that this case
24 should only be provided in exceptional cases, to
25 suggest that it's more restrictive than the criteria

1 for this care here in America.

2 Do you know for a fact that that is
3 correct?

4 A All I know is what the National Board of
5 Health and Welfare from Sweden said that, "The risks
6 of puberty-suppressing treatment with GnRH analogues
7 and gender-affirming hormonal treatment currently
8 outweigh the possible benefits. The treatment should
9 be offered only in exceptional cases."

10 Q But these --

11 A That was a quote --

12 Q These guides -- I'm sorry.

13 A That was a quote from the Swedish source
14 and I don't know that that quote --

15 Q Again, I'm not asking you to read the
16 document. I'm asking about the --

17 A But you are -- you are giving me this as
18 the source of it, but I'm not certain that you're
19 actually giving me the proper source.

20 Q You don't think that this publication from
21 the National Board of Health and Welfare is an
22 accurate reflection --

23 A The one that contains that quote, I don't
24 think that it -- it -- necessarily. I'd have to read
25 the whole thing to know that that's where the quote

1 came from.

2 Q What quote? I'm sorry. What are you
3 talking about?

4 A The quote that says that "The risks
5 currently outweigh the possible benefits and
6 treatment should be offered in exceptional cases."

7 Q You're saying that you --

8 A Puberty blockers. From the Swedes.

9 Q Are you saying that this isn't the source
10 that you got your quotation from?

11 A I'm not recognizing what you're showing me
12 here. I'm sorry.

13 Q So that -- understanding that, what I'm
14 asking is that you --

15 A It says, "Until a research study is in
16 place, the NBHW deems that the treatment" --

17 Q Dr. Donovan, I'm sorry, I'm not asking you
18 to read from this document.

19 A -- "may be given in exceptional cases."

20 Q If you can wait until I've posed a --

21 MS. DUNN: I think we might need to take a
22 break.

23 MR. BEATO: That's fine. We can take a
24 five-minute break.

25 (Recess taken from 4:02 p.m. to 4:08 p.m.)

1 (Whereupon, Exhibit Number 27 was marked
2 for identification purposes and made a part of the
3 record.)

4 Q (By Ms. Dunn) So, again, I have to clear up
5 my sloppiness around labeling exhibits. So the
6 Swedish guidelines we just looked at will be marked
7 as Plaintiffs' Exhibit 27.

8 So I'm just going to go back to your report
9 again, Dr. Donovan, and move on to the section that
10 you reference, quote, "The Fundamental Flaw," which
11 is on Appendix 240.

12 (Document is displayed).

13 So in this section you say, in the second
14 sentence of this paragraph, that "After close
15 scrutiny, it can only be seen as off-label
16 experimental."

17 And by that you're referencing -- the "it"
18 you're referencing is gender-affirming care, as we --
19 we discussed already, the hormonal treatments,
20 the gender-confirming surgeries and the
21 puberty-blocking medications; is that right?

22 A Yes.

23 Q And so this seems to associate off-label
24 medications with experimentation. Is that the
25 suggestion you're making?

1 A No, not exactly.

2 Q So what do you mean by "off-label
3 experimentation"?

4 A Well, that's two different phrases. One is
5 "off label," the other is "experimentation."

6 Experimentation is when you are --
7 sometimes it's also referred to as innovative
8 practice, but when you're doing things that are
9 trials in which the outcomes have not been
10 sufficiently determined or documented.

11 The --

12 Q Just to be clear --

13 A -- "off label" part is referring to the
14 FDA approval, which is useful if it's for a specific
15 indication, but is not necessary for --

16 Q So -- I'm sorry. I didn't mean to cut you
17 off.

18 So just to be clear, those terms are
19 interchangeable --

20 A No.

21 Q -- off label and experimental?

22 A No. No, they're not interchangeable.

23 Q So a medication -- just because a
24 medication is used off label doesn't mean that that
25 medication is necessarily experimental?

1 A I have used medications off label for
2 indications that were clearly documented but never
3 had sought FDA approval.

4 Q In this paragraph you talk a little bit
5 more about what we discussed earlier with, "The
6 change in terminology in the DSM-5 led to a shift
7 from seeking to correct the underlying cause of the
8 dysphoria to instead focusing on transitioning to
9 one's affirmed gender."

10 Is that a fair -- is that what you're
11 writing about here in this report?

12 A That is a quote, yes.

13 Q Okay. And what do you rely on in this
14 discussion around the impact of the change in
15 semantics?

16 A I was quoting. I was quoting the people
17 who put out the DSM-5 and the American Psychiatric
18 Association. You know, those are quotes.

19 Q Do you have any other -- was there any
20 other source you relied on in your discussion of this
21 change of semantics?

22 A I mean, this was the APA's rationale. I
23 thought that they would be reliable in terms of what
24 they were intending.

25 Q And perhaps to be more specific, in your

1 bibliography -- which I'll flip over to very
2 quickly --

3 (Document is displayed).

4 -- you cite a source that's named "Gender
5 dysphoria in the DSM-5: The change in terminology."
6 That's "HLI.org/resources/DSM-5-gender-dysphoria/."

