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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 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:
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24
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*Uh-uh is a negative response
*Uh-huh is a positive response

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D E P O S I T I O N

VIDEOGRAPHER: This is the video-recorded deposition of corporate representative for Agency for Healthcare Administration, in the matter of August Decker, et al. vs. 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 February 8th, 2023 and the time is 10:08 a.m. The court reporter is Dana Reeves. My name is RL Minnich. I'm the videographer. Would counsel please introduce themselves and the court reporter please swear in the witness?

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

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

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

MR. JAZIL: Mohammad Jazil for the defense.

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

MR. PERKO: And Gary Perko on behalf of the 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](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- Florida is spelled out --
23 [.com//Medicaid/prescribed_drug/pharm](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- P-H-A-R-M --
24 [_thera](https://AHCA.myflorida.com/Medicaid/prescribed_drug/pharm_thera/PDF/PDL.pdf) -- 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
14 _criteria.shtml](https://AHCA--A-H-C-A--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

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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.
gperko@holtzmanvogel.com

2
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

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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

DATE

25

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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.

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

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