7 A Well, no, I wasn't using --

8 Q Is --

9 A I'm sorry, I didn't mean to interrupt. I
10 thought that was -- that was not what I used in this
11 report.

12 Q So you did not -- in talking about that
13 change in semantics, you didn't rely on that Human
14 Life International article?

15 A True.

16 Q Do you know how it was used in your expert
17 report?

18 A I don't know. We could go back through it,
19 I suppose.

20 Q Well, we can table that momentarily.

21 Do you believe that this shift in semantics
22 in changing the diagnosis to gender dysphoria, do you
23 believe that change was harmful?

24 A Well, I think it shifted the focus away
25 from the patients presenting with what they describe

1 as "being in the wrong body" as saying that that is
2 somehow normal and not a disorder.

3 Q Do you believe that the best course of
4 treatment for a person experiencing gender dysphoria
5 is to help that person understand they're not trapped
6 in the wrong body?

7 A I think that that probably would be the
8 best approach and I think that it should have been
9 compared to what is being done.

10 Q You say that -- and I think it's going to
11 be in the next paragraph, so let me just find where
12 I'm referencing so I can point you directly.

13 In this second paragraph on this page,
14 we're currently on Page 5 of your report marked as
15 Appendix 241, you say -- the third sentence in this
16 second paragraph you say, "Self-diagnosing
17 psychiatric conditions is always fraught with the
18 possibility of error."

19 You aren't a psychiatrist by -- in your
20 practice; is that right?

21 A That's correct.

22 Q You're also not a licensed mental health
23 professional; is that correct?

24 A Correct.

25 Q How often during your time as a clinician

1 did you provide mental health diagnoses when you were
2 a pediatric gastroenterologist?

3 A I'm sorry, I lost you there.

4 Q Oh, I'm sorry.

5 A Can you repeat that?

6 Q Yes, of course. I think the Internet is
7 getting a little buggy.

8 So you testified that there were occasions
9 where you would give presumptive mental health
10 diagnoses to patients in your --

11 A Yes.

12 Q -- pediatric gastroenterology practice; is
13 that right? I'm sorry, did you --

14 A Yes.

15 Q Yeah. The answer to that was yes?

16 A I said "Yes."

17 Q I'm sorry, I think I lost you then, so I
18 apologize.

19 Can you estimate how many patients --

20 A Okay. I think you're right. We're having
21 some problems.

22 Q Yeah. I apologize for that. I don't know
23 if it's our Internet, but let's try to do the best we
24 can.

25 Can you estimate how many patients during

1 your time as a clinician you provided a mental health
2 diagnosis for?

3 A No.

4 Q You can't even give an estimate of that?

5 A No. I mean, no. I was in practice for 30,
6 40 years. I couldn't begin to guess accurately.

7 Q Was it common for you to be providing
8 mental health diagnoses for your pediatric patients?

9 A Oh, no, I wouldn't be providing them, I
10 would be suspecting them and referring them.

11 Q So, I guess, was that a common instance
12 that happened frequently?

13 A No, because the psychiatric diseases in
14 children aren't that common compared to the other
15 types of diseases.

16 Q And so, again, you weren't actually
17 providing these diagnoses, you suspected diagnoses
18 and were making referrals to mental health
19 clinicians?

20 A Correct.

21 Q So what basis do you have to support a
22 statement that self-diagnosing psychiatric conditions
23 is always fraught with the probability of error?

24 A I said "possibility of error." And I -- I
25 don't see that as terribly controversial. I don't

1 see anyone in psychiatry disagreeing with that.

2 I would find any patient whose
3 self-diagnosis always fraught with the possibility of
4 error. And not just in psychiatry, in medicine in
5 general.

6 Q How do we -- what conditions are
7 self-diagnosing?

8 A Well, the way it applies in this particular
9 case is when there's no confirmatory evidence in --
10 like we've talked about before, in lab, in X-rays,
11 and in other tests --

12 Q But that's --

13 A -- that could confirm it. That would be --
14 that means, basically, the patient comes in with
15 their own diagnosis. And I -- you know, I assume, if
16 somebody overruled that diagnosis, you know, that
17 that would fall in the same category as well. But
18 that wouldn't be my job.

19 Q Are all psychiatric conditions based on
20 self-reported symptoms?

21 A No.

22 Q They can't be -- they can be -- there are
23 psychiatric conditions that are confirmed by lab
24 tests?

25 A No. But they're not all self-diagnosed. I

1 don't think most schizophrenics come in and say, "I'm
2 schizophrenic."

3 Q Well, I guess, what evidence do you have
4 that individuals who are diagnosed with gender
5 dysphoria are self-diagnosing?

6 A You understand what we've been talking
7 about. This is how they present. They come in and
8 say, "I am a woman. This is a male body." They are
9 the ones who determine that.

10 Q They're reporting symptoms. But it's a
11 clinician who makes --

12 A That's not a symptom, ma'am.

13 Q What -- I -- what evidence do you have that
14 patients experiencing gender dysphoria are
15 self-diagnosing?

16 A The patients are the ones who claim that
17 they are in the wrong body.

18 Other people are not walking up to them and
19 saying, "You know, you look just like a man but I
20 think you're a woman." That doesn't happen.

21 Q But the clinician provides the diagnosis.

22 A Only after the patient has presented
23 themselves as a woman in a man's body. Okay? You
24 could say they're confirming it, but that doesn't
25 necessarily equate to providing it because it's

1 already been provided when they enter the room.

2 Q Have you cited any evidence in your report
3 that individuals experiencing gender dysphoria are
4 self-diagnosing their psychiatric condition?

5 A I -- this is -- I mean, it's in the
6 definition of "gender dysphoria."

7 Q I'm sorry, I -- can you provide a citation
8 for that?

9 A No.

10 Q The third paragraph on this page you say
11 that, "The claim of urgency, coupled with an impulse
12 towards nonjudgmental empathy, for the disturbed
13 patients has led to a frantic insistence on a single
14 approach."

15 What is the single -- I'm sorry.

16 Is the single approach that you're
17 referring to "providing gender-affirming care"?

18 A Yes.

19 Q And you call this approach "cult-like"?

20 A It seems like that to some people and I see
21 why it does.

22 Q Well, and your source for this statement is
23 two articles that are cited here; is that correct?

24 A Uh-huh. Yes.

25 Q One of these articles was from The Daily

1 Signal; is that right?

2 A Yes.

3 Q And were you aware that The Daily Signal is
4 the Heritage Foundation's news organization?

5 A No.

6 Q And one was from The Daily Mail Online; is
7 that correct?

8 A Yes.

9 Q The Daily Mail Online is a British tabloid?

10 A Yes. These were reports from parents
11 directly, so they would not appear in the academic
12 literature.

13 Q But these are your sources for your
14 suggestion that this single approach is cult-like?

15 A Made the parents feel like, yes, because
16 that's what they said.

17 Q You say that, "Love-bombing wrongly
18 encourages children to be transgender."

19 What is your citation for this proposition?

20 A I'm trying to remember if that was with the
21 same -- the next citation or something else. No,
22 that's a separate citation. I have it in my files,
23 but I don't have it cited here.

24 Q So there's no citation provided for that
25 statement here?

1 A That it's the result of overenthusiastic
2 acceptance? I think overenthusiastic acceptance is a
3 reality, but you could also see it as an opinion, you
4 know, is the glass half full or half empty?

5 I would say that the -- the rush to be
6 affirming is overenthusiastic acceptance.

7 So perhaps I'm the authority there, because
8 this is an opinion after all.

9 Q Are you -- do you have personal experience
10 with this so-called love-bombing or overenthusiastic
11 acceptance?

12 A No, no. These are the opinions that I've
13 formed from reading the experience of others.

14 Q And are these -- the experiences of others,
15 are they primarily in news articles or what sources
16 are you reading these --

17 A I think it's very hard to live in today's
18 world without realizing there is a strong urge in
19 schools, in medical circles, and in the general
20 environment to be affirming and only be affirming to
21 someone who presents with a -- with a feeling that
22 they are in the wrong body. I don't think that
23 that's really very controversial or difficult to
24 perceive.

25 Q Is it your opinion that this is

1 problematic?

2 A Absolutely.

3 Q You say -- I think going down to -- I'm
4 sorry, I'm trying to find a reference here.

5 So you also discuss an issue that arose in
6 Virginia where a sexual assault was -- well, as you
7 put it, was committed by a, quote, "Self-described
8 trans female."

9 Do you see that section?

10 A Yes.

11 Q And you quote -- or, I'm sorry, you cite to
12 an article here that was published in the Washington
13 Examiner?

14 A Uh-huh.

15 Q I'm going to show you that article.

16 (Document is displayed).

17 Is this the article that you were citing
18 to?

19 A Probably.

20 (Whereupon, Exhibit Number 28 was marked for
21 identification purposes and made a part of the
22 record.)

23 Q (By Ms. Dunn) I'm going to -- I will mark
24 this as Plaintiffs' Exhibit 28.

25 A Can you enlarge it?

1 Q Of course. Can you tell me where you got
2 the information that this person who committed this
3 sexual assault was a, quote, "Self-described
4 trans female"?

5 A There was more than one article about this.
6 This is only one that I cited.

7 Q And here it just says there was "a male
8 perpetrator who was wearing a skirt."

9 This article, which is the one you cited in
10 your report, doesn't identify this individual as a
11 trans person -- transgender person?

12 A Oh, no, there have been several reports. I
13 cited one, but this, you know, was clearly reported
14 in the news.

15 And, yes, the reason he was in the girls
16 bathroom was because he had felt proclaimed to be
17 transgender. I think that that self-diagnosis might
18 be questionable. I don't think that people who truly
19 feel they're transgender are at risk for sexual
20 assaults opposite their biologic sex.

21 Q I'm just -- at this point I'm just asking
22 about your citation here. So you have described the
23 person who committed this assault as a
24 "self-described trans female," and then you cited
25 this article.

1 And I just want to confirm that this
2 article does not refer to this person as a
3 self-described trans female.

4 A Well, this is -- this is a reference to the
5 article, but it looks like -- that does say he was
6 wearing a skirt.

7 There are a couple of links there. Do they
8 also mention that he had described himself as
9 transgender? Because he had. And we can find it.
10 Do you want to look?

11 Q Well --

12 A Can you click those links about "sexual
13 assault" or "May 21 sexual assault"?

14 Q Dr. Donovan, I'm not asking you to read
15 from the report, respectfully.

16 I am asking -- you cited this article in
17 your assertion that this individual was a
18 trans female. So I'm just asking -- in looking at
19 this document, it does not state that the individual
20 who committed this assault was a self-described
21 trans female; is that correct?

22 A And I was saying I think it may be
23 contained in those links about the same incidents.

24 Q Well, then -- but you did not provide a
25 citation to those particular articles when you wrote

1 your report?

2 A I just provided this citation.

3 Q And I'm going to pull up one more article
4 on this issue.

5 (Document is displayed).

6 So this is a CNN article that's about this
7 same sexual assault in Virginia.

8 Have you ever seen this article,
9 Dr. Donovan?

10 A I don't recall seeing it.

11 (Whereupon, Exhibit Number 29 was marked for
12 identification purposes and made a part of the
13 record.)

14 Q (By Ms. Dunn) I'm going to mark this as
15 Plaintiffs' Exhibit 29.

16 So CNN looked into this issue and they
17 report here on this page that they "could not find
18 evidence substantiating that the student identified
19 as transgender or gender-fluid."

20 Were you aware that that report had not
21 been substantiated by other news sources?

22 A I don't know how they failed to find it. I
23 don't -- I don't know what this refers to. I don't
24 know if they interviewed him or somebody else. I
25 mean, this tells me nothing.

1 Q I'm just asking if you were aware that
2 competing news sources were not able to substantiate
3 the claim that this person was a trans female?

4 A I -- I actually would -- it's easier to say
5 yes or no on this one rather than go into the
6 details, but I'll accept that.

7 Q So you were not aware that other sources
8 were unable to substantiate that claim?

9 A An unsubstantiated claim doesn't mean a
10 false claim. That's all I'm trying to indicate here.

11 But, yes, I -- I don't know anybody who's
12 interviewed the guy directly. The thing was -- it
13 was very difficult to get information on the details.
14 He was in a girl's bathroom wearing a skirt. You
15 know, whether or not he had been diagnosed by himself
16 or someone else as transgender is completely unknown
17 to me. I would doubt the diagnosis that he gave.

18 Q But you cited to one article, and I'm just
19 asking if you were aware of this other information
20 from another news source.

21 A And I said "no."

22 Q You're not aware?

23 A Not this news source.

24 Q Thank you.

25 On Page 6 of your report, which I'll pull

1 up in just one moment.

2 (Document is displayed).

3 You cite to an article by Abigail Schrier.
4 Are you familiar with this article?

5 A Yes.

6 Q Do you know where this article was
7 published?

8 A Oh, there, "Top Trans Doctors Blow the
9 Whistle on Sloppy Care."

10 Q And where was this article published?

11 A Says "Emmaus Road Ministries, 5 October
12 2021."

13 Q And is that a peer-reviewed source?

14 A You're not going to find very many
15 discussions about these things in peer-reviewed
16 sources. They basically, you know, have one
17 orientation.

18 No, this, I don't think, would be a
19 peer-reviewed source either.

20 Q Moving on to Page 7. We'll go to the
21 second paragraph. So this is Page 7, Appendix 243.
22 The second paragraph.

23 I'm sorry, I'm having trouble. I think I
24 have a different version of the report pulled up than
25 one of my colleagues, so I'm trying to identify

1 where --

2 A Okay. Well, whatever you have is what I'm
3 looking at as well.

4 Q Okay. Simone was looking at the actual
5 pages in the PDF and not the numbered pages and
6 that's why we had some confusion, so that's my fault.
7 Okay. I'm wondering why I was so confused and now I
8 understand. All right. I apologize in wasting your
9 time in trying to figure that out.

10 So we're going back up to Page 5, which is
11 Appendix 241. And you say, "The rate of suicide
12 among post-operative transgender adults in a study
13 from Sweden found an incidence 20 times greater than
14 that of the general population."

15 What study are you citing here?

16 A I don't see it. I don't even see the --
17 what you're reading to me.

18 Q Oh, I'm sorry. It's --

19 A Which paragraph?

20 Q -- the second paragraph. I'm looking at
21 the second to last sentence in that paragraph.

22 A Oh, okay. Yeah. Yes, I do remember
23 reading that. I didn't cite the article there.

24 Q Can you provide us with a name of that
25 study here today?

1 A Not off the top of my head, no.

2 Q Slightly before this, the third to last
3 sentence of that paragraph you say, "Studies have
4 shown that adult transgender persons continue to have
5 evidence of depression and suicidality following
6 treatment."

7 What studies are you referencing there?

8 A Actually, I don't know. That may even be
9 the -- among others, may be the same study, but I
10 don't have the reference down there.

11 Q So there's no citation provided in your
12 report --

13 A Right.

14 Q Regarding either of these two studies?

15 A That's true.

16 Q Are you aware of any studies that found
17 there were positive mental health outcomes among
18 transgender adolescents and young adults after
19 receiving gender-affirming care?

20 A Well, there have been positive results
21 reported.

22 Q And did you consider those studies when you
23 were preparing your opinions in this report?

24 A Of course.

25 Q Do you reference any of those studies in

1 this report?

2 A If you're going to ask me for citation
3 saying that there's -- on supportive ones, no, I
4 didn't put that in there either.

5 One of the problems is that so many of
6 these studies have been criticized because of the
7 form in which they were done, how the questions were
8 asked, and how they were reported, who was asked and
9 who wasn't asked, you know, and who refused to ask.

10 So, yes, I know that they had been
11 reported. I don't know that they are any more
12 convincing evidence.

13 Q What evidence do you have with regard to
14 those criticisms?

15 What evidence do you have of those
16 criticisms? What are you referring to?

17 A Oh, you mean are there criticisms of some
18 of the transgender reports or satisfaction surveys or
19 something?

20 Q I'm asking what criticisms. I'm asking --

21 A Yeah. I don't even --

22 Q -- if you --

23 A -- have that stated here, so, no, I don't
24 have a citation for that. I didn't even use that
25 citation, seeing as how if it was sloppy work I

1 didn't think I'd want to cite that.

2 Q So I'm going to move down again to Page 6.
3 This is marked as Appendix 242. So you reference two
4 phenomena that may be associated with -- you say
5 "this," and I -- I think we're maybe referring to
6 this idea of overenthusiastic affirmation or
7 love-bombing. Is that correct that that's what
8 you're referring to?

9 A A strong affirmation for the diagnosis and
10 treatment.

11 Q So you say here that, "It may not only be
12 easier to identify as transgender in today's
13 environment, it may be more difficult to turn one's
14 back on that diagnosis."

15 What evidence do you have to support this
16 statement?

17 A I said it "may." That's my opinion, that
18 it may be more difficult to turn one's back if you're
19 being strongly affirmed in any direction.

20 Q Have you cited any data to support that
21 assertion?

22 A Well, I think maybe the subsequent lines
23 about re-transitioning and de-transitioning and
24 switching back and forth may be supportive of that.

25 Q But you're suggesting that because a recent

1 study found that fewer youth re-transitioned, that
2 that is because it's more difficult to turn one's
3 back on a diagnosis of gender dysphoria?

4 A Yes.

5 Q Why -- how can -- I guess, what evidence do
6 you have that the lower rate of re-transition is
7 caused by the fact that it's harder to turn one's
8 back on the diagnosis?

9 A I'm sorry, I misunderstood your previous
10 question, I'm afraid.

11 No, I think that enthusiasm and support for
12 the diagnosis may be making it harder for people to
13 then change their minds about their condition.

14 Q But then when I asked what evidence you had
15 to support that, you cited to the evidence that
16 follows in that paragraph, which is evidence that --
17 it's a study where the rate of re-transition, where
18 someone changed their gender identity back, is -- is
19 significantly lower than it was in earlier studies.

20 Does that data support your contention that
21 it's harder to turn one's back on a diagnosis?

22 A I think that if you are being strongly
23 affirmed, yes, you will be less likely to say, "I
24 change my mind."

25 Q But what evidence do you have of that, that

1 that's what's happening?

2 A It's really kind of what we had just
3 discussed, I think, that, you know, in fact, if you
4 see stronger affirmation you may see fewer people
5 saying that they no longer feel that way compared to
6 historic data.

7 Q But merely citing a study which says that
8 rates of re-transition have decreased does not
9 necessarily mean that it's because of the cause --
10 the -- the hypothetis- -- I mean, you hypothesize
11 that there are two phenomena that may be, you know,
12 related to this, but those statistics about lower
13 rates of re-transition don't necessarily prove that
14 that was caused by these phenomena that you
15 identify; isn't that correct?

16 A It says it may be an explanation.

17 Q But you have no evidence to demonstrate
18 causation?

19 A That's why you say things like "it may be
20 an explanation."

21 Q So here at the top of Page 7, Appendix 243,
22 you say that, "All of this leads to the conclusion
23 that we must ask if this represents a shift towards
24 being trapped in the wrong diagnosis rather than a
25 child being trapped in the wrong body."

1 What diagnosis would be right in this
2 situation?

3 A The wrong diagnosis, I think, is when we
4 are saying that your gender identity is both correct
5 and the cause of all your problems.

6 Q So what diagnosis would be the right
7 diagnosis in that situation?

8 A Perhaps what used to be thought of as
9 gender identity disorder would be closer to accuracy.

10 Q And going further down on this page, in the
11 second paragraph about midway through, you say that,
12 "We may be making a fundamental mistake in
13 approaching transgender phenomena, not as a disease
14 or disorder but as a dysphoria that is a cause for
15 affirmation."

16 So you believe that being transgender
17 should be treated as a disease or disorder?

18 A It was a disorder until most recently. And
19 I think that the transition to a dysphoria does not
20 serve the interest of the patient.

21 Q So you believe that the medical community
22 should return to a time when being a transgender
23 person was a mental health condition that was treated
24 only with psychotherapy?

25 MR. BEATO: Object to form.

1 Dr. Donovan, you can answer.

2 THE WITNESS: I think that it would be a
3 very appropriate thing to do to test that theory. It
4 hasn't been.

5 Q (By Ms. Dunn) So is it your opinion that
6 the most appropriate treatment for gender dysphoria
7 is psychotherapy with a goal of re-aligning a
8 person's gender identity with their sex assigned at
9 birth?

10 A That's not what I said, no. I said that
11 both of those approaches are essentially untested
12 hypotheses.

13 The purely psychiatric or psychological
14 approach has fallen into great disfavor and the
15 affirming approach is the predominant one with, in
16 many cases, a nod towards some psychological
17 discussions. But, in reality, that's not been used
18 as a exclusive approach, nor has it been tested
19 against gender-affirming therapy as it has now been
20 practiced.

21 Q What is -- what evidence do you rely on to
22 say that gender-affirming care is an untested
23 hypothesis?

24 A Well, I think that we've kind of covered
25 the fact that the long-term studies have been rather

1 deficient in testing the results of the therapy.

2 Q Is there a specific source in your report
3 that supports that the impacts of gender-affirming
4 treatment are unknown?

5 A Well, I didn't actually say they were
6 totally unknown. I said that what is known is
7 insufficient.

8 Q And what studies are you relying on to make
9 that assertion?

10 A Well --

11 MR. BEATO: Object to the form.

12 Dr. Donovan, you can answer the question.

13 THE WITNESS: Okay. I think that what
14 you -- what you have to understand is what I'm saying
15 is that there are -- there's an absence of studies.
16 You can't rely on studies that don't exist.

17 And in terms of good, scientifically
18 designed and carried out programs with sufficient
19 numbers of patients to actually test a theory, you
20 don't find those.

21 Q (By Ms. Dunn) But can you cite to any one
22 study that supports this assertion?

23 A You're asking about a study that supports
24 that there aren't studies?

25 Q No, a study that supports the fact that

1 there are unknown risks that are of such a concern
2 that this care should not be provided.

3 A I'm sorry, that doesn't completely compute.
4 Try that again, if you would be so kind.

5 Q Well, you're making the assertion that we
6 don't know enough about the impacts of this care in
7 order for it to be provided.

8 A Yes. And that would be by definition of
9 unknown risk. So you really can't have a study of
10 the unknown risks --

11 Q So there's no --

12 A -- because they haven't been able to
13 determine the risks.

14 Q But what evidence of these unknown risks
15 are you relying on in formulating your opinions about
16 whether the care should be provided?

17 A Ms. Dunn, there have been suggestions that
18 there could be risks that they've shown up in
19 individuals, but we don't know in how many
20 individuals or how long or how -- whatever. But that
21 is, by definition, an unknown risk.

22 And by definition, you can't know the
23 unknown risks until you have done the studies that
24 could reveal them.

25 Q So are you relying on anecdotal, you know,

1 examples of these risks?

2 I'm just trying to understand where the
3 information of these unknown risks that keep being
4 referenced -- I just want to -- I'm trying to figure
5 out where that information is coming from, where we
6 can look to to help understand that.

7 A You are actually giving a good definition
8 for the need to do careful, large, controlled studies
9 because that's how you find unknown risks. Nobody
10 will find an unknown risk without that. At least not
11 be able to document it in large numbers.

12 Has it been documented in individuals? Of
13 course. This is why people are calling for the
14 studies.

15 Q But there are always unknown risks in
16 providing medical care. I'm just trying to determine
17 what information you're relying on in saying that
18 this type of care is associated with such a risk that
19 it should not have been provided.

20 MR. BEATO: Object to form.

21 Dr. Donovan, you can answer.

22 THE WITNESS: Actually, I did say that if
23 you were going to provide this care, it should be
24 done in a controlled, experimental venue where you
25 were also comparing it to something else that might

1 be effective without the risks of surgery or hormones
2 or whatnot. That was actually my contention all
3 along.

4 Q (By Ms. Dunn) Have you reviewed any studies
5 that demonstrate that gender-affirming care is
6 both -- is safe?

7 A Safe for what?

8 Q That it's a safe method of medical
9 treatment.

10 A Well, I think this is what we've been
11 talking about.

12 First off, there's no medical treatment
13 that's completely safe. You know, that's just a
14 truism.

15 But if you're talking about, you know, do
16 we have the studies that demonstrate sufficient
17 safety to overcome concerns about, you know,
18 potential harms, that's exactly what I'm asking for.

19 Q Have you read any studies that demonstrate
20 that gender-affirming medical treatments are safe and
21 effective?

22 A Nothing that should be considered
23 definitive or reliable, no. That's why I think the
24 studies need to be done.

25 Q But there are no studies showing the safety

1 or efficacy of gender-affirming care that you find
2 credible to rely on?

3 A I don't think that they have been done
4 carefully in a large enough series of patients for a
5 long enough period of time and conducted in an
6 appropriate manner to be able to answer that
7 question.

8 Q And what are these studies that you're
9 referring to that are unreliable?

10 A I haven't found any that should fit the
11 reliability category that we're discussing here, in
12 terms of sufficient numbers, sufficient duration,
13 sufficient design.

14 You know, and it depends on which kind of
15 question you're trying to ask. So, I mean, are you
16 talking about their psychological benefits or their
17 physical harms or -- you know, basically we just
18 don't have enough to -- to rely on at this stage.

19 Q So I guess what I'm asking, though, is can
20 you name a single study that you have read that you
21 determined was not reliable?

22 These studies we're talking about that are
23 not sufficiently reliable, can you name a single one?

24 A I have read studies and I can't name any
25 that are reliable, so I certainly couldn't name the

1 ones that aren't.

2 Q Okay. I'm going to show you a document,
3 Dr. Donovan.

4 (Document is displayed).

5 Do you recognize this document?

6 A I actually don't recognize it, but it's got
7 my name on it, so I believe it.

8 Q So you don't recall sending this email?

9 A When was that done? May 12th? No, I sure
10 don't.

11 (Whereupon, Exhibit Number 30 was marked for
12 identification purposes and made a part of the
13 record.)

14 Q (By Ms. Dunn) I'm going to mark this as
15 Plaintiffs' Exhibit 30.

16 Do you recall that Devona Pickle and Jason
17 Weida and Andrew Sheeran were the individuals at the
18 Agency for Healthcare Administration that you worked
19 with?

20 A That sounds right.

21 Q Do you recall the draft of the report that
22 you were preparing that was attached to this email?

23 A No, definitely not.

24 Q I'm going to pull up a draft of your report
25 so we can see if it might be that one.

1 (Document is displayed).

2 Do you recall seeing this draft of your
3 report?

4 A No.

5 (Whereupon, Exhibit Number 31 was marked for
6 identification purposes and made a part of the
7 record.)

8 Q (By Ms. Dunn) Okay. So if we could mark
9 this as Plaintiffs' Exhibit 31.

10 I'm just going to scroll down to --

11 A Pardon me. Just to clarify, this is not
12 something I submitted finally; is that right?

13 Q I believe this was a draft. This wasn't
14 what was publicly released with the GAPMS memo, but
15 this is a draft of that same report, as far as I can
16 tell, that has some, you know, redline edits in it.
17 They're actually green or blue on this copy, but --

18 A Okay. I can't see any edits at all, but
19 I'll trust you.

20 Q So I'll just show you. So right here do
21 you see these redlines? Or they're not red, they
22 appear to be green.

23 But you don't recognize this?

24 A Not really, no.

25 Q Well, I'm just going to ask you about a

1 specific statement in this particular report.

2 So one difference between this report and
3 the report that we were just reviewing that was the
4 final report, that was publicly released with the
5 GAPMS -- during the GAPMS process is the sentence
6 that's bolded here.

7 It says, "It should be noted that none of
8 my observations and criticisms are based on any
9 so-called religious objections."

10 Why did you feel the need to include that
11 statement in this draft of the report?

12 A Probably hoping to skip the first two hours
13 of this deposition.

14 Q Is there a reason -- was anyone concerned
15 that your opinions would be viewed as based on
16 religious objections?

17 A Well, we did seem to spend an inordinate
18 amount of time talking about various religious
19 connections this morning. And I just wasn't -- they
20 were irrelevant to what I was writing, so I thought I
21 would put that in. But it didn't even show up in the
22 last one. Maybe they didn't want to tempt anyone
23 beyond their ability to resist.

24 Q Do you know why it was removed?

25 A I don't.

1 Q Do you know if anyone internal to AHCA, so
2 anyone at the agency, expressed concern that your
3 opinions might be considered to be religious?

4 A Oh, no, that didn't come from anybody else.
5 That was all me.

6 Q So today we've reviewed the sources you
7 relied upon in formulating your opinions in the
8 case; is that correct?

9 A Correct.

10 Q We've discussed that kind of ad nauseam.
11 And I'm going to pull up your bibliography
12 just one last time.

13 (Document is displayed).

14 Which of these articles are peer-reviewed
15 articles, journal articles that you relied on for
16 your -- your expert report?

17 A I will have to tell you that I did not rely
18 on exclusively peer-reviewed articles because
19 peer-reviewed articles are extremely difficult to
20 come by in -- on this topic unless you're in favor of
21 gender-affirming care. There is such a strong urge
22 towards supporting it that anything negative is very
23 difficult to get published.

24 Q Can you identify whether any of these
25 articles were -- are peer-reviewed journal articles?

1 A I think -- looks like the Clayton one and
2 the Levine one are. And the Abbruzzese one looks
3 like it is. And the DSM is not peer-reviewed, it's
4 just what it is.

5 Q Well, I'm sorry, so if we can just go a
6 little bit more slowly --

7 A I'm going from the bottom to the top.
8 Sorry.

9 Q That's okay. So Clayton we looked at, and
10 I'm happy to pull it up again, but that was a letter
11 to the editor.

12 A Oh, was it? Well, okay, that wouldn't have
13 been peer-reviewed. That would have been published
14 literature but not peer-reviewed.

15 So, basically, I think we have been through
16 them all. I don't have anything to change on that
17 then.

18 Q And you didn't cite to the DSM-5, in fact,
19 you cited to a Human Life International --

20 A Oh, okay.

21 Q -- article -- online article on gender
22 dysphoria in the DSM-5. Is that not correct?

23 A That looks right.

24 MS. DUNN: I am done with my questions on
25 direct. So at this point I'll turn it over to see if

1 your attorney has any questions for you. Or not your
2 attorney, I'm sorry, the defense attorney --
3 defendants' attorney.

4 MR. BEATO: Sure. And thank you for your
5 testimony, Dr. Donovan. I know it's been a long day,
6 but I just have four questions to ask you.

7 THE WITNESS: Okay.

8 CROSS-EXAMINATION

9 BY MR. BEATO:

10 Q So we established that you submitted a
11 report attached to the GAPMS report, correct?

12 A Correct.

13 Q Did AHCA, the defendant in this case, did
14 AHCA ask you to opine on treatments for gender
15 dysphoria as an experienced ethicist?

16 A Only as an ethicist.

17 Q Okay. We reviewed your report attached to
18 the GAPMS report. Do you today stand by the
19 conclusions that you made in your report?

20 A I do.

21 Q Dr. Donovan, do you think that treatment
22 for gender dysphoria is a controversial subject
23 matter?

24 A Yes.

25 Q And my question is, why wade into this

1 controversial subject matter?

2 A Why did I or why do others?

3 Q Why do you. Why do you specifically.

4 A Simply because my entire life has been in
5 serving the needs of children and being concerned
6 about the ethical aspects of those treatments, and I
7 thought that there were people reluctant to speak up
8 about this, so I felt somewhat obligated when asked.

9 MR. BEATO: No further questions.

10 MS. DUNN: May I just have one brief
11 second? I won't be long, I promise, and then I think
12 we'll be all done.

13 MR. BEATO: Absolutely.

14 (Recess taken from 5:02 p.m. to 5:04 p.m.)

15 MS. DUNN: Thank you for your time today,
16 Dr. Donovan. Plaintiffs are done with their
17 questioning as well.

18 THE WITNESS: Thank you, Ms. Dunn. I'm
19 happy to hear that you are done.

20 MR. BEATO: Okay. He will read.

21 Dr. Donovan, in reading you get to look
22 over the transcript, and if there's any changes you
23 want to make there's a sheet for them.

24 THE WITNESS: Fine.

25 MS. DUNN: Plaintiffs will order the

1 deposition transcript and we'd like it expedited,
2 please.

3 MR. BEATO: We would like the transcript,
4 too. Not expedited.

5 (Deposition adjourned at 5:05 p.m. CST)

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J U R A T P A G E

I, G. KEVIN DONOVAN, M.D., M.A., do hereby
state under oath that I have read the above and
foregoing videotaped deposition in its entirety and
that the same is a full, true and correct transcript
of my testimony so given at said time and place,
except for the corrections noted.

G. KEVIN DONOVAN, M.D., M.A.

Subscribed and sworn to before me, the
undersigned Notary Public in and for the State of
Oklahoma, by said witness _____, on this
the ____ day of _____, 2023.

Notary Public

My Commission Expires: _____

JH

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Jana C. Hazelbaker, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that G. KEVIN DONOVAN, M.D., M.A., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, in the case aforesaid; that the above and foregoing videoconference deposition was by me taken in shorthand and thereafter transcribed; that the same was taken on MARCH 22, 2023, located in SAND SPRINGS, Oklahoma; that I am not an attorney for nor relative of any of said parties or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 27th day of March, 2023.

<%8249,Signature%>

Jana C. Hazelbaker, CSR
State of Oklahoma CSR No. 1506

1 G. Kevin Donovan, M.D. c/o Michael Beato, Esq.
2 mbeato@holtzmanvogel.com

3
4 March 28th, 2023

5 RE: Dekker, August, Et Al. v. Weida, Jason, Et Al.

6 3/22/2023, G. Kevin Donovan, M.D., M.A. (#5815158)

7 The above-referenced transcript is available for
8 review.

9 Within the applicable timeframe, the witness should
10 read the testimony to verify its accuracy. If there are
11 any changes, the witness should note those with the
12 reason, on the attached Errata Sheet.

13 The witness should sign the Acknowledgment of
14 Deponent and Errata and return to the deposing attorney.
15 Copies should be sent to all counsel, and to Veritext at
16 transcripts-fl@veritext.com

17 Return completed errata within 30 days from
18 receipt of testimony.

19 If the witness fails to do so within the time
20 allotted, the transcript may be used as if signed.

21
22 Yours,

23 Veritext Legal Solutions
24
25

1 Dekker, August, Et Al. v. Weida, Jason, Et Al.

2 G. Kevin Donovan, M.D., M.A. (#5815158)

3 E R R A T A S H E E T

4 PAGE_____ LINE_____ CHANGE_____

5 _____

6 REASON_____

7 PAGE_____ LINE_____ CHANGE_____

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21 REASON_____

22 _____

23 _____

24 G. Kevin Donovan, M.D., M.A. Date

25 _____

1 Dekker, August, Et Al. v. Weida, Jason, Et Al.

2 G. Kevin Donovan, M.D., M.A. (#5815158)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, G. Kevin Donovan, M.D., M.A., do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 G. Kevin Donovan, M.D., M.A.

_____ Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
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18 _____
19 NOTARY PUBLIC
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[& - 23]

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[affirming - anybody]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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.

